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 19
Name of provider:	Stewarts Care DAC
Address of centre:	Dublin 20
Type of inspection:	Announced
Date of inspection:	15 January 2025
Centre ID:	OSV-0005853
Fieldwork ID:	MON-0037108

About the designated centre

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

Stewarts Care Adult Services Designated Centre 19 provides long stay residential care and support for up to six adults with intellectual disabilities and complex support needs. The centre is comprised of a large bungalow, located on the provider's campus in Dublin. The centre is wheelchair accessible, and contains bedrooms, a small kitchen, a large open-plan living room, a large sun room, and other communal spaces. It is located in close proximity to local amenities, transport links and community facilities. The centre aims to provide a comfortable home that maintains and respects residents' independence and wellbeing, and provides a high standard of care and support to them in accordance with evidence based practice. The person in charge is full-time, and care and support is provided by a team of social care workers, nurses and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Wednesday 15 January 2025	09:10hrs to 17:00hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This announced inspection was carried out as part of the regulatory monitoring of the centre and to help inform a decision on the provider's application to renew the centre's registration. The inspector used observations, engagements with residents, conversations with staff, and a review of documentation to form judgments on the quality and safety of the care and support provided to residents in the centre. The inspector found that the centre was operating at a good level of compliance with the regulations, and that residents were safe. However, some improvements were required in areas including the management of restrictive practices, notification of incidents, staff training, the premises, and health care.

The centre comprises a large single-storey building on a large campus operated by the provider. The campus is close to many community services and amenities such as shops, cáfes, and public transport. The inspector carried out an observational walk around of the centre. The building contains residents' bedrooms, store rooms, offices, bathrooms, a utility room, a small kitchen, a dining room, a large sun room, a relaxation room, and a large open plan living room.

The centre was bright, warm, and clean. However, aspects of the centre were institutional in aesthetic due to the size and design of the premises. For example, while the main living space was very spacious it lacked a homely layout and design and the cubicle-style toilets were not homely. Efforts had been made to make the centre more homely. It was pleasantly painted, nice photographs and pictures were displayed, and the furniture was comfortable. Most of the residents' bedrooms were small, but they were nicely decorated and personalised to their individual tastes. Within the main living areas, there was information displayed on the upcoming HIQA inspection, safeguarding, advocacy, and the Assisted Decision-Making (Capacity) Act 2015. The inspector observed that equipment used by residents, including ceiling hoists and electric beds, was in good working order. Generally the centre was well maintained; however, some minor upkeep was required.

The inspector observed physical and environmental restrictions. While the rationale for their use was clear, the arrangements to ensure that they were applied in line with the provider's policy required improvement. For example, not all restrictions had yet been approved for use by the provider's rights committee.

There were good fire safety arrangements, such as a newly installed addressable fire panel and fire-fighting equipment through the centre. The premises, restrictive practices and fire safety are discussed further in the quality and safety section of the report.

There were six residents living in the centre. In June 2024, the provider had reduced the number of residents from eight to six after two residents moved to a community-based home. This was part of the provider's plan to de congregate the

campus.

The inspector met all six residents. They communicated in different ways including through gestures, eye contact, and some words. They appeared to be content in their home, and the inspector observed staff interacting with them in a kind and warm manner. One resident spoke with the inspector with support from staff. They clearly communicated to the inspector that they did not like wearing an orthopaedic aid (they were not wearing it at that time), and the inspector brought this to the attention of the person in charge.

In advance of the inspection, staff supported residents to complete surveys on what it was like to live in the centre. Generally, the feedback was positive, and indicated that residents were safe, liked the staff, and received good care. However, there were some areas for improvement. Four residents said that the food could be better, one resident said that they would like to live in a community-based house, and one resident said that sometimes they were overwhelmed if it was too noisy in the centre. The provider's quality team had reviewed the surveys, and met with staff to discuss it in more detail. The person in charge also told the inspector that the feedback would be explored more to ensure that it was addressed.

On the day of the inspection, residents had a house meeting. The inspector reviewed a sample of the meeting minutes from November and December 2024, which showed discussions on activity and events planning, healthy eating, staffing, national standards, and human rights' principles such as autonomy, protection, having choice and being treated fairly. The inspector also read residents' communication plans. The plans guided staff on residents' communication means, and included important information on their interests and preferences.

The inspector did not have the opportunity to meet any of the residents' representatives. However, the annual review, dated February 2024, noted that one family returned a survey and gave positive feedback on the service provided in the centre.

The inspector met and spoke with staff throughout the inspection, including the person in charge and programme manager who facilitated the inspection, the Director of Care, a social care worker, a care assistant, and a household staff member.

The person in charge and service manager said that residents were safe, had a good quality of life, and received high quality care. They said that the centre met the residents' varied needs and was resourced appropriately. For example, the staffing arrangements were adequate, and residents could access the provider's multidisciplinary team services. They had no concerns, and said that there had been improvements since the last inspection in September 2023. For example, the reduction in the number of residents had contributed to more opportunities for residents to engage in leisure and social activities. They told the inspector that the centre was regularly audited and that actions were identified to drive further improvements.

A household staff member told the inspector that residents appeared to be happy in

the centre, and that the addition of a social care worker to the staff team had been positive for residents as they were doing now more social and leisure activities. They had no concerns for the residents' safety, but said that they could raise concerns if they had.

A social care worker told the inspector that residents were happy, safe, and that there was a homely atmosphere in the centre. They said that residents were supported to plan their activities weekly, but could change their minds on the day of the planned activity. They told the inspector about the residents' interests which included music, therapeutic and sensory treatments, spending time with family and friends, shopping, physical exercises, and eating out. They said that residents' rights were promoted in the centre. For example, staff got to know residents as individuals to understand their interests and preferences. The social care worker and a care assistant said that there was sufficient access to vehicles to facilitate community activities.

Overall, the inspector found that residents were safe and in receipt of good care and support. However, some improvements were required, and are discussed further under regulations 6, 7, 16, 17 and 31.

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

This announced inspection was carried out as part of the provider's application to renew the registration of the centre. The application included an up-to-date statement of purpose, residents' guide, and copy of the centre's insurance contract.

The inspector found that there were effective management systems in place to ensure that the service provided to residents living in the centre was safe and appropriate to their needs. Overall, the provider had ensured that the centre was well resourced. For example, staffing arrangements were appropriate to residents' needs, specialised equipment was available, and residents could avail of the provider's multidisciplinary team services.

The management structure was clearly defined with associated responsibilities and lines of authority. The person in charge was full-time, and found to be suitably skilled, experienced, and qualified for their role. The person in charge reported to a programme manager, and there were effective arrangements for them to communicate.

The provider and person in charge had implemented management systems to monitor the quality and safety of service provided to residents. Annual reviews and six-monthly reports, as well as various audits had been carried out in the centre.

Actions identified from audits and reports were monitored to ensure that they were progressed. However, the inspector found that not all incidents, as specified under regulation 31, that had occurred in the centre were notified to the Chief Inspector of Social Services.

There were no open or recent complaints. However, the provider had implemented a complaints procedure for residents to use if they wished to make a complaint, and it was in an accessible easy-to-read format.

The staff skill-mix consisted of nurses, healthcare assistants, and a social care worker. The person in charge and programme manager were satisfied that the skill-mix and complement was appropriate to the assessed needs of the current residents. There were no vacancies in the complement. The person in charge maintained planned and actual rotas that showed the names of staff working in the centre and the hours they worked.

Staff were required to complete training as part of their professional development. The inspector reviewed the staff training log with the person in charge. While most staff were up to date with their training, eight staff had not completed training in supporting residents with modified diets. This posed a risk to the quality and safety of care that they provided when assisting residents with their meals.

The inspector also found that the provision of epilepsy training for non-nursing staff required more consideration from the management team. The programme manager planned to review this matter to ensure that the arrangements for supporting residents with epilepsy were appropriate.

There were effective arrangements for the support and supervision of staff working in the centre, such as management presence and formal supervision meetings. Staff could also contact an on-call service for support outside of normal working hours.

Staff also attended team meetings which provided an opportunity for them to raise any concerns regarding the quality and safety of care provided to residents. The inspector read the October, November and December 2024 staff team meeting minutes which reflected discussions on residents' updates and care plans, incidents, safeguarding, staffing, training, maintenance issues, restrictive practices, audit findings, and complaints.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider submitted an application to renew the registration of the centre. The application contained the required information set out under this regulation and the related schedules. For example, the residents' guide and statement of purpose.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. They were suitably skilled and experienced for the role, and possessed relevant qualifications in social work and management. They had commenced in their role in July 2024 and prior to that had worked as a social care worker in the centre. They were based in the centre, and were ensuring that the centre operated in accordance with the statement of purpose.

Judgment: Compliant

Regulation 15: Staffing

The staff skill-mix and complement comprised two nursing whole-time equivalents, one social care worker whole-time equivalent, and 11.4 healthcare assistant whole-time equivalents. There were no vacancies. The person in charge and programme manager were satisfied that the skill-mix and complement was appropriate to number and assessed needs of residents' living in the centre.

The inspector reviewed November and December 2024 and January 2025 planned and actual rotas. They showed the names of staff and the hours they worked in the centre. Two staff Schedule 2 files, including vetting disclosures and copies of qualifications, were reviewed and found to be in place.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were required to complete training as part of their professional development and to support them in the delivery of appropriate care and support to residents. The training included safeguarding of residents, human rights, manual handling, supporting residents with modified diets, infection prevention and control, positive behaviour support, and fire safety. The inspector reviewed the most recent training log, dated January 2025, with the person in charge. The log accounted for 16 staff, and showed that eight staff required training in supporting residents with modified diets. Four residents required support in this area, and the lack of training for all staff posed a potential risk to the quality and safety of support that they received.

The person in charge ensured that staff were supported in their roles, and provided them with formal supervision in line with the provider's policy.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had effected a contract of insurance against injury to residents and other risks in the centre including property damage.

Judgment: Compliant

Regulation 23: Governance and management

There were effective management systems in place to ensure that the service provided in the centre was safe and effectively monitored.

There was a clearly defined management structure in the centre with associated lines of authority and accountability. The person in charge was full-time and based in the centre. The person in charge reported to a programme manager who in turn reported to a Director of Care. There were good arrangements for the management team to communicate, including formal meetings and informal communications. The senior management team also visited the centre as part of their oversight arrangements.

The provider had implemented good systems to monitor and oversee the quality and safety of care and support provided to residents in the centre. Annual reviews (which had consulted with residents and their representatives) and six-monthly reports were carried out, along with various audits in the areas of residents' documentation and finances, health and safety, and infection prevention and control (IPC). The audits identified actions for improvement where required, and were monitored by the person in charge. For example, following the recent IPC audit in January 2025, the laundry facilities had been rearranged and infection hazards had been reported to the maintenance department.

There were effective arrangements for staff to raise concerns. In addition to the support and supervision arrangements, staff attended team meetings which provided a forum for them to raise any concerns.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose containing the

information set out in Schedule 1. It was last reviewed in November 2024, and was available in the centre for residents and their representatives.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had not ensured that incidents, as detailed under this regulation, which had occurred in the centre were notified to the Chief Inspector.

The inspector reviewed incidents that had occurred in the centre in the previous 12 months, such as allegations of abuse, minor injuries, and the use of restrictive practices. They found that five allegations of abuse and the use of restrictive practices in the previous two quarters had not been notified to the Chief Inspector. The programme manager and person in charge submitted the outstanding notifications during the inspection and on the following day.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had implemented an effective complaints procedure for residents, which was underpinned by a written policy. The policy outlined the processes for managing complaints including the stages of resolution, the associated roles and responsibilities, and how residents could access advocacy services. The procedure had been prepared in an easy-to-read format for residents and their representatives. There were no recent or open complaints.

Judgment: Compliant

Quality and safety

The inspector found that residents' safety and welfare was maintained by a good standard of care and support. Staff supported residents in a kind and familiar manner. Since the previous inspection in September 2024, the number of residents had reduced by two, and this was having a positive effect. For example, residents had more opportunities for social activities.

The person in charge had ensured that residents' health care needs had been assessed to inform the development of personal plans. Residents had access to the

provider's multidisciplinary team services, and within the centre nurses oversaw their health care needs. However, the arrangements for ensuring that residents could access health screening services required improvement.

The provider had implemented arrangements to safeguard residents from abuse. For example, staff had received relevant training to support them in the prevention and appropriate response to abuse. The inspector reviewed the records pertaining to three safeguarding incidents in 2024, and found that they had been managed appropriately.

Residents were supported to manage their behaviours of concern. Behaviour support plans had been prepared to guide staff, and staff had completed relevant training to inform their practices. However, the oversight and management of restrictive practices required improvement to ensure that they were applied in line with the provider's policy and that residents' views were respected and documented.

The premises comprised a large single-storey building on a campus operated by the provider. The centre was warm, clean, and bright. Residents had their own bedrooms, and communal spaces included a a large open-plan living space, a large sun room, a relaxation room, a kitchen, and a dining room. Parts of the premises required maintenance and upkeep, and the majority of the works had been reported to the provider's maintenance department.

The inspector observed good fire safety precautions. There was fire fighting and detection equipment throughout the centre, and staff had received fire safety training. However, the inspector found that some improvements were required to the fire safety arrangements. For example, the fire evacuation procedure required more detail to guide staff on using the fire panel and on what the 'safe evacuation' time was. The provider’s fire officer and person in charge addressed these matters before the inspection concluded.

Regulation 11: Visits

The registered provider had ensured that residents could receive visitors as they wished. There was space and facilities for visitors to be received in the centre. There were no restrictions on visitors, and some residents received frequent visitors such as friends and family members.

Judgment: Compliant

Regulation 13: General welfare and development

The previous inspection of the centre in September 2023 found this regulation to be not compliant. This inspection found that improvements had been made to provide

residents with better opportunities to participate in activities in line with their interests, capacities and needs.

Staff supported residents with their daily social care needs and facilitated their leisure and recreational activities. Residents' activities were planned at weekly meetings. A social care worker had responsibility for organising the activities and for auditing the facilitation of the activities. The inspector reviewed three residents' activity records for December 2024. They included community-based activities such as going to the pub, park, mass, hairdressers, and shopping; campus-based activities such as walks around the campus and using the provider's gym and social groups; and in-centre activities such as massages, watching movies, listening to music, and using sensory aids. On the day of the inspection, residents engaged in different activities including going to the shop, arts and crafts, having massages, and listening to music.

Staff told the inspector that since the previous inspection, access to transport had improved. The centre now shared a vehicle with another location, and there were other vehicles also available on the campus that could be borrowed. There was a small number of staff in the centre who could drive the vehicles. Staff said that currently the number was adequate. However, this required ongoing consideration from the provider.

Judgment: Compliant

Regulation 17: Premises

The premises comprised a large single-storey building on a campus operated by the provider. It contained residents' bedrooms, offices, storage areas, a relaxation room, a laundry room, bathrooms, a kitchen, a small dining room, a large sun room, and a large open plan living area.

The centre clean, tidy, warm, and well equipped. The inspector observed that specialised equipment was available to residents as they needed it, such as ceiling hoists, electric beds, and an accessible bath. The equipment was in good working order and serviced regularly. Aspects of the premises were institutional in design and layout. For example, the walls and doors in two cubicle-style toilets did not fully meet the floor and ceiling which could impinge on privacy. However, efforts had been made to make the premises more homely. The furniture was comfortable, nice photos and pictures were displayed in communal areas, and residents' bedrooms were personalised to their individual tastes. Some residents had their own televisions which they used to stream entertainment.

Some maintenance and upkeep was required to the premises. For example, some doors and their frames were marked from contact with wheelchairs, flooring was marked in places, one of the sun room doors was damaged, the kitchen counter was chipped, and areas of the centre needed repainting. The storage facilities in the

storage rooms also required enhancement to ensure that items were stored off the floor. Most of these issues had been already identified in the provider's internal infection prevention and control, and health and safety audits, and had been reported to the provider's maintenance department.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider has prepared a residents' guide. The guide was up to date, available in the centre to residents, and included the required information such as the terms and conditions relating to residency.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had implemented effective fire safety precautions in the centre. There was fire detection (which had been recently upgraded) and fighting equipment, emergency lights, and it was regularly serviced to ensure it was maintained in good working order. The inspector released a sample of the fire doors, including the kitchen, dining, hall and bedroom doors, and observed that they closed properly.

The inspector observed that some improvements were required to the fire safety arrangements. The fire evacuation procedure required more direction for staff on using the fire panel, there was no guidance for staff to refer to on the different fire zones in the building, and the procedure had not identified a 'safe evacuation' time. The inspector brought these matters to the attention of the person in charge during the inspection. The person in charge contacted the provider's fire officer , and they addressed these matters before the inspection concluded. They prepared the required guidance on the fire zones, and updated the evacuation procedure to reference the fire panel and include a 'safe evacuation' time.

The person in charge had prepared up-to-date individual evacuation plans which outlined the supports required by residents to evacuate the centre. Staff had completed fire safety training, and fire drills, including drills reflective of night-time scenarios, were carried out to test the effectiveness of the plans.

Judgment: Compliant

Regulation 6: Health care

Generally, the provider and person in charge had ensured that residents were in receipt of appropriate health care that was in accordance with their assessed needs. However, improvements were needed to demonstrate that residents were supported to access, if they wish to, national screening services.

The inspectors reviewed three residents' health care assessments and care plans. They were up to date and informed by relevant health and social care professionals including speech and language and occupational therapists. Within the centre, nurses oversaw the implementation of the care plans. However, there was no plan related to the use of a orthopaedic aid for a resident. This posed a risk that staff would not apply the aid and monitor its use appropriately.

The inspector reviewed the national screening services records for four residents. There was evidence of residents using some screening services (as appropriate to their eligibility) such as Diabetic RetinaScreen and BowelScreen. However, the records in relation to other screenings were unclear. This required attention from the person in charge to ensure that residents could access screening services, and where they declined services, that these decisions were clearly recorded.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector found that residents were receiving support to manage any behaviours of concern. The inspector viewed five behaviour support plans. They were up to date and had been reviewed by the appropriate health care professional. The plans were readily available to guide staff. Staff had also completed positive behaviour support training to inform their practices.

The management and oversight of restrictive practices in the centre required improvement. The inspector reviewed the restrictive practice records related to four residents. The restrictions included environmental and physical restrictions. The person in charge had completed protocols for the restrictions which had been submitted to the provider's rights committee for approval. However, approval had so far only being received for one. The recording of use of the restrictions also required improvement. For example, the inspector observed gaps in the daily recording log used for an audio monitor.

The inspector spoke with one resident regarding an orthopaedic aid. They clearly expressed that they did not want to use the aid. Staff told the inspector that it was last used approximately nine months ago as the resident screams if staff try to use it. However, this information was not recorded in the associated protocol. Further assessment was required from the provider to ensure that the views of each

resident was respected when considering and reviewing restrictive practices.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse. Staff working in the centre completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns, and there was guidance for them in the centre to refer to. At the time of the inspection, the provider was reviewing its safeguarding policy.

Inspectors reviewed the records of three safeguarding incidents reported in 2024, and found that they had been appropriately reported and managed to promote the residents' safety.

The person in charge had ensured that intimate care plans had been prepared to guide staff in delivering care to residents in a manner that respected their dignity and bodily integrity. The inspectors reviewed three resident's intimate care plans and found that they were up to date and readily available to staff to guide their practice.

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 19 OSV-0005853

Inspection ID: MON-0037108

Date of inspection: 15/01/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Since the HIQA inspection on 15/01/25, all staff are now trained on FEDS (Feeding, eating, drinking and swallowing) to support residents who are on modified diets. All staff have now completed training in epilepsy (observing and responding to seizures- Buccal Midazolam training included).	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All five NF06 (notifications for allegations of abuse) have since been logged onto the HIQA portal. In Quarter 4 (2024) notification, the PIC also included restraints in the reporting (NF39A). This practice will continue going forward.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

The 2 cubicle style toilets referred to have been listed for renovation by our technical services team. This will allow full privacy for the residents when using them. This work is expected to be completed before the end of April 2025.
Since the inspection, 2 shelving units have been installed in the storage room to ensure that items are stored off the floor.
Kitchen counters shall be repaired /replaced by the end of April 2025.
Flooring issues are allocated for repair and shall be fixed before end of April 2025.
Doors shall be repaired and repainted where required. This will be completed before the end of April 2025.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Since the inspection there are now care plans in place for the use of orthopedic aids for the residents in the DC.

There is now a system in place in terms of tracking the residents' participation in National Screening Services. This auditing tool also allows us to capture when residents de-consent to screenings.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Since the inspection all protocols have been reviewed and approved by the restrictive practice committee.

The use of all restrictive practices in the DC are now being recorded in the restrictive practice log and will continue to be recorded for each use going forward.

The consent process is captured in the restrictive practice protocol which staff adhere to.

The logs in place in the DC now record the consent/ refusal decision daily.

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 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.	Substantially Compliant	Yellow	30/04/2025
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	30/04/2025
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated	Substantially Compliant	Yellow	30/04/2025

	centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Substantially Compliant	Yellow	30/04/2025
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	30/04/2025
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each	Substantially Compliant	Yellow	30/04/2025

	resident, or his or her representative, and are reviewed as part of the personal planning process.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/04/2025
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	30/04/2025
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	30/04/2025