Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Stewarts Adult Respite Home Centre 14
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	11 November 2021
Centre ID:	OSV-0004104
Fieldwork ID:	MON-0033900

About the designated centre

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

Designated Centre 14 is a centre that comprises of four houses; two five bedroom semi-detached houses located in a suburb of North Kildare, a five bedroom bungalow also located in Kildare and a nine bedroom house located in a rural area of South Meath. The centre can provide respite accommodation to up to 20 residents with intellectual and physical disabilities. The five bedroom bungalow provides respite services to children while the other houses provide respite for adult service users. The provider organisation is Stewarts Care. The centre is managed by a person in charge, who is supported in their role by a CNM 2. Residents are supported by a staff team of nurses and health care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Thursday 11 November 2021	08:55hrs to 17:15hrs	Jennifer Deasy	Lead
Thursday 11 November 2021	08:55hrs to 17:15hrs	Michael Muldowney	Support

What residents told us and what inspectors observed

Inspectors visited all four houses which made up the designated centre. The inspectors used conversations with key staff, observations and a review of documentation to form a judgment on the quality of care in the designated centre. The inspectors wore appropriate personal protective equipment (PPE) and maintained social distancing in line with current public health guidance at all times. Overall, the inspectors found that residents were receiving a person-centred service and that the houses were equipped to meet residents' individually assessed needs. Improvements were required to the fire precautions, infection prevention and control measures and the risk management in some units of the designated centre. This will be discussed further in the quality and safety section of the report.

Inspectors were informed that, due to a combination of COVID-19 pod arrangements and staffing shortages, the respite houses were operating at a reduced capacity at the time of inspection. The designated centre was endeavouring to accommodate residents who were in the same pods in day services or school in order to reduce the risk of a COVID-19 outbreak. On the day of inspection, there were four residents staying across two of the houses. Another house was due to be providing respite service to an additional resident commencing the evening of the inspection.

Inspectors commenced the inspection in the childrens' respite service, Dochas House. Dochas House is located in a rural setting but close to local towns. Inspectors briefly met two children before they left for school. The children greeted the inspectors and appeared comfortable and content. The children were having breakfast and getting ready for school when the inspectors arrived. Inspectors met care staff and observed them engaging with the residents in a very warm, respectful and professional manner. The staff members were knowledgeable regarding the childrens' individually assessed needs and preferences. Inspectors found the house to be clean and well-equipped to meet the childrens' needs. Children had access to a recently refurbished kitchen with dining area as well as a play room and sensory room. The play room was large and inviting, containing sensory aids, toys, a ball pit, and a climbing wall. The back garden was spacious and was equipped with new swings, a trampoline and sheltered area for residents to sit under. There were some minor maintenance issues identified on this premises. These will be set out in the quality and safety section of the report.

Inspectors completed a walk-through of the two respite houses in Kilcock. These were unoccupied on the day of inspection. Inspectors found the houses to be clean, warm, and homely. All bedrooms were single occupancy and there were adequate communal living and bathroom facilities. Some minor premises issues were also identified in these houses and these will be further detailed in the quality and safety section of the report.

Inspectors spent most of the visit in Ferrier House, another unit which is located in

Co. Meath. This house is located on a large, rural site opposite a day service and equestrian centre for people with disabilities. The house has nine single occupancy bedrooms, two sitting rooms, a kitchen and utility. Inspectors did not have the opportunity to meet any residents as the residents had left for day service when inspectors arrived. Inspectors did have the opportunity to meet with a parent of one of the residents. This parent's adult child had been on a waitlist for adult respite services for some time and recently had been offered a respite place. The parent was visiting the unit in order to commence the induction and assessment process with the person in charge. The parent commented to the inspector that they felt the house was well-equipped to meet their child's needs. The parent commended the individual resident rooms which they felt offered a peaceful relaxation space. The parent also commented on the approachable staff and stated that they felt that their child would be very happy and safe in the designated centre.

Staff spoken with in Ferrier House appeared knowledgeable regarding the residents' needs, interests and preferences. Inspectors were informed that residents have access to a variety of in-house and community based activities. While some parts of the house, such as the downstairs resident bedrooms, were observed to be large, clean and well-equipped, other parts of the house required upkeep in order to provide for a homely experience and to mitigate against the risk of a healthcare associated infection. Additionally, significant concerns were identified in relation to the fire management procedures for this house. These will be discussed in the quality and safety section of the report.

The next two sections of this report presents the inspection findings in relation to governance and management in the centre, and how governance and management affected the quality and safety of the service being delivered.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations. This section of the report sets out the findings of inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

Overall, the inspectors found that improvements were required to the governance and management arrangements of the designated centre in order to enhance oversight of the quality and safety of care in each unit. While the designated centre was managed by a full-time person in charge who was suitably skilled and experienced, staffing vacancies meant that the person in charge did not have on the ground support in the day to day running of each of the units. There were no shift leads identified in each unit to support the person in charge in having oversight of the quality and safety of care. The inspectors observed the person in charge fielding multiple phone calls on the day of inspection in response to various issues arising in units. Additionally with the units spread across a reasonably large geographical area,

the person in charge explained that it can be difficult to set foot in each unit as often as they would like in order to enhance oversight.

The provider led audits had also failed to identify pertinent issues in the units. An unannounced quality and safety report and a fire audit were completed by the provider in 2021. These audits had failed to identify risks in the units such as the premises and fire containment issues which were identified by inspectors on the day of inspection. Therefore the provider's audits were not considered to be effective tools in identifying all risks and driving quality improvements.

Furthermore, the provider had failed to implement robust planning mechanisms to ensure the provision of a safe and quality service. For example, staff supervision was not completed and there was no plan or time frame to complete supervisions. The person in charge had also not received any formal supervision since commencing in their role. At the time of initial request for a training matrix, the inspectors were informed that there was none available in the designated centre. It took several hours for one to be provided to the inspectors. A review of the training matrix identified that several staff were out of date in key training areas including in fire safety, managing behaviour that is challenging, safeguarding and Children First.

The registered provider had prepared a statement of purpose which included much of the information as prescribed by Schedule 1 of the regulations. Inspectors found that the service was operating outside of it's statement of purpose as the function of rooms in two houses had been changed, for example a bedroom was converted to an office in Ferrier House. Additionally in Dochas House, the structure of the building had been changed with a doorway being removed and a resident living area converted into an office. The provider had not applied to vary any conditions of registration in line with these changes.

Schedule 5 policies and procedures were prepared by the provider. However, inspectors found that some of the policies printed in a folder had not been updated within three years. Where policies had been updated, they were not all available to staff and staff were referring to older versions as evidenced by recent staff signatures. This posed a risk to the quality and safety of care provided to residents as it meant that staff may not have been providing care which was in line with current evidence-based best practice.

The provider had prepared a policy on the management of complaints. The policy was reviewed and updated in October 2020. Information on complaints was included in the centres respite information booklet for service users and families. There was also an additional accessible guide for parents on making complaints. Inspectors observed accessible information displayed in the centre. There were no open complaints at the time of inspection.

Registration Regulation 8 (1)

The provider had made changes to the footprint of the designated centre. The

structure of the unit Dochas House had been changed and a living area was repurposed in to a staff office. An application to vary was not submitted to the chief inspector

Judgment: Not compliant

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge with the required qualifications, skills and necessary experience.

Judgment: Compliant

Regulation 15: Staffing

Despite ongoing recruitment efforts to fill vacant roles, the provider had not ensured that the number and skill mix of staff was in line with the designated centre's statement of purpose. It was acknowledged that the provider was managing staffing vacancies by operating at a reduced capacity. This meant that residents continued to be in receipt of good quality care as per their assessed needs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A training matrix was not maintained in the designated centre. When it was received and reviewed by inspectors, it demonstrated that several staff required mandatory training. The training needs identified included:

- fire safety: 47% of staff required this
- managing behaviour that is challenging: 27% of staff required this
- safeguarding: 20% of staff required this
- Children First: 20% of staff required this
- fire drill: 43% of staff required this
- manual handling: 20% of staff required this

It was also found that staff, including the person in charge, did not have access to regular supervision.

Judgment: Not compliant

Regulation 23: Governance and management

The provider did not have effective management systems in place to ensure oversight of all units in the designated centre. The provider's audits failed to identify risks in the units. For example, a fire audit was completed in one unit in August 2021 which did not identify several high risk areas in relation to fire. The designated centre's risk register also failed to capture risks in relation to premises, infection prevention and control and fire precautions. The provider's audits were not effective in identifying areas of need and in driving effective quality improvements.

The person in charge highlighted the busyness of having four units under their remit. The inspectors observed that the person in charge fielded multiple phone calls over the course of the inspection from those units to deal with issues arising. There were no shift leads identified in each unit to support the person in charge in having oversight.

Additionally, the provider had not put in place robust planning mechanisms to ensure a safe and quality service. For example, staff supervision and trainings were out of date and there was no plan or time frame for completion of these. Furthermore, staff did not have access to the most recent policies in order to guide them in best practice.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which contained much of the information as set out in Schedule 1 of the regulations. The statement of purpose was available in the centre. However, the statement of purpose had not been updated to reflect the changes of function and structure to rooms observed in some units. The statement of purpose further set out the incorrect registration conditions for the designated centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had prepared a complaints policy which was up to date and accessible

to residents and their families. Information on complaints was displayed in a prominent position in the centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had prepared written policies and procedures as per schedule 5 of the regulations. However, not all policies were reviewed within three years. This meant that staff may have been care and support which was not in line with current best practice.

Judgment: Substantially compliant

Quality and safety

Generally, the inspectors found that the day-to-day practice within this centre ensured that residents were safe and were receiving a good service. Improvements were required to the maintenance of the premises, the infection prevention and control measures, fire precautions and risk management. Many of the risks generated by these issues were reduced because the respite service was operating at a reduced capacity. The inspectors were not assured, that should the service increase capacity, that the provider would have measures in place to effectively mitigate against these risks.

Inspectors visited all four properties that comprised the designated centre. Due to the nature of the multiple units and the separate issues identified in each one, an overview of the premises will be provided before discussing other findings in more detail.

Dochas House:

Dochas House, the childrens' respite was found to be warm and nicely decorated. Since the last inspection the kitchen had been renovated and was bright and clean. The house contained large sensory and play rooms. These rooms were well decorated and contained a variety of toys and sensory aids for children to use. The bedrooms and bathroom facilities were clean and appropriately maintained, however, minor painting work was required in one bedroom. There were overhead tracking hoists in some rooms for residents who required this support. Servicing stickers on the hoists indicated that the servicing was up to date.

The back garden was spacious and contained swing sets, a trampoline and a sheltered area for residents to sit. The garden required upkeep, specifically, there

were derelict sheds that were due to be removed, an old picnic table, and overgrown weeds and grass. There was also a build up of moss on the roof and in the gutters. The windowsills at the back of the house were observed to be damaged and required repair and painting. Other areas in the house requiring attention included damaged skirting boards, a torn sofa and slight damage to the flooring in one of the bedrooms.

The provider had taken precautions against the risk of fire. There was evidence that fire extinguishing equipment was readily available and was serviced regularly. Fire evacuation routes were clearly displayed and staff were aware of the procedure to follow in the event of a fire. However, the fire door connecting the utility room and kitchen did not have a self-closing device.

Kilcock Respite Houses:

Inspectors briefly visited the two properties in Kilcock and completed a walk around. The houses were very homely, clean and well decorated. The front gardens were clearly well maintained with bright flower pots evident. Minor renovation works were required. For example, the carpet on the stairs in one of the houses was very worn and required replacement. The inspectors were informed that this carpet was due to be replaced in the coming weeks.

The provider had taken precautions against the risk of fire, however, it was again noted that there were no self-closing mechanisms fitted to the utility doors in both of these houses. The risk of fire spreading from the utility in these houses was greater as the double doors connecting the kitchen and sitting rooms also did not have self-closing mechanisms.

Ferrier House:

General maintenance work was required throughout the house, particularly in order to enhance infection prevention and control measures. There were three bedrooms upstairs which were not being used by residents at the time of inspection. One of these bedrooms had been converted into a staff office. The upstairs bedrooms required cleaning and repair work. There was a hole in the ceiling of one bedroom which had not been filled. The flooring in the upstairs bathroom had lifted and did not meet the base of the toilet.

Downstairs, some door frames and doors were marked and damaged. In the downstairs bathroom, the grab rails by the toilet had rusted, making them difficult to clean. Some of the bedrooms required repainting and there was evidence of a leak in the ceiling of two bedrooms. The fabric of the couch in the sitting room was torn. The inspectors were informed that replacement sofas had been ordered. The kitchen required maintenance, several of the cabinet's laminate covers were beginning to peel off. There was mould around the exit door at the utility room.

Ferrier House required significant enhancement of the measures to mitigate against the risk of fire. The inspectors observed that the utility door was not a fire door and was not fitted with a self-closing mechanism. Additionally, the provider could not give assurances that glass windows in a corridor which connected the utility room

with resident bedrooms were fireproofed. A review of the floor plans identified several attic areas within the house. The provider could not give assurances on the day of inspection that there were adequate fire detection devices in the attic and that measures had been taken to prevent fire from spreading through the attic.

There were inadequate means of escape identified. Several of the final exit points from the building required a key to open them and could not be opened immediately in the event of fire. Further compounding this risk, was that one of the break glass boxes in order to access a final exit key did not contain a key. The escape route from two of the upstairs bedrooms, in the event of the stairs being inaccessible was identified as being through a window out on to a steep, moss covered roof. The emergency light in one of the upstairs bedrooms was also not working. The provider had completed a fire risk assessment of this unit in July of 2021 which did not identify these risks.

The inspectors were not assured that the fire containment and evacuation arrangements were adequate. During the inspection, inspectors met with the provider's person responsible for fire safety oversight and expressed their concerns. Assurances were provided that final exits would be fitted with thumb locks as a matter of urgency to ensure an unimpeded exit. Inspectors reviewed a sample of residents' individual evacuation plans, and found them to be up to date and reflective of the supports required by the residents. Inspectors also spoke to two staff members who were knowledgeable on the evacuation arrangements and needs of the residents. The person in charge and staff on duty assured inspectors that the residents staying in the house on the night of the inspection could be safely and promptly evacuated in the event of a fire. The risk of fire to residents was somewhat mitigated by the reduced occupancy arrangements and that there was one to one staff to resident ratio for care by day and night.

A risk register for the four units was maintained however this risk register did not reflect the risks identified on inspection in relation to the premises issues, infection prevention and control and fire precautions. The risk register highlighted at an overview the known risks in relation to the designated centre as a whole, but did not reflect risks as specific to each unit. The inspectors found that the risks presenting in each unit varied significantly and a more unit-specific risk register would assist with identifying risks and driving quality improvement. Where residents presented with individual risks, risk assessments were available for these and were up to date.

Improvements were required to the measures to prevent residents from acquiring a healthcare associated infection across all four units. While inspectors observed that staff were wearing face masks, engaging in social distancing and adhering to good hand hygiene practices, the procedures in relation to preventing a COVID-19 outbreak required enhancement. The designated centre's COVID-19 management plan was not comprehensive and did not provide specific guidance on how staff should mange a suspected case of COVID-19. The plan was not dated or signed and so it was not possible to determine when it had been written and who was responsible for reviewing and updating the plan. There was a COVID-19 folder available to staff however the guidance in this folder was from 2020 and was not reflective of current public health guidelines. The centre's COVID-19 risk assessment

was also out of date, having last been updated in August 2020. Some aspects of the premises issues, particularly in Ferrier House, such as the mould and damaged furniture and flooring presented as an infection prevention and control risk.

The provider had ensured that all of the units provided facilities for recreation, occupation and time to be alone. The children's respite house offered choice of several large play areas while the adult respite houses provided adequate space to allow residents to engage in activities in line with their interests. Residents had assessments to identify their interests and staff supported residents to engage in these interests. The inspectors read about two residents' interests and found, from speaking to staff and from reviewing daily records, that these interests were been supported. Residents were supported to partake in activities in and outside of the centre such as going shopping, bowling, and going to the cinema. The centre had its' own vehicles to transport residents to their day services or school, and to community amenities.

Inspectors reviewed a sample of residents' individualised assessments and personal plans. Comprehensive individualised assessments were carried out by a staff nurse. The assessments covered the residents' health, personal and social care needs, and were updated as required. Personal plans were prepared for residents which reflected the residents' assessed needs and outlined their required supports. One resident's personal plans referred to a behaviour of concern which staff informed the inspector that the resident no longer engages in. A behaviour support plan was developed for the behaviour and was present in the resident's file. It had not been clearly noted that the behaviour was historic and was no longer required. Residents had personal goal plans. Inspectors found that some of the goals had been achieved, however, were not closed or developed into another goal. A plan required development to outline the practices in place to support the safety needs of one resident. The residents were receiving appropriate health care. Nursing support was provided to residents as based on their on assessed needs. Inspectors also found that residents' communication needs were supported and there was accessible information where required.

The provider had implemented measures to protect residents from all forms of abuse. At the time of inspection, the person in charge and staff spoken to told inspectors that there was no safeguarding concerns or incidents. The provider has prepared a written policy on the prevention, detection and response to abuse. The policy was available to staff and was reviewed in line with it's revision date. The centre had also prepared a Child Safeguarding Statement; which was based on risk assessments and outlined the procedures and controls to manage the risks. The inspectors reviewed a sample of residents' personal care plans and found them to adequately outline the assistance that residents required with their intimate care. The service had an adequate amount of bathrooms and residents had their own bedrooms to ensure their privacy. The inspectors reviewed the centre's staff training log and found that some staff required mandatory training in safeguarding vulnerable persons from abuse and in Children First.

Regulation 13: General welfare and development

The provider had ensured that adequate arrangements and facilities were in place to support the general welfare and development of residents when they used the respite service.

There were ample facilities and spaces for children to play including play and sensory rooms, toys, and a garden with play equipment such as swings and trampoline.

Adult respite services also had outdoor spaces and sufficient indoor spaces to allow residents to engage in activities. Residents were supported to take part in activities that they enjoyed and that were meaningful to them. Residents had opportunities to be alone and were able to choose their own bedroom when they came into the centre. The centre had its own vehicles so residents could avail of community amenities. Staff had a good understanding of residents' personal interests and supported them to engage in associated activities of their choosing.

Judgment: Compliant

Regulation 17: Premises

A summary of the premises issues which required improvement are listed below:

Dochas House:

- minor painting work required in one bedroom
- sheds in back garden were broken and unused
- an old picnic table was damp and covered in moss
- overgrown weeds on patio
- build up of moss on the roof and in the gutters
- damaged skirting boards
- a torn sofa
- slight damage to flooring in bedroom off the dining area

Kilcock:

- carpet on the stairs in one house was very worn.

Ferrier House

- flooring in the upstairs bathroom had lifted and did not meet the base of the toilet
- hole in the ceiling of one bedroom upstairs and emergency light unit with build up of dead insects

- downstairs, some door frames and doors were marked and damaged
- the grab rails by the toilet in downstairs bathroom had rusted
- some communal areas required repainting
- torn fabric of the couch in the sitting room
- parts of the kitchen cupboards had lifted
- mould around the utility room exit door.

Judgment: Not compliant

Regulation 26: Risk management procedures

A risk register for the designated centre was maintained however this risk register was not comprehensive and did not reflect all risks in the units. Several of the provider's audits had failed to identify hazards in the units. It was not demonstrated that the provider had effective systems in place to identify hazards and manage risks in the units.

Where residents presented with individual risks, risk assessments had been completed and were reviewed in a timely manner.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The centre had taken measures to protect staff and residents from acquiring a healthcare associated infection by ensuring there were adequate hand washing facilities and personal protective equipment for staff. Staff and residents were also monitored for symptoms of COVID-19. Temperature checks were completed on arrival to the designated centre and a visitors log was maintained to support contact tracing. The units were operating at a reduced capacity and were facilitating residents to stay in pods as per their day service and school arrangements.

However, the planning and procedures to manage a healthcare associated infection required enhancement. The COVID-19 contingency plan was not comprehensive and did not provide clear guidance to staff on how to manage a suspected case of COVID-19. COVID-19 information maintained in the centre required updating to reflect the most current public health guidance.

While some components of the centre were clean and well maintained, other areas required attention to ensure that the risks posed by infection were mitigated. Furniture, flooring and mobility aids were found to be compromised and therefore could not be thoroughly cleaned.

Judgment: Not compliant

Regulation 28: Fire precautions

The fire safety arrangements, particularly in Ferrier House, required improvement. Several high risk areas were identified including:

- absence of fire door in utility room
- lack of clarity regarding the fire-proofing capability of glass panels
- lack of clarity regarding the fire detection and containment measures in the attic and void space
- emergency lighting in one bedroom not working
- inaccessible fire exits from upstairs bedrooms (not in use at the time of inspection)
- keys missing from emergency boxes
- not all final exits could be opened immediately

The utility doors in the other units were not fitted with self-closing mechanisms. Additionally, several staff required fire safety and fire drill training.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that a comprehensive assessments of residents' health, personal, and social care needs had been undertaken. Nursing staff were responsible for carrying out the assessments and reviewing them as required. Personal plans were prepared reflecting the residents' assessed needs. These were available to staff in order to guide their practice of care and support. The relevance of some personal plans required review to ensure that plans were reflective of residents' current needs. One plan required development to outline the practices required to ensure the specific safety needs of a resident were clear to staff.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were receiving appropriate health care whilst availing of the respite service. Nursing staff were involved in the assessment of residents' health care needs and in the development of associated plans. Nursing support was provided to

residents where required by residents.

Judgment: Compliant

Regulation 8: Protection

The provider had implemented measures to protect residents from all forms of abuse. The provider had prepared a written Child Safeguarding Statement and policy on the prevention, detection and response to abuse. Residents had their own bedrooms when they used respite services and there was sufficient amount of bathroom facilities. In addition, residents had personal care plans to ensure that staff delivered intimate care in a manner respecting the residents' dignity and integrity.

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	
Registration Regulation 8 (1)	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Stewarts Adult Respite Home Centre 14 OSV-0004104

Inspection ID: MON-0033900

Date of inspection: 11/11/2021

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**
Registration Regulation 8 (1)	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 8 (1): An act to vary was completed and sent on the 17th of December with updated floor plans.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Currently staffing levels in DC 14 is as follows; CNM3, 4 senior staff nurses, 3 junior staff nurses along with 20 HCAs. The plan in 2022 is to recruit 1 CNM2, 1 CNM1 and a social care staff. 1 staff nurse and 2 Healthcare assistants started on the 6th of Decmber. Ongoing recruitment continues with weekly interviews to fill the the remaining vacancies. All vacancies to be filled by the 31st of March 2021.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: As of the 7th of December Safeguarding training is at 100%, Children's first is at 100%,	

fire drill and Fire Safety Awareness training is 100% for all staff.
All staff are booked on MAPA training and this will be all completed by the 15th January.
All staff are booked onto Manual handling and will be completed by 30th January.

Supervisions for the 4th quarter are completed for all staff and PIC supervision is scheduled for the 17th of December.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The plan in 2022 is to recruit 1 x CNM2, 1x CNM1 and 1 x social care worker to strengten the governance and management over DC 14 while we increase the occupancy for each home.

An additional quality officer was employed to the quality office on the 1st of December to strengten the providers audits.

Since this inspection a new fire door has been installed in the utility room in Ferrier house. All external doors now have a thumb lock for quick and easy evacuation. The attic had already wired smoke alarms in place. Closing devices have been installed to both utility room doors in both the Royal Meadows.

All schedule 5 policies are being updated and will be complete by the 31st of December.

As of the 7th of December Safeguarding training is at 100%, Children's first is at 100%, fire drill and Fire Safety Awareness training is 100%.
All staff are booked on MAPA training and this will be all completed by the 15th January.
All staff are booked onto Manual handling and will be completed by 30th January.

All homes will have an IPC audit completed by the 31st of December in DC 14 along with an additional fire audit by the 28th of February.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The floor plans were updated on the 17th of December and this is now reflected on the

SOP.
The statement of purpose had been updated to reflect the changes of function and structure to rooms observed in some units. The statement of purpose now sets out the correct registration conditions for the designated centre.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A new policy committee commenced in November 2021. All schedule 5 policies will be updated by the 31st of December. All other policies will completed by the 28th of February 2022.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Dochas House:
Minor painting in Dochas was completed on the 12th of November. Broken sheds to be removed by the 30th April. Old picnic table has been removed. Overgrown weeds have been treated in the garden on the 17th of November. Build up of moss on roof and gutters to be resolved by 30th of April. Damage on skirting board in utility to be fixed by 30th of January. New sofas delivered on the 17th December 2021. Slight damage to flooring in bedroom to be fixed by the 28th of February.

Kilcock:
New carpet on the stairs has been fitted on 15th December.
Ferrier House:
Home improvement team to spend 3 weeks in Ferrier house in the second quarter of 2022.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: A substantial review of the risk register will be complete by 31st January 2022. A Quality officer has been employed since 15th November2021

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection: A new comprehensive Covid Contingency Plan with detailed guidance for staff on how to manage a healthcare associated infection and a suspected case of Covid 19 was completed on 24th November 2021 and is now in place in all respite homes. . COVID-19 information maintained in the centre has been updated to reflect the most current public health guidance. Our home improvement team will be in Ferrier House in the second quarter of 2021

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Ferrier House: • Fire door is now installed within the utility room. There is a self-closer installed also on Nov 30th 2021. • Glass panels in the utility room will be changed out by Declan Cosgrove by 04-01-2022 to ensure we have adequate fire proofing capacity within the panels. • Fire detection is installed within the attic area- fire containment measures are in place, and will be reviewed regularly to ensure compliance. • Emergency lighting working in all areas - emergency lighting not working in the bedroom on day of inspection is now working completed by Electrician from Reconair December 3rd 2021. • Thumb turn locks installed on all final exits, this will ensure all final exits will be opened easily this was completed by the Lock Hospital on Nov 30th this will also minimize the risk of keys missing from emergency boxes as the emergency boxes are not required going forward. • Inaccessible fire exits from upstairs bedrooms- removed from the evacuation plan completed December 15th 2021.

Royal Meadows:

• All utility doors are now fitted with self-closing mechanisms completed on December 8th 2021.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Updated Care Plans will be developed by Nursing team in Ferrier House for two service users identified as requiring same on next admission. These plans will be discussed with all staff.
One service user has Risk assessment for PICA in day service. A care plan will be developed on their next admission in collaboration with day service.

The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances. This will occur no less frequently than on an annual basis as this may take up to twelve months due to frequency of admission of service users.

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 8(1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Not Compliant	Red	07/01/2022
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.	Substantially Compliant	Yellow	31/01/2022

Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Red	28/01/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2021
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.	Not Compliant	Orange	30/06/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Red	14/01/2022
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	31/01/2022
Regulation 23(1)(b)	The registered provider shall	Not Compliant	Orange	31/01/2022

	ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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	31/12/2021
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any	Substantially Compliant	Yellow	31/05/2022

	concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	31/12/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	24/11/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the	Not Compliant	Red	24/12/2021

	prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	24/12/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	24/12/2021
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	24/12/2021
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	24/12/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	24/12/2021
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in	Not Compliant	Red	07/01/2022

	fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/12/2021
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	31/12/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently	Substantially Compliant	Yellow	31/12/2021

	as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			