Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Stewarts Care Adult Services Designated Centre 25
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Short Notice Announced
Date of inspection:	10 February 2021
Centre ID:	OSV-0005837
Fieldwork ID:	MON-0028030

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

This centre aims to support and empower people with an intellectual disability to live meaningful and fulfilling lives. The centre provides long term residential support to no more than nine people with complex support needs. The centre is a wheelchair accessible bungalow, each resident has a private bedroom, there is a large communal living room, dining room, family room, multi-sensory room and music room. Healthcare is provided by residents' General Practitioner along with allied healthcare professionals and the centre is staffed by both nursing staff, health care assistants and an activity staff member. The centre has a full time clinical nurse manager to supervise the staff team.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 10 February 2021	09:45hrs to 16:00hrs	Andrew Mooney	Lead

What residents told us and what inspectors observed

In response to residents' needs, the inspector did not meet with residents on the day of inspection. The inspector used a review of documentation, such as resident questionnaires and discussions with the person in charge to inform their judgements. Overall, the inspector found that residents felt safe in their home, they were content with the people they lived with and were very comfortable with staff.

A review of resident questionnaires and the annual review of quality and care noted that in general residents were very happy with the support they received from staff. Residents said that they felt safe in their home and that they liked having their own bedrooms. One resident questionnaire noted that the resident was "happy here " and "its a lovely place to live in".

However, a number of residents commented on how improvements within the premises would improve their quality of life. This included the completion of maintenance issues and an upgrade of a bathroom within the centre. One resident said " another shower room would be great, it would help to lesson the wait time in the mornings". These premises issues were compounded as the provider had planned to reduce the numbers within the centre, however, to date resident transitions had not progressed in line with the providers time lines.

At the time of inspection the provider had implemented all appropriate guidance in response to the COVID-19 pandemic. Unfortunately, this did limit residents access to community activities but was in keeping with current public health guidance. Furthermore, visitor access was limited to essential access only. The provider had contingency arrangements in place where, when appropriate and in line with public health guidance, visitors could meet residents in a safe manner.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

This inspection found that while residents were happy in their home the current governance and management arrangements required improvement. Overall the governance and management arrangements within the centre did not ensure that staffing levels were sufficient to ensure residents' assessed needs could be met at all times.

The inspector found that the centre was managed by a suitably qualified, skilled and experienced person. The person in charge was found to have a good knowledge of the care and support requirements for residents living in the centre and was in a full time post.

There was a management structure in place that identified the lines of accountability and responsibility. However, the governance arrangements in place were not robust and this meant that the lines of accountability and responsibility were not clear. For instance the provider had deployed staff from other parts of the campus to work in the centre at night, these staff did not report to the person in charge directly. This led to the person in charge not having full oversight of staff working within the centre at night. Furthermore, a review of the centres progress with their compliance improvement plan, which was linked to a restrictive condition of their registration, found that insufficient progress had been made with this plan. For example, the centres' compliance improvement plan had identified that resident numbers within the centre should reduce to eight by the end of 2019 and to seven by the end of 2020. These discharges had not occurred and there was no progress made on the initial transition plans. This demonstrated that while the provider could self identify areas of improvement, they did not have the capacity and capability to follow through on these plans in a timely manner.

It was unclear from a review of the staff rota if there was sufficient staff to meet the assessed needs of residents at all times. The person in charge outlined that the centre currently had one walking night care staff at night. However, the centre relied upon external staff resources each night to ensure residents assessed needs could be met. For instance a night nurse based on the campus was required to attend the centre to administer regular medication each night. Additionally, staff from the campus were required to attend the centre at different periods during the night to support residents with their personal care needs. The person in charge outlined that they did not have oversight of these staff and there was no formal structure in place within the designated centre to record what staff were present and when. Furthermore it was unclear if staff working in the centre at night had the required competencies to support residents who required nursing care. An immediate action was issued in relation to this and the provider gave assurances that measures had been put in place to ensure residents had access to nursing care at night. There was a planned and actual rota in place but it required improvement, as the current rota did not clearly identify the hours worked by each staff on duty in the centre.

Staff were provided with suitable training such as fire safety, manual handling, positive behaviour support infection control. There were some gaps in this training but the provider was aware of these gaps and had made arrangements to address them and ensured all mandatory training was provided. The provider had a staff supervision system in place and staff received appropriate supervision.

A review of accidents and incidents records within the centre, demonstrated that the person in charge had ensured all required incidents were notified to the Office of the Chief Inspector.

Regulation 14: Persons in charge

The centre was managed by a suitably skilled, qualified and experienced person in charge.

Judgment: Compliant

Regulation 15: Staffing

It was unclear if the current staffing arrangements were sufficient to meet the assessed needs of residents at all times. For example the centre relied on external staffing resources based on the campus for night time staffing.

It was unclear if nursing care was consistently available at night, in line with residents' assessment of needs. For example nursing staff were not noted consistently at night on the rota.

The rota required improvement to ensure it reflected all staff members that worked in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

The education and training available to staff enabled them to provide care that reflected up-to-date practice. Appropriate refresher training had been completed and/or was scheduled. Staff were supervised appropriate to their role.

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured that an annual review of quality and safety of care was completed. However, this review did not take account of the National Standards.

While the provider had ensured that an unannounced inspection of the centre was completed every six months, these inspections required improvement. They failed to adequately self-identify pertinent areas of non compliance, such as the lack of

progress being made with the centres plan to transition residents from the centre and to therefore reduce the overall numbers within the centre.

It was unclear if the centre was resourced sufficiently, for instance the current night time arrangements were insufficient to meet residents needs at all times.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had ensured that all appropriate notifications were notified to the Office of the Chief Inspector, in line with the regulations.

Judgment: Compliant

Quality and safety

Overall, this inspection found that the day to day practice within the centre ensured residents were safe. Arrangements were in place to ensure that residents were safeguarded during the pandemic. However, improvements were required in some systems to ensure residents emergency healthcare needs could be met. Furthermore, the provider had not ensured transitions form the centre were progressed in line with the centres transition plans.

Generally residents' healthcare needs were supported appropriately. Residents had good access to healthcare supports, such as a General Practitioner (GP) of their choice and access to a variety of multi-disciplinary supports such as dietitians, occupational therapists and speech and language therapy. However, residents' emergency healthcare needs could not always be met, as they were not consistently supported with appropriately trained staff. For instance residents who may require emergency medicines relating to their assessed healthcare needs were accompanied in the community without suitably qualified staff. They therefore could not be administered this medicine in accordance with their agreed healthcare plans.

As outlined in the capacity and capability paragraph, the centres' compliance improvement plan had identified that resident numbers within the centre should reduce to eight by the end of 2019 and to seven by the end of 2020. These discharges had not occurred and there was no clear progress made on these initial transition plans. A review of two resident transition plans noted that these plans had been commended in March 2018. However, it was unclear what measures had been taken since then to progress these transitions or if barriers to these transitions had been encountered, there was no clear plan in place to address over come them.

There were arrangements in place to ensure that each resident had a comprehensive assessment of need and a personal plan in place that detailed their needs and outlined the supports required to maximise their personal development and quality of life.Appropriate supports were in place to support and respond to residents' assessed support needs. This included the on-going review of behaviour support plans. Restrictive procedures were implemented when assessed as required. This included the use of mechanical and environmental restrictions. These restrictions were implemented in line with the providers policy on restrictive practices. Documentation reviewed demonstrated that there had been a considerable reduction in the use of restrictions within the centre. There was a clear emphasis that when restrictions were required, they should be the least restrictive option and only used for the shortest duration possible.

The provider had systems in place to safeguard residents from all forms of potential abuse. All incidents, allegations and suspicions of abuse at the centre were investigated in accordance with the centre's policy. Staff had a good understanding of safeguarding processes and this limited the impact of potential safeguarding incidents.

There were clear arrangements in place to protect residents and staff from acquiring or transmitting COVID-19. There were procedures in place for the prevention and control of infection. Suitable cleaning equipment was in place and stored appropriately. Sufficient facilities for hand hygiene were observed and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. The provider had developed an appropriate COVID-19 contingency plan, which included adopting relevant public health guidance, such as daily staff temperature checks, individual isolation plans if residents developed symptoms and staffing contingency plans. The provider engaged regularly with the Department of Public Health and made key information in relation to infection control measures available to staff.

The centre had a risk management policy in place for the assessment, management and ongoing review of risk. This included a location-specific risk register and individual risk assessments which ensured risk control measures were relative to the risk identified. The person in charge and provider had ensured that pertinent risks were placed on the register and were reviewed regularly. This included risk assessing the potential impact of residents and staff acquiring COVID-19, how to support residents to safely use their community and receive visits, when public health advice permitted this.

The provider had ensured that there were fire safety measures in place, including detection and alarm system, fire fighting equipment and containment measures. There were personal evacuation plans in place for all residents and staff understood what to do in the event of a fire. Regular fire drills were conducted within the centre. However, these drills required improvement as they did not demonstrate that the centre could be safely evacuated when the maximum number of residents were on site and the minimum number of staff on the rota were available.

Regulation 25: Temporary absence, transition and discharge of residents

Discharges from the centre had not been implemented in line with the centres compliance improvement plan. For example the centres' compliance improvement plan had identified that resident numbers within the centre should reduce to eight by the end of 2019 and to seven by the end of 2020.

Judgment: Not compliant

Regulation 26: Risk management procedures

Arrangements were in place to ensure risk control measures were relative to the risk identified.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had introduced a range of measures to protect residents and staff from acquiring COVID-19. These arrangements included excellent infection control procedures, the use of appropriate PPE (Personal Protective Equipment), social distancing, good hand washing facilities, hand sanitising facilities, clinical waste arrangements and laundry facilities.

Judgment: Compliant

Regulation 28: Fire precautions

There were appropriate systems in place for the prevention and detection of fire and all staff had received suitable training in fire prevention and emergency procedures.

Regular fire drills were taking place, however they required some improvement as they were not reflective of all possible fire scenarios. For example, these drills did not demonstrate that the centre could be safely evacuated when the maximum number of residents were on site and the minimum number of staff on the rota were available.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was a comprehensive assessment of need used that was used to inform an associated plan of care for residents and this was recorded as the residents' personal plans.

Judgment: Compliant

Regulation 6: Health care

Residents' emergency healthcare needs could not always be met, as they were not consistently supported with appropriately trained staff. For instance residents who may require emergency medicines relating to their assessed healthcare needs were accompanied in the community without suitably qualified staff. They therefore could not be administered this medicine in accordance with agreed their healthcare plans.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Appropriate supports were in place for residents with behaviours that challenge or residents who were at risk from their own behaviour. Where restrictive procedures were implemented, they were applied in accordance with the providers policy.

Judgment: Compliant

Regulation 8: Protection

The person in charge initiated and carried out an investigation in relation to any incident, allegation or suspicion of abuse and took appropriate action where a resident was harmed or suffered abuse.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 25 OSV-0005837

Inspection ID: MON-0028030

Date of inspection: 10/02/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1.From the date of the inspection a registered nurse was immediately assigned to work within the DC each night to provide nursing care to the residents in line with their assessed needs 2.This nurse will be replaced in May 2021 with an appropriately trained care staff for administration of emergency medicines if required for the residents assessed healthcare needs. 3.The TMS rostering team have being consulted by the programme manager to work with the Night manager to ensure all staff have been reallocated on the Electronic rostering system to ensure the Person in Charge can accurately complete the roster for the DC.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1The Annual Review of Care has been revised and is amended to take into account the National standards, commencing with the 2020 review. 2.The Service Provider Audit has being revised to capture the progress on Transitions within the DC. 3.The night time staffing level has been increased with the redeployment of a registered nurse to the DC each night. 4. The Programme Manager has put in place a schedule of monthly meetings for 2021	

with the Person in Charge, where all relevant issues in relation to the Governance of the Designated Centre will be reviewed.
5. The Programme Manager will collate a governance report for the Care Management Team on a monthly basis in 2021 where issues relating to the Designated Centre are discussed.

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
1. A transitions team has been formed, chaired by the Director of Nursing to review and action the Providers plans for decongregation.This team meet fortnightly.
2. The commitment remains that there will be no more than 6 residents living in the DC by the December 2021.
3. The Programme manager and the PIC will review the compatibility of the residents and identify the most appropriate persons to transition from the DC in line with their identified needs and wishes by 30th April 2021.
4 The team will commence the discovery process and transition planning immediately.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. A fire drill will be completed with the maximum number of residents and the minimum number of staff at night on the 30/03/2021
2.Any identified actions from this fire drill will be responded too by the Person in Charge

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1.All staff working within the DC will be trained in the administration of emergency rescue medication by 27.04.21.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	10/02/2021
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Red	10/02/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the	Substantially Compliant	Yellow	30/04/2021

	day and night and that it is properly maintained.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	10/02/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	17/02/2021
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	31/03/2021
Regulation 25(3)(a)	The person in charge shall ensure that residents receive support as they transition between residential services or leave residential	Not Compliant	Orange	30/12/2021

	services through:the provision of information on the services and supports available.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/03/2021
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	27/04/2021