



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 23
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Announced
Date of inspection:	11 January 2022
Centre ID:	OSV-0005843
Fieldwork ID:	MON-0027126

About the designated centre

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

Designated centre 23 is intended to provide long stay residential support for service users to no more than seven men with complex support needs. This centre is a wheelchair accessible bungalow, which offers residents their own individual bedrooms, kitchen, a communal living room, sun room-dining room, relaxation room and open access to a secure back garden. The centre is staffed with nurses, healthcare assistants and activity staff under the management of a person in charge. Healthcare is supported by medical doctors, a clinical team and nursing care is available within the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:

4

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 (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
Tuesday 11 January 2022	10:30hrs to 17:00hrs	Ann-Marie O'Neill	Lead

What residents told us and what inspectors observed

This report outlines the finding of an announced inspection of this designated centre. This inspection was carried out on foot of the provider's application to renew registration of this designated centre.

The inspector ensured physical distancing measures were implemented as much as possible with residents and staff during the course of the inspection and also wore personal protective equipment (PPE). The inspector greeted all residents that were present during the course of the inspection. At all times, the inspector also respected residents' choice to engage with them or not during the course of the inspection.

During the inspection, the inspector met briefly with all four residents present in the centre. At the time of the inspection, there were two vacancies.

Residents living in the centre did not use verbal language communication to express their needs or wishes. The inspector was therefore unable to seek verbal feedback about the service provided to them.

A number of written feedback questionnaires had been completed by staff on behalf of residents. The inspector reviewed these questionnaires and noted they had provided positive feedback. While staff had made a concerted effort to communicate residents' feedback on the service they received, the inspector noted the feedback process could be further enhanced through the utilisation of independent advocates for each resident. This enhanced process would support staff and the provider in understanding where they could improve their service while also identifying areas where service provision was meeting residents' needs well.

The inspector also reviewed additional feedback questionnaires that residents' families had completed. These were positive and documented complementary feedback with regards to the care and support their loved one received from staff in the centre.

The inspector carried out some observations of residents during the course of the inspection. Overall, it was demonstrated staff were kind and pleasant towards residents. They spoke nicely to residents and were observed reading to them, providing hand massages and sitting near them at times to chat or engage with them. Residents living in this centre required sensory supports and could engage in self-injurious behaviours from time-to-time.

The provider had ensured residents were provided with a sensory room space in their home which was equipped with sensory lights, music, a weighted blanket and soft furnishing options for residents to use. In addition, a space in one living room area had been set out with soft mats where some residents could choose to lie down on during the day or during a time when they required additional supports to

manage their self-injurious behaviours.

These were good provisions for residents and demonstrated a recognition and understanding by staff, and the provider, that residents living in the centre required such supports. Some additional improvement in this regard was noted by the inspector during the course of the inspection and is further outlined in the Quality and Safety section of this report.

Residents living in this centre required modified diets and additional mealtime supports from staff. The inspector observed a number of small dining tables and chairs were located in the communal spaces in the centre. The person in charge described how these tables and chairs had been placed to ensure staff and residents had adequate space during mealtimes. Each table was nicely laid with a pleasant table coverings.

The inspector observed staff supporting residents having an evening meal and observed each resident was supported by one staff member while having their dinner. The atmosphere was pleasant and not rushed. The location and provision of dining tables, the space provided and the one-to-one support, ensured residents were being provided with a pleasant mealtime experience.

Overall, the inspector observed the premises was clean and homely in a number of areas. Residents were provided with overhead tracking hoists in a number of bedrooms and one accessible bathroom area. The centre was well lit and there were provisions for monitoring the temperature of the rooms in the centre to ensure the environment was comfortable for residents.

On a previous inspection of this centre, in March 2021, it was noted premises upgrades were required in this centre.

On this inspection, the inspector observed that the provider had undertaken to address some of these issues by repainting a number of areas throughout the home. New fitted kitchen units had been installed and residents' bedrooms and other areas in the centre nicely decorated and furnished. For example, sofas and soft furnishings had been replaced in the living room area. These were modern furniture pieces which were wipeable and could provide enhanced infection control standards while also appearing modern and homely.

However, some premises enhancement works, identified on the last inspection, had not been fully addressed. Two of the three bathrooms still required renovation.

In one area the bath was no longer operational and this space was used as a storage area. A second bathroom provided a large shower space with a shower trolley and two separate toilet cubicles. Each toilet was located on a tiled platform area which required residents to step up onto in order to use toilet. The doors the the toilets could provide privacy, but had a gap between the bottom of the door and the floor.

While these facilities were functional and clean, they appeared institutional in design

and aesthetic and took away from the homely feel of the centre.

The inspector also observed some other areas where premises improvements were required. There were noticeable areas where paint was bubbling and cracking on one wall in the living room space. Door frames were heavily scuffed and marked and while repainting work had occurred there remained some areas that required painting.

The inspector discussed these matters with the person in charge who outlined that the provider had carried out a technical services environmental review of the centre and had identified a suite of works required. There was a plan in place to address these outstanding premises improvements later in the year. It was also noted the provider was carrying out a suite of premises upgrades across their organisation and this centre had been identified as part of this organisational premises improvement plan for 2022.

Overall, it was demonstrated residents were receiving a good service. The provider had carried out a suite of provider-led audits to monitor and oversee the care and support for residents in this centre and had self-identified areas where improvements were required. This provided an assurance that the provider was knowledgeable of the areas where improvements were required. For example, the provider had identified the requirement for enhanced fire containment measures in the centre and on the day of inspection a new fire rated door was being fitted to the utility room space.

The inspector did identify areas where additional fire safety enhancements were required in relation to the fire alarm panel to ensure it was fully addressable so staff could accurately identify the location of a fire in the centre, for example.

While some residents presented with sensory based behaviours, it was not demonstrated they had received a sensory assessment which would provide staff with specific knowledge which could in turn enhance behaviour support arrangements and planning.

Some improvements were required to the premises however, as discussed the provider did have a plan in place to address this and had put in place a plan to implement these improvements later in the year. While premises improvements were required it was not demonstrated that residents privacy or dignity or intimate care needs were being adversely impacted on, for example.

In summary, residents living in this designated centre were experiencing a good quality service with some areas that required improvement. It was demonstrated that the provider had considerably enhanced their quality oversight and review mechanisms for the service which in turn had resulted in provider-led plans to improve the service for residents going forward resulting in an assurance that quality improvements would be ongoing for the next registration cycle.

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 to each resident living in the centre.

Capacity and capability

Overall, it was demonstrated the provider had enhanced their capacity and capability since the previous inspection which in turn was ensuring a better service provision for residents.

The provider had considerably enhanced the governance and oversight arrangements for the centre by introducing a suite of quality focused auditing in key compliance and risk areas. These in turn had resulted in the provider taking action to address areas where risk was identified and put plans in place to enhance the service quality provision going forward.

For example, the provider had completed an annual report for the service for the previous year. Six- monthly provider led audits, as required by the regulations had also been completed and were comprehensive in scope and reviewed key areas of compliance with the regulations.

Additional quality focused audits had been carried out by key stakeholders of the provider in areas of fire safety, infection control, safeguarding and risk management. A compliance tracker, which incorporated all actions identified across these audits had been compiled and at the time of the inspection the person in charge and provider were working to address any actions identified.

The inspector observed examples of this during the course of the inspection. The provider had self-identified areas of the premises that required upgrade. A premises improvement and upgrade schedule had been put in place for the organisation and this designated centre had been identified on the plan for upgrade.

The inspector also noted that a fire door was being installed in the utility space of the centre on the day of inspection. This containment requirement had been identified through a recent audit of the centre by the provider's fire safety officer and demonstrated actions were being taken where risks were identified. New wipeable sofas had been put in place to enhance infection control measures on foot of a recent infection control audit of the centre.

There was a statement of purpose in place that described the model of care and support delivered to residents in the centre. It contained all the information set out in the Regulations.

Some revisions to the statement of purpose were required to ensure the conditions of registration were accurately set out and the whole-time-equivalent hours of the person in charge were identified. The provider undertook to address these actions shortly after the inspection and therefore, Regulation 3 was met with compliance.

There was a suitably qualified and experienced person in charge who demonstrated that they could lead a quality service. There were clearly defined management structures which identified the lines of authority and accountability within the centre. The person in charge carried out operational management audits for the centre in the areas of residents' finances and medication management, for example.

Previously, there had been a regulatory not compliant finding in relation to staffing. On this inspection it was noted that the staffing arrangements were suitable to meet the needs of residents. As discussed, the centre was operating with two resident vacancies at the time of inspection. The staffing whole-time-equivalent numbers were suitable to meet the resident numbers and assessed needs as observed on inspection. There were however, adequate staffing number provisions in place for when there were an increase in resident numbers again in the centre. Ongoing staff recruitment drives were being implemented by the provider, however there was an ongoing challenge in recruitment which was reflective of a wider National issue in staff recruitment in social care services.

Staff rosters had been revised and improved since the previous inspection and now clearly identified the full name of staff, the hours they worked and their role. This enhanced the oversight of skill-mix arrangements in the centre. There was a planned and actual roster also maintained. Staffing arrangements could be flexible and increased should there be a change of resident need, for example.

Staff were provided with suitable training such as fire safety, safeguarding vulnerable adults, manual handling, management of potential and actual aggression, and infection control. Refresher training arrangements were also in place and it was demonstrated all staff had received refresher training in these areas.

The provider had also undertaken to enhance the skills of staff working in the centre by introducing training in the administration of emergency rescue medication for the management of seizures. This ensured there were enhanced first response measures in the centre for residents during the day and at night time. This skills improvement initiative was ongoing.

The provider had a staff supervision system in place and staff were appropriately supervised. The centre utilised individual staff supervision to reflect on staff practice and this enabled staff to support residents safely with their assessed needs. Staff team meetings were held every month with the person in charge and minutes of these meetings were maintained. Key areas of practice improvement and quality were discussed during these meetings and specific themes were also incorporated, for example, safeguarding had been a theme across the most recent team meetings in the centre.

As discussed there were two resident vacancies in the centre at the time of inspection. The inspector discussed potential admissions to the centre with the person in charge. They outlined that a resident had been identified to transition to the centre.

The inspector reviewed the transition planning arrangements and noted they were comprehensive and had ensured a full assessment review had taken place to ensure

the centre was suited to meet the assessed needs of the potential new admission. The person in charge had also completed a compatibility assessment which had determined that the new admission would be compatible with their peers. The potential new resident had also visited the centre and had been supported to pick the colour paint they wanted for their bedroom and would be supported to bring their personal effects with them on admission. They had also been consulted and asked if they were happy to transition and they and their family had agreed to the process.

Contracts of care for residents in the centre had been updated and enhanced to ensure a comprehensive outline of the services and supports they received were in place. The fees they were required to pay were outlined. Each contract had been signed by a representative of the resident and dated.

Registration Regulation 5: Application for registration or renewal of registration

The provider was required to submit a revised floor plan of the centre to ensure it provided an accurate colour coding outline for the bedrooms and non-bedroom spaces in the centre and to ensure each room was labelled with an accurate description of its function.

The provider was required to submit a new floor plan declaration following the review of the floor plan as set out above.

The provider was required to submit the revised statement of purpose for the centre ensuring it accurately outlined:

- Conditions of registration as set out in the registration certificate for the centre.
- Whole-time-equivalent working arrangements for the person in charge to demonstrate they worked in a full-time capacity with a remit for two designated centres.
- Correct and revised floor plan for the centre entered onto the statement of purpose.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge for the centre.

They were found to meet the requirements of Regulation 14 in relation to management experience and qualifications.

The person in charge was responsible for two designated centres, both centres were located within walking distance from each other on the congregated campus setting.

Each centre comprised of one bungalow each which ensured an overall, reasonable regulatory and management oversight remit for the person in charge.

Judgment: Compliant

Regulation 15: Staffing

Revised planned and actual rosters were in place. These clearly outlined the full name of staff, staff working shift and role.

On review of staffing rosters it was demonstrated the staffing levels and skill-mix were maintained to the levels as set out in the whole-time-equivalent numbers of the statement of purpose.

The working roster for the person in charge was also maintained and demonstrated the shifts and hours they worked each week.

Schedule 2 staff files were not reviewed on this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided with suitable training such as fire safety, safeguarding vulnerable adults, manual handling, management of potential and actual aggression, and infection control. Refresher training arrangements were also in place and it was demonstrated all staff had received refresher training in these areas.

The provider had also undertaken to enhance the skills of staff working in the centre by introducing training in the administration of emergency rescue medication for the management of seizures. This ensured there were enhanced first response measures in the centre for residents during the day and at night time. This skills improvement initiative was ongoing.

The provider had a staff supervision system in place and staff were appropriately supervised.

Staff team meetings were held every month with the person in charge and minutes of these meetings were maintained. Key areas of practice improvement and quality were discussed during these meetings and specific themes were also incorporated, for example, safeguarding had been a theme across the most recent team meetings

in the centre.

Judgment: Compliant

Regulation 23: Governance and management

The provider had submitted a full and complete application to renew registration.

The provider had completed an annual report for the previous year that met the requirements of Regulation 23.

The provider had completed required six-monthly provider-led audits for the centre. These audits were comprehensive and provided an action plan to improve compliance in the centre.

The provider had also instated additional quality oversight auditing in the centre by ensuring audits and quality reviews were carried out by key qualified provider stakeholders in specific areas.

For example, quality and risk audits had been completed in the area of infection control, risk management, safeguarding and fire safety. In addition, the provider's technical services team had also reviewed the environment and premises and identified areas that required improvement.

The provider had begun to implement actions identified through their enhanced auditing framework.

The provider had appointed a full-time person in charge for the centre that met the requirements of Regulation 14.

The provider had ensured there were clear lines of responsibility and reporting for the management oversight of the centre.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Each resident had been provided with a contract of care that set out the terms and conditions of the resident's service provision.

Each contract clearly set out the services that they were entitled to receive and the fees and services that they may be required to pay and were not part of the service agreement.

Each contract had been signed by a representative of the resident and dated.

Good transition planning arrangements were in place to ensure compatibility was assessed prior to a resident's admission. Residents identified to transition into the centre had been provided with an opportunity to visit the centre, chose their new bedroom and decorate it within their will and preference.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had created a statement of purpose that met the requirements of Schedule 1.

Judgment: Compliant

Quality and safety

This inspection found that residents were in receipt of a service that was person-centred and for the most part, meeting their social and health care needs within the context of COVID-19. Improvements were required in the area of premises, positive behaviour supports and fire safety arrangements.

As discussed earlier in the report there were some premises upgrade works required to this centre to ensure it was maintained in the most optimum standard and could provide residents with a homely environment throughout.

Premises upgrade works were required to the toilet and bathing facilities of the centre to ensure they presented as not only functional but were homely in design and aesthetic. Other aspects of the centre required repainting, door frames were marked and scuffed in areas and there was noticeable paint bubbling and cracking on one wall in the living room space of the centre.

The provider had self-identified the requirement for refurbishments to take place in this centre and had carried out a full environmental premises review. Improvement works were due to commence later in the year.

There was a schedule of maintenance in place for fire safety equipment. The inspector reviewed servicing check records noted they were up-to-date. Staff had received training in fire safety management with refresher training available and provided as required. The centre had also undergone a fire safety audit by a stakeholder of the provider with a remit in fire safety.

Containment measures were in place in the centre and overall were to a good standard. Some fire containment enhancements were underway on the day of inspection and a fire rated door was being fitted to the utility room which having been identified as required through the provider's own fire safety audits. Fire doors that were in place were fitted with door closers and smoke seals.

Recorded fire drills had been carried out during and were maintained in the fire register for the centre. Each resident had a documented personal evacuation plan which was in date maintained.

The inspector reviewed the fire alarm panel for the centre. It was located behind a fire rated door in a small storage room. The location of the panel required some review as it was not readily accessible for staff in location that formed part of the evacuation route of the centre and required staff to enter another room to review in the event of the alarm sounding. In addition to this, it was not demonstrated the alarm was fully addressable as is required to ensure staff could locate the exact location of a fire in the centre.

On the alarm panel the inspector noted it had two zones, one zone was linked to the gas mains and the other zone correlated to the bungalow itself. This meant, while staff would know from looking at the panel that there was a fire located in the centre, it could not tell staff the location where the alarm had been sounded from.

On discussion of this matter with the person in charge and review of fire safety procedures, it was noted that staff would need to search the entire premises to establish the source of fire or smoke on the activation of the alarm. This required improvement to ensure effective systems were in place for supporting staff in locating the source of fire and smoke in order to evacuate residents to an exit furthest away, for example.

The inspector reviewed infection control management in the centre and noted good contingency planning was in place. Alcohol hand gels were maintained at key areas, resident and staff temperature checks were taken and recorded daily. Daily cleaning checklists were maintained and updated each day. The premises across all residential houses were maintained to a good standard of hygiene. Personal protective equipment (PPE) was available for staff and staff were observed wearing face coverings during the course of the inspection which were in line with recent changes to public health guidance.

The provider had ensured a comprehensive infection control audit in each residential house had been completed by a clinical nurse specialist in Infection Control. This audit had not only reviewed matters relating to COVID-19 but had also reviewed other areas related to standard infection control precautions. This audit identified where good infection control standard precautions were being implemented and where improvement actions were required. For example, some soft furnishings in the centre had been changed on foot of the audit to ensure surfaces were wipeable and could be maintained in a clean condition.

A centre based cleaning staff member was also utilised in the centre. The inspector observed their cleaning routine during the course of the inspection and noted

throughout the centre was kept to a good standard of cleanliness throughout. Cleaning liquids were available in the centre and residents' laundry and towels were stored separately to prevent cross contamination. Residents also had access to location based laundry facilities in the utility room space. This space provided adequate facilities for sluicing of dirty laundry if required and space for folding and segregating laundry. Alginate bags were provided and used in the centre as part of the overall laundry infection control arrangements in the centre.

Residents' healthcare needs were assessed and planned for. Residents' healthcare information was kept up to date and there was a plan in place for their assessed healthcare needs. Residents had access to their own general practitioner (GP) and had received an annual health check. Residents had also been supported to attend out patient clinics and reviews by relevant healthcare physicians. Appointments and follow up tests had been arranged for residents and they had been supported to attend these.

Residents were also supported to avail of National Screening programmes and there was evidence to demonstrate they had received relevant tests and screening in this regard.

End-of-life care and support arrangements were in place. Each residents' will and preference for their end-of-life had been discussed with their family and a written record was maintained in their personal plan. These plans were kept under review and updated as required by the person in charge. The person in charge also had created good links with palliative care support services in the wider community and had found these to be very supportive and efficient during periods where some residents had required end-of-life care in the preceding year.

Residents living in the centre presented with behaviours that challenge that could present in personal risk behaviours of self-injurious behaviour and episodes of smearing. Each resident had received a review of their behaviour supports in the previous year and behaviour support planning arrangements were in place. Overall, it was noted there was a limited number of restrictive practices used in the centre with bedrails and bed bumpers in place for some residents as required.

As part of some residents behaviour support and mental health interventions, they were prescribed PRN (as required) medications for periods of extreme distress. The criteria for administration of these medications were set out in residents' behaviour support plans and also as part of their overall mental health care intervention planning.

While there were appropriate behaviour support planning arrangements in place, it was noted some of the personal risk behaviours engaged in by residents could have a sensory function. The inspector noted some behaviour support recommendations had identified the requirement for residents to under go a sensory assessment. However, it was not demonstrated such assessments had been carried out. The inspector noted for example, a referral had been made in 2020 for one resident to receive a sensory assessment.

However, at the time of inspection this assessment had not been completed. This

required improvement to ensure residents with sensory based behavioural presentations were in receipt of sensory based activities, interventions and supports that met their assessed needs.

Medication systems were well managed in the centre. Medication was securely stored in the centre. Each resident had their own individual supply of medications which were provided by residents' community based pharmacy. Medications were clearly labelled and open dates were documented on all liquid and cream medications. A medication storage fridge was also provided in the centre and daily temperature checks were recorded. Medication administration charts were legible and clearly recorded.

Appropriately trained staff administered medications in the centre only. Medications that required crushing were clearly documented on medication administration charts and suitable facilities for crushing medications were available in the centre. Suitable systems were also in place for returning out-of-date medications to the pharmacy, records were maintained when such medications were returned.

Regulation 17: Premises

Some premises upgrade works required to this centre to ensure it was maintained in the most optimum standard and could provide residents with a homely environment throughout.

Premises upgrade works were required to the toilet and bathing facilities of the centre to ensure they presented as not only functional but were homely in design and aesthetic.

Other aspects of the centre required repainting, door frames were marked and scuffed in areas and there was noticeable paint bubbling and cracking on one wall in the living room space of the centre.

A bath in the centre was not functional and could not be used by residents.

The provider had self-identified the requirement for refurbishments to take place in this centre and had carried out a full environmental premises review. Improvement works were due to commence later in the year.

Judgment: Substantially compliant

Regulation 27: Protection against infection

It was noted good COVID-19 outbreak contingency planning was in place.

Alcohol hand gels were maintained at key areas, resident and staff temperature checks were taken and recorded daily. Daily cleaning checklists were maintained and updated each day.

Personal protective equipment (PPE) was available for staff and staff were observed wearing face coverings during the course of the inspection which were in line with recent changes to public health guidance.

The provider had ensured a comprehensive infection control audit in each residential house had been completed by a clinical nurse specialist in Infection Control for each residential home that made up the centre. This audit had not only reviewed matters relating to COVID-19 but had also reviewed other areas related to standard infection control precautions.

There were good laundry infection control facilities available in the centre. There were provisions for segregating dirty laundry, alginate bags were provided and used as part of overall laundry management in the centre and utility facilities provided space for staff to sluice and segregate linen and residents' clothes in a manner that supported good infection control systems

Judgment: Compliant

Regulation 28: Fire precautions

There was a schedule of maintenance in place for fire safety equipment.

Fire equipment servicing records were up-to-date.

Staff had received training in fire safety management with refresher training available and provided as required. The centre had also undergone a fire safety audit by a stakeholder of the provider with a remit in fire safety.

Containment measures were in place in the centre and overall were to a good standard. Some fire containment enhancements were underway on the day of inspection and a fire rated door was being fitted to the utility room. Fire doors that were in place were fitted with door closers and smoke seals.

Recorded fire drills had been carried out during and were maintained in the fire register for the centre. Each resident had a documented personal evacuation plan which was in date maintained.

The fire alarm panel for the centre was located behind a fire rated door in a small storage room. The location of the panel required review as it was not readily accessible for staff in a location that formed part of the evacuation route of the centre and required staff to enter another room to review in the event of the alarm sounding.

It was not demonstrated the fire alarm was fully addressable.

The fire alarm panel had two zones, one zone was linked to the gas mains and the other zone correlated to the bungalow itself. This meant, while staff would know from looking at the panel that there was a fire located in the centre, it could not tell staff the location where the alarm had been sounded from.

On discussion of this matter with the person in charge and review of fire safety procedures, it was noted that staff would need to search the entire premises to establish the source of fire or smoke on the activation of the alarm.

This required improvement to ensure effective systems were in place for supporting staff in locating the source of fire and smoke in order to evacuate residents to an exit furthest away, for example.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medication systems were well managed in the centre.

Medication was securely stored in the centre. Each resident had their own individual supply of medications which were provided by residents' community based pharmacy.

Medications were clearly labelled and open dates were documented on all liquid and cream medications. A medication storage fridge was also provided in the centre and daily temperature checks were recorded.

Medication administration charts were legible and clearly recorded.

Appropriately trained staff administered medications in the centre only.

Medications that required crushing were clearly documented on medication administration charts and suitable facilities for crushing medications were available in the centre.

Suitable systems were also in place for returning out-of-date medications to the pharmacy, records were maintained when such medications were returned

Judgment: Compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP) and a multidisciplinary team which consisted of a psychiatrist, psychologists, occupational therapist, physiotherapist, speech and language therapist, clinical nurse specialist in behaviour, social workers and dietitians.

Residents were supported to avail of National Screening programmes if required and with due regard to their wishes.

Each resident had received an annual health care check with their General Practitioner.

Residents' end-of-life care needs were reviewed and updated regularly. The person in charge had ensured good links with community based palliative care teams.

Judgment: Compliant

Regulation 7: Positive behavioural support

As part of some residents behaviour support and mental health interventions, they were prescribed PRN (as required) medications for periods of extreme distress. The criteria for administration of these medications were set out in residents' behaviour support plans and also as part of their overall mental health care intervention planning.

While there were appropriate behaviour support planning arrangements in place, it was noted some of the personal risk behaviours engaged in by residents could have a sensory function.

Some behaviour support recommendations had identified the requirement for residents to under go a sensory assessment. However, it was not demonstrated such assessments had been carried out.

The inspector noted for example, a referral had been made in 2020 for one resident to receive a sensory assessment. However, at the time of inspection this assessment had not been completed.

This required improvement to ensure residents with sensory based behavioural presentations were in receipt of sensory based activities, interventions and supports that met their assessed needs.

While staff had received training in managing actual and potential aggression, it was not demonstrated all staff had received training in positive behaviour support and de-escalation strategies.

Judgment: Substantially 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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 23 OSV-0005843

Inspection ID: MON-0027126

Date of inspection: 11/01/2022

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
Registration Regulation 5: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: 07/02/2022: <ul style="list-style-type: none">• Revised floor plan with an accurate colour coding outline for bedrooms and non-bedroom spaces in the centre was correctly entered onto the statement of purpose and submitted to the inspector on the 14/01/2022• Condition of registration as set out in the registration certificate was also revised to demonstrate PIC worked in a full-time capacity with a remit for two designated centres.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 07/02/2022 <ul style="list-style-type: none">• A full environmental premises review has been completed. The areas requiring refurbishment have been identified. The improvement works are due to commence later in the month with painters being scheduled and tasked to do the required jobs.• The bath in the centre was not functional has been identified for removal.	

Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions: 07/02/2022</p> <ul style="list-style-type: none"> • The fire alarm panel and system is due for upgrading. • The Provider Nominee issued a letter to HIQA on the 31st January 2022. • Following audits in Q4 of 2021 and following consultation with the provider nominee the organisation is pursuing a plan to upgrade the fire detection and alarm systems. • Each new system shall be constructed and installed to the addressable L1 Standard. • The plan will be undertaken in six steps, appointment of specialist consultants, design phase, tender, and commencement of works, commissioning and completion of works. • These works are resource dependent. 	
Regulation 7: Positive behavioural support	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: 07/02/2022</p> <ul style="list-style-type: none"> • Training in Positive Behaviour Support and de-escalation strategies was scheduled for the 18th and 19th of January. The training needed to be cancelled and has been rescheduled with a new date to be issued at the end of the month. The PIC is monitoring compliance and supporting staff through the supervision process as the need arises. • Sensory screening clinic was completed on the 03/02/2022. The residents in question will have full sensory diets as required, supported by the relevant clinicians. 	

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Substantially Compliant	Yellow	31/03/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/08/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and	Substantially Compliant	Yellow	31/08/2022

	suitably decorated.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/12/2022
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	31/07/2022
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	31/05/2022