Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Stewarts Care Adult Services Designated Centre 24
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	10 January 2023
Centre ID:	OSV-0005836
Fieldwork ID:	MON-0036886

About the designated centre

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

Designated Centre 24 is a designated centre operated by Stewarts Care Ltd. The centre provides full-time residential support for no more than four women and men with intellectual disabilities and associated complex behaviour support and mental health needs who require bespoke single occupancy living arrangements. Designated Centre 24 comprises four separate single-occupancy living areas, which are located on the ground floor within a larger building in a congregated campus based setting. Residents have access to a range allied health professional services as part of their ongoing assessment of needs and support requirements. Residents are supported by a staff team of a person in charge, social care workers and care staff.

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 (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 10 January 2023	09:35hrs to 16:35hrs	Michael Muldowney	Lead
Tuesday 10 January 2023	09:35hrs to 16:35hrs	Karen McLaughlin	Support

What residents told us and what inspectors observed

This report outlines the findings of an unannounced inspection of the designated centre. The previous inspection in March 2022 found that improvements were required under a number of regulations, and the purpose of this inspection was to assess the provider's progress in implementing and sustaining these improvements, as outlined in the compliance plan submitted to the Chief Inspector of Social Services, in order to meet compliance.

In line with public health guidance, inspectors wore face masks during the inspection and maintained physical distancing as much as possible during interactions with residents and staff. Staff working in the centre were also observed wearing face masks, and masks and hand-sanitising facilities were readily available in the centre. There was also signage on COVID-19 and infection prevention and control (IPC) matters throughout the centre.

The centre was located on a campus setting operated by the provider and connected to a large building that contained offices and another designated centre. The centre comprised four self-contained single occupancy apartments. Inspectors completed a thorough walk-around of the centre with the person in charge. Each apartment contained a bedroom, toilet and bathroom facilities, and living areas. The kitchens were well equipped, and inspectors observed a good selection and variety of food and drinks in the centre for residents to choose from which was hygienically stored. Some of the apartments had access to a garden.

Since the previous inspection, renovation works such as painting and replacement of flooring had been taken place in three of the apartments, and further works were planned for the fourth apartment. Inspectors found that the centre was clean, however some upkeep and maintenance was required, and the storage facilities were inadequate. Efforts had been made to make the centre more homely, for example, nice photos and pictures were displayed, and there was comfortable furniture. However, inspectors found that further work was required to soften the institutional aesthetic that remained in parts of the centre, for example, there was exposed pipes and wires, and deactivated key pads at exit doors that were not conducive to a homely environment. In addition to some of the premise issues which posed an IPC risk, inspectors also observed some IPC practices that required improvement and these are discussed further in the quality and safety section of the report.

In the first apartment, the resident's bedroom was personalised to their tastes, however the door required painting. The bathroom was very spacious and had good hand-washing facilities, however, the storage facilities were poor and some of the fittings were slightly water damaged. Inspectors were informed by the person in charge that there were plans to install a bathtub and upgrade the furniture and storage facilities.

The second apartment comprises a bedroom, living room, laundry room, kitchen, and small sensory room. There was also a garden with a trampoline. In the bedroom, there were net curtains and black tape covering part of the windows which were not adequate to ensure the resident's privacy was maintained and that there was appropriate levels of light in the room. Some of the furniture also required attention, for example, the fabric on an armchair was very damaged which impinged on how effectively it could be cleaned. The storage facilities in the utility room were limited and inspectors observed the counter to be cluttered. There was mould on the ceiling room, the person in charge advised that it had been previously treated but returned. Inspectors observed some environmental restrictions in the apartment, for example, locked doors, which were implemented for the resident's safety.

In the bathroom of the third apartment, inspectors observed no storage facilities for the residents personal products, the fan was dirty, and there were thick cobwebs on the ceiling. The kitchen was very small, but adequately equipped. The base of some of the cupboards required attention as they were damaged. Radiator covers had been installed in the living room and bedroom since the last inspection, however they had not been painted to match the décor of the rooms. Inspectors also observed that some of the soft coverings on the exposed radiators pipes were torn.

In the fourth apartment, some of the skirting boards and flooring was damaged, painting was required in areas, and the ceiling in the living room was damaged. The person in charge had also requested for handrails to be installed at the exit to assist the resident in safely evacuating, however this work was outstanding. The bedroom was spacious and nicely decorated.

Inspectors released several fire doors with self-closing devices and they closed properly. However, in one of the apartments, some of the fire doors did not have self-closing devices, and one door did not have a visible intumescent strip which forms part of the overall fire containment measures for fire doors. Inspectors also observed that some exit doors were key operated which posed a potential risk to the prompt evacuation of the centre in the event of an emergency. Overall, inspectors were not assured that the fire safety arrangements in the centre were adequate and these matters are discussed further in the quality and safety section of the report.

On the day of the inspection, residents were engaged in different activities, such as family visits, medical appointments, going for walks and meals out. The person in charge told inspectors about the activities that residents enjoyed, such as eating out, day trips, shopping, walks, swimming, gym, cinema, going to pubs, shopping, using smart tablets, and visiting family. The person in charge told inspectors that there were plans for residents to explore attending day services in the future. The person in charge told inspectors that during COVID-19 national restrictions, there were more in-house activities and residents kept in touch with their loved ones through phone calls and video technology. There was no dedicated vehicle available to the centre, however vehicles could be booked through the provider's transport department and residents could also use taxi services.

Inspectors met three of the residents. Two did not communicate their views, but appeared comfortable in the home. One resident chose to briefly speak with

inspectors. They said that they were happy living in the centre and with their bedroom and environment, and liked the staff. They said that they liked grocery shopping and had their favourite meals often.

Inspectors spoke with several staff members including the person in charge, social care workers, and care staff. Staff were observed interacting warmly with residents, and residents appeared relaxed in their company.

The person in charge told inspectors that the quality and safety of service provided to residents was good, and that their needs were being met in the centre. However, they did have some concerns regarding maintaining appropriate staffing levels to cover staff leave. They said that although staff leave was covered as much as possible with familiar staff, on occasion the required complement was not met.

Two care staff spoke together with inspectors. They said that residents were receiving a good quality of service, and gave examples of how residents were supported to have choice and control in their lives, for example, planning activities they enjoy. They were found to have a good understanding of the residents' needs, and spoke about residents' behaviour support plans, safeguarding arrangements, IPC measures, and fire evacuation plans.

A social care worker told inspectors about their role and responsibilities which included leading shifts, providing supervision to staff, ensures regulations and policies were being adhered to, and promoting a social care model in the centre. They felt that the quality and safety of care provided to residents was very good and that their needs were being met, however at times staffing deficits were negatively impacting on them. They were aware of the safeguarding arrangements and fire plans. They told inspectors about how residents were supported to attend weekly meetings, and inspectors viewed recent meeting minutes which noted discussions on national standards for residential services, healthy eating, activity planning, human rights principles, advocacy, and safeguarding.

Staff spoken with with had no other concerns, but felt comfortable raising any potential concerns with the management team. They advised inspectors that they were up to date with their training and were satisfied with the supervision and support they received from the person in charge.

Overall, inspectors found that the provider and person in charge had failed to implement all of the actions outlined in their compliance plan following the previous inspection. This was resulting in a failure to meet compliance with the associated regulations and standards. Improvements were required to ensure that the governance and management arrangements were effective, and that the service provided to residents in the centre was appropriate to their care and support needs.

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

Capacity and capability

The purpose of this inspection was to assess the provider's progress in implementing and sustaining improvements to the service provided to residents in the centre. Inspectors found that overall the actions outlined in the compliance plan submitted to the Chief Inspector following the previous inspection of the centre in March 2022 had not been fully completed. Furthermore, the findings of this inspection did not demonstrate that the provider was effectively monitoring the quality and safety of the service provided to residents or ensuring that the centre was adequately resourced, for example, there were staffing deficits.

While the provider had monitoring systems in place such as audits and reviews, inspectors found that improvements were required, as not all actions identified for improvement were effectively addressed, for example, inspectors found similar issues that had been previously identified in an IPC audit in 2021.

There was a clearly defined management structure in the centre with associated roles and responsibilities. The centre was managed by a full-time person in charge who was based in the centre. Their remit consisted solely of the centre. They were found to be suitably qualified and experienced. The person in charge was supported in managing the centre by two social care workers, and reported to a programme manager.

The staff skill-mix consisted of social care workers and care staff. The person in charge was not assured that the skill-mix was sufficient in relation to nursing input. However, the provider told inspectors that they were satisfied that it was appropriate. There was one whole-time equivalent vacancy, however it was due to be filled by the end of the month. The person in charge described challenges in maintaining adequate staffing levels to cover staff leave, and inspectors found that this was having an adverse impact on residents, for example, access to the community had been reduced during staff shortages. Inspectors were also told that although residents require consistent familiar staff, staff were frequently moved from apartment to apartment.

The person in charge maintained planned and actual staff rotas showing staff working in the centre, however they were found to require improvement to plan for the required staffing levels.

Staff working in the centre were required to complete training as part of their professional development. Inspectors found that some staff required training, including refresher training, in a range of areas including positive behaviour support, infection prevention and control, and autism. The training deficits posed a risk to the quality and safety of support and care provided by staff to residents.

There were good arrangements for the support and supervision of staff in the centre. The person in charge, supported by social care workers, completed formal supervision with staff on a quarterly basis which was in line with the provider's

policy. Outside of the support provided by the person in charge, staff had access to an on-call system and could escalate any concerns to the programme manager. Staff advised inspectors that they felt confident in raising any potential concerns about the service provided to residents. Staff also attended regular team meetings which provided an opportunity for them to raise concerns.

The inspector spoke to staff working in the centre about a wide range of topics. They were knowledgeable on the topics discussed and demonstrated a good understanding of the residents' needs.

The statement of purpose was readily available in the centre and had been recently updated. The statement of purpose contained the required information set out in Schedule 1, however the information regarding the care and support needs that the centre intended to meet was not specific, and the staffing arrangements required review.

The maintenance of records required improvement, as not all of the records as outlined in Schedule 4 were kept in the centre.

Regulation 14: Persons in charge

The person in charge was full-time and had the required qualifications, skills, and experience to manage the centre.

Since the previous inspection, the provider had reduced the remit of the person in charge to consist solely of the centre concerned to support the effectiveness of the governance, operational management and administration of the centre.

Judgment: Compliant

Regulation 15: Staffing

The staffing skill-mix and complement consisted of a full-time person in charge, two social care workers, and 19 whole-time equivalent care staff. There was one care staff vacancy, however the provider had successfully recruited for the post and it was due to be filled by the end of the month. The social care workers commenced in the centre following the previous inspection and their role was enhancing the overall service provided in the centre, for example, they supported the person in charge in managing the centre and were promoting a social care model of care.

Inspectors found that appropriate staffing levels in accordance with the residents' assessed needs were not consistently in place over the previous three months. Staff told inspectors that the deficits had an adverse impact on residents, and daily notes recorded examples of this, for example, community activities were curtailed which

impacted residents' mood and freedom of movement. Some residents had previously made complaints about the staffing deficits.

Inspectors were advised by the person in charge and staff that residents required consistent staff that they were familiar, however also told inspectors that movement of staff within the centre from one apartment to another was frequent. A log of movements noted 12 moves in the previous three months, however inspectors were informed that more moves had likely happened but were not recorded.

Inspectors viewed a sample of the planned and actual rotas from the previous three months. Some of the planned rotas required improvement as they did not align with the required staffing complement, for example, the December 2022 rota planned for less staff than was actually required.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff working in the centre had access to training as part of their continuous professional development and to support them in the delivery of effective care and support to residents. The training programmes included fire safety, safeguarding residents from abuse, safe administration of medication, manual handling, infection prevention and control, and positive behaviour support. Inspectors viewed the most recent staffing training log with the person in charge and found the following:

- Eight staff had completed medication administration training and another five were on a waiting list for the training.
- 15 staff required positive behaviour support training, and this was scheduled to take place later in the month.
- 12 staff required autism training and four required epilepsy training, however there was no time frame for them to complete the training.
- The training logs were not comprehensive, as they did not record mandatory infection prevention and control training, and the person in charge was only able to confirm that eight staff had completed this training.

The training deficits posed a risk to the quality and safety of care provided to residents in the centre, especially as some of the training was considerably overdue, for example, the provider had outlined in their compliance plan that staff would have completed behaviour support training by May 2022.

There were arrangements for the support, and informal and formal supervision of staff. The person in charge was supported by social care workers in the provision of formal supervision to staff. Formal supervision was scheduled every three months as per the provider's policy. Inspectors viewed a sample of the supervision records maintained by the person in charge. Staff spoken with told the inspector that were very satisfied with the support and supervision they received. In the absence of the

person in charge, staff were supported by the social care workers and could also contact the programme manager. There was also an on-call service for staff to contact outside of normal working hours.

Judgment: Not compliant

Regulation 21: Records

The registered provider had not ensured that up-to-date maintenance records of fire-fighting equipment were kept in the designated centre. Recent servicing records of the fire alarms and emergency lights were not maintained in the fire register or electronically for the person in charge to access, and were not made available for inspectors to view.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, inspectors found that the provider had not fully implemented the actions outlined in the compliance plan submitted to the Chief Inspector following the previous inspection in March 2022, and had failed to ensure that the service was effectively monitored. Actions in the compliance plans were due to be completed by June 2022, inspectors found that actions under regulations 14 and 23 had been completed, however some of the actions under regulations 7, 15, 16, 17, 21, 27 and 28 were outstanding. Inspectors also found that the centre was not consistently resourced to meet the assessed needs of the residents, for example, there were staffing deficits on occasion and renovation works were outstanding.

The provider had implemented systems to monitor and oversee the quality and safety of care and support provided to residents in the centre. Comprehensive annual reviews and six-monthly reports were carried out to identify actions for improvement. Audits had also been carried out by staff working within the centre and members of the provider's multidisciplinary, for example, infection prevention and control. However, the oversight and implementation of actions was poor, for example, the IPC audit carried out in November 2021 identified issues which had not been adequately addressed such as storage issues and use of unlabelled cleaning chemicals. The annual review had also noted actions which had not been achieved within their time frames, for example, staff to complete positive behaviour support training.

There was a clearly defined management structure with associated lines of authority and accountability. There were two social care workers in the centre and their responsibilities included supporting the person in charge to manage the centre. The

person in charge was supported in their role by a programme manager who in turn reported to a Director of Care.

There were arrangements for staff to raise concerns. In addition to the supervision arrangements, staff also attended regular team meetings which provided a forum for them to raise any concerns. Staff spoken with advised the inspector that they were confident in raising any potential concerns with the management team.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose containing the information set out in Schedule 1. The statement of purpose was available in the centre and last revised in November 2022. The information regarding the specific care and support needs that the centre is intended to meet was generic and limited in scope, and the staffing complement was not accurate.

The person in charge updated the statement of purpose during the inspection to outline the specific care and support needs, however further revisions were still required regarding the staffing arrangements.

Judgment: Substantially compliant

Quality and safety

Inspectors found that the effectiveness of the quality and safety of service provided to residents in the centre was compromised due to premise issues, infection prevention and control (IPC) arrangements, and poor fire safety systems.

The centre was part of a larger building that also contained offices and another designated centre. It was located on a campus setting operated by the provider, and close to many amenities and services. It comprised four self-contained single occupancy apartments. The facilities included bedrooms, living areas, bathrooms, and some garden space. Some renovation works had been carried out since the previous inspection such as painting and replacement of flooring, however as described in the first section of the report some works were outstanding. The design of the centre presented an institutional aesthetic, and while efforts had been made to make it more homely, further works and enhancements to the décor were required. A shed had been purchased since the previous inspection to improve the storage facilities. However, inspectors observed poor storage arrangements within the centre, for example, boxes of personal protective equipment (PPE) were stored on the floor at the front entrance of the centre and were not moved before the

inspection concluded.

The centre was clean, and the provider had implemented some good IPC measures, however some improvements were required to meet compliance with the associated standards. The provider had prepared written policies and procedures for staff to refer to, and they also had access to public health guidance to inform their practices. The COVID-19 management plan required updating and expansion to consider other potential infections. There was an IPC team available to provide guidance and support, and they had also completed a comprehensive IPC inspection in the centre which identified areas for improvement, however inspectors found that some of these areas had not been adequately addressed. There were good hand washing facilities and access to PPE. However, some of the measures to prevent infection cross contamination required improvement, as there was an insufficient stock of colour coded cleaning equipment. Staff were required to complete IPC training, however it could not be demonstrated that all staff had completed training in this area. Inspectors spoke with staff during the inspection and they had a good understanding of the IPC matters discussed.

The fire safety systems were found to require enhancements. There was fire detection, containment, and fighting equipment, and emergency lighting throughout the centre. However, not all of the equipment servicing records were maintained in the centre and assurances could not be provided to inspectors that all of the servicing was up to date. Furthermore, the fire panel was located outside of the centre and not easily accessible to staff. Inspectors found that some of the fire doors did not have closing devices, and one did not have a visible intumscent strip.

The maintenance and accessibility of fire related documentation required improvement, for example, the fire risk assessment was over due review and evacuation plans required revision. While fire drills took place on a regular basis, there were no records to demonstrate that a night-time scenario drill had taken place reflective of the maximum number of residents and minimum staff levels. The arrangements to ensure the prompt evacuation of the centre in the event of a fire required more consideration. Staff had completed fire safety training, and staff spoken with were aware of the evacuation arrangements.

Regulation 17: Premises

The centre comprised four self-contained apartments. Each apartment contained a bedroom, toilet and bathroom facilities, and living areas. Parts of the centre had been renovated since the previous inspection. However, further works were required including painting, upgrading of flooring, and upkeep of furniture. The storage facilities were not adequate, for example, inspectors observed boxes stored on the floor.

The design of the centre presented an institutional aesthetic. While efforts had been made to make it more homely and personalised, inspectors observed areas that required more attention, for example, there was exposed pipes and wires, painting

was required, and deactivated key pads that were no longer in use had not been removed. The soft furnishings in a resident's bedroom also required enhancement.

Residents spoken with told the inspector that they were happy with their homes.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The registered provider had implemented infection prevention and control (IPC) measures and procedures, however aspects were found to require improvement.

There were policies and procedures on infection prevention and control for staff to refer to. There was also signage and posters throughout the centre on IPC and COVID-19. The provider had an established IPC team and they provided support and guidance on IPC matters. However, the COVID-19 management plan required updating as it referred to the previous person in charge and arrangements that were no longer in place. The plan also required expansion beyond just COVID-19.

A detailed IPC audit had been carried out by the IPC team in November 2021and included actions for improvements. A follow-up audit was due to take place by the end of January 2023. Inspectors found that some of the issues found in audit such as the use of unlabelled cleaning chemicals, had not been properly addressed.

There was good access to hand hygiene facilities and PPE in the centre. There were arrangements for the management of soiled laundry and bodily fluid spills, for example, alginate bags and spill kits. However, the stock of colour coded cleaning equipment was not sufficient. The premises and some furniture also required upkeep to mitigate and reduce IPC risks.

Staff were required to complete relevant IPC training, however the person in charge could only provide assurances that eight staff had completed the training. COVID-19 and IPC was also a recurring topic discussed at team meetings. Staff spoken with advised the inspector on some of the IPC measures, such as the arrangements for soiled laundry and bodily fluid spills, cross contamination precautions, components of their training, and the reporting of IPC concerns.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Inspectors were not assured that the fire safety systems implemented in the centre were adequate.

There was fire detection, containment, and fighting equipment, and emergency lights in the centre. Servicing stickers on fire extinguishers and blankets indicated that they were up to date with their servicing. However, servicing records for the fire alarm and emergency lights were not maintained in the centre, and were not provided to inspectors during the inspection as requested, to provide assurances that the servicing was up to date. The fire panel was not located within the centre for staff to refer to. The provider however, had a comprehensive plan in place to upgrade the fire alarm and emergency lighting system for all designated centres on the congregated campus. This would result in each centre having a high standard fire alarm system and addressable fire panel installed in the centres on a phased basis.

Inspectors tested a sample of the fire doors with self-closing devices and they closed properly when released. However, in one of the apartments, some of the fire doors did not have self-closing devices, and one door did not have a visible fire intumscent strip.

The maintenance of fire documentation was poor. The fire safety risk assessment for the centre, dated June 2021, required review and updating. The fire evacuation plans were not easily retrievable for staff to access, and furthermore some of the plans appeared to require updating and revision in relation to residents' needs. Fire drills were taking place on a regular basis, however records could not be provided to the inspectors to demonstrate that drills reflective of a night-time scenario had taken place. Therefore, inspectors were not assured that the fire evacuation plans were effective. In addition, the compliance plan previously submitted to the Chief Inspector had outlined that evacuation routes would be a standard agenda item at staff team meetings, however inspectors viewed the meeting minutes since the previous inspection and none of them noted such discussions. However, staff spoken with were confident in describing how they would support residents to safely evacuate and knew the location of the assembly point.

Since the previous inspection, some of the exit doors had been upgraded to ensure prompt evacuation in the event of an emergency. However, not all of the doors had been upgraded, for example, some were key operated, and the rational for this was not clear.

Judgment: Not 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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 24 OSV-0005836

Inspection ID: MON-0036886

Date of inspection: 10/01/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider has recruited an additional Health Care Assistant to work in the Designated Centre. There is now a full complement of staff in the designated centre to ensure staffing levels are appropriate in accordance with the resident's needs. There is also a health care assistant relief panel across all designated centres to ensure any unforeseen staff gaps are filled. The Person In Charge completes rosters in the Designated centre. The rosters are reviewed by the PPIM. The PPIM ensures there is a full staffing complement in the home. The Registered Provider has ensured the staffing resources are fully available for rosters in the home. The review of the rosters occurs on a weekly basis to ensure the provision of staff meets with the residents assessed needs.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Supported by the Person in Charge, the Person Participating in Management has engaged with the Learning and Development department to ensure the staff who have been identified with training deficits are resolved. Clear timetables with guidelines and expectations are in place for the staff identified during the inspection. All mandatory training and site specific training will be complete by March 31st.	

Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The Registered Provider has provided access to the suite of proprerty service records in electronic format for review. Records are also mainained in the fire folder in each home of the designated centre. Records are present in the Fire folder of the homes.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Registered Provider is committed to completing the works identified in the inspection of January 2023. The Provider recognises there are actions remaining for completion, however under the following regulations, issues with compliance have been addressed since the January inspection: Regulation 7: Behaviour support training has been provided to staff by a Behavioural Specialist in the Designated Centre since the date of inspection. The remaining staff to have their training complete by March 31st, 2023. Regulation 15: The designated Centre is fully staffed to meet the residents' identified needs. Regulation 16: Staff training is reviewed weekly by PPIM supported by the PIC. Staff have access to centre specific training such as mental health and Autism on HSELand. The remaining staff will have their training complete by March 31st, 2023. Regulation 17: The Registered Provider has an on-going timetable of works that detail the actions to resolves the concerns raised in the recent inspections. • The centre had some doors and skirting boards identified as requiring improving. The door to a garden of a bedroom required being obscured to offer privacy. This task has been raised to glass contractor and will be completed by 6th March 2023. • A fire door was identified as an action and will require painting after replacement. This has also been assigned to a painting contractor and will be completed by 22nd February 2023. A kicker board in the kitchen of the home needs replacement and will be completed by 6th March 2023 • The large shower/toilet area has been reviewed with the resident living in this area. There is a shower to be removed and resealed. This task has been assigned to a Plumbing Contractor and will be completed by 6th March 2023. • The accurate ordering and timely storage of delivered materials will negate the need for boxes to be left unkempt floors through the Designated Centre.	

• The sink identified requiring improvement and will be rehung. This task has been assigned to Plumbing Contractor for completion by 6th March 2023
• A toilet seat needs a replacement. This task has been assigned to a Plumbing Contractor for completion by 6th March 2023.
• The storage facilities in a bathroom needs replacement. The purchase of a unit will replace the existing unit.
• Bedrooms and living areas have pictures and soft furnishings as per residents' wills and preference.
• Painting of the apartment 4 has been assigned to a Painting Contractor. The date for completion is 22nd February 2023.

Regulation 21: The Registered Provider has granted access to the suite of service records in electronic format for review. The Person in Charge has been granted access for review and discussion at team meetings held in the Designated Centre.
Regulation 27: Staff training in IPC will be completed by March 31st ,2023. Colour coordinated cleaning products are present in the homes. The refurbishments work will be completed by March 6th.
Regulation 28: Records of equipment are saved in folders in the homes and in digital format. Day and night-time fire evacuations have been completed and signed by the fire officer. The documents present now provide clear guidance to the staff members working in the homes.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Statement of purpose is update to date and processed to Registration.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Register Provider has implemented a timetable for bringing premises into compliance. The date for completion of all tasks is March 6th.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The Person In Charge has provided all required updates to the COVID 19 management plan and located same in an appropriate folder. The Person in Charge has reviewed all cleaning products in all apartments and all labels are now present as required. The Person in Charge has acted and resolved the insufficient stock of colour-coded cleaning equipment. All training will be complete by March 31st, 2023. An IPC audit has been requested for completion by March 31st 2023.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The maintenance of fire documentation has improved since the inspection. The fire safety risk assessment for the centre has been updated and is scheduled for review in March 2023. The fire evacuation plans are now easily retrievable for staff to access. Fire drills records are now available demonstrating that nighttime drills have taken place. Fire evacuation procedure remain a standard agenda point at staff team meetings. The doors have been identified for upgrade and will be completed by March 6th. The rationale for doors being key operated is designed to reduce restrictive practices in the homes. The provider has provided a separate document on the 15/02/2023 in relation to upgrading fire systems.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	28/02/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	28/02/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	31/01/2023

	showing staff on duty during the day and night and that it is properly maintained.			
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	Orange	31/03/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/03/2023
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	31/03/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/03/2023
Regulation 17(7)	The registered provider shall	Substantially Compliant	Yellow	31/03/2023

	make provision for the matters set out in Schedule 6.			
Regulation 21(4)	Records kept in accordance with this section and set out in paragraphs (6), (11), (12), (13), and (14) of Schedule 4, shall be retained for a period of not less than 4 years from the date of their making.	Substantially Compliant	Yellow	31/01/2023
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.	Substantially Compliant	Yellow	28/02/2023
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	28/02/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are	Substantially Compliant	Yellow	28/02/2023

	protected by adopting procedures consistent with the standards for the 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	Orange	31/03/2024
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.	Substantially Compliant	Yellow	31/03/2023
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/03/2023
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	31/01/2023
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	28/02/2023
Regulation 28(3)(a)	The registered provider shall	Substantially Compliant	Yellow	31/01/2023

	make adequate arrangements for detecting, containing and extinguishing fires.			
Regulation 28(3)(b)	The registered provider shall make adequate arrangements for giving warning of fires.	Substantially Compliant	Yellow	31/03/2023
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	28/02/2023
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Substantially Compliant	Yellow	31/01/2023
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	31/01/2023