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:	Ralahine Apartments
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	15 July 2020
Centre ID:	OSV-0005232
Fieldwork ID:	MON-0029753

About the designated centre

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

This centre is located in a town in Co. Clare and provides a residential service for a maximum of four residents who are all over the age of 18 years. The centre comprises of three separate ground floor apartments where two residents have their own apartment and the remaining two residents share an apartment. Each apartment provides residents with their own bedroom, bathroom, kitchen and living area, the latter being shared in the shared living arrangement. While the centre is managed and operated as one unit, each apartment has a staff team and management and oversight of the centre in its totality is maintained by a social care worker in conjunction with the person in charge. Staff are on duty in each of the apartments both day and night to support the residents; the night time staffing arrangement is a sleepover duty.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 July 2020	09:45hrs to 16:45hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was completed within the ongoing requirement for infection prevention and control measures in the context of COVID 19. The inspector therefore did not enter all apartments and met with two of the four residents, the two residents who reside in the shared apartment. Staff were flexible in their approach to facilitating the inspection while mindful and dutiful of infection prevention and control measures. While there were limits to the opportunity to directly observe what life was like in the centre the inspector saw that staff were supporting residents to reintegrate with their community and their families in line with the easing of COVID 19 restrictions. For example one resident was looking forward to their first visit back to the hairdresser on the morning of the inspection. The inspector observed how staff were innovative and utilised purposeful opportunities to encourage mobilisation and exercise. Much of the discussion with residents related to family and home, there was discussion of recent personal loss and the comfort that was brought by being able to attend the funeral ceremony, again in the context of the COVID 19 restrictions. A resident was looking forward to attending a family event that had been rescheduled for later in the year and described their outings to meet family that had recently recommenced. From records seen the inspector was assured that the provider understood and sought to ease the impact on residents of such restrictions. For example one resident had returned home for sometime so as to ease the impact of the pending restrictions following discussion between family and the provider. Staff had facilitated visual visits from family, daily telephone contact and introduced letter writing. Residents had a good understanding of the risk that COVID 19 posed and explained how they used a face covering as appropriate and performed hand hygiene. The residents that were spoken with said that they liked their apartment and loved their bedrooms. There was one aspect of living in the centre that was not liked and that was discussed in a balanced and respectful manner with the inspector, this was the same matter that was observed and reported to the inspector at the time of the last Health Information and Quality Authority (HIQA) inspection in May 2018. While residents lived amicably together much of the time and there was an evident bond and loyalty, the assessed needs of residents are not compatible and the shared living arrangement and the amount of available space is not conducive to these incompatible needs. Resident feedback was that the situation was good at the moment but the impact of the times that were not so good was also spoken of. The provider had implemented measures that sought to ease the impact for residents of this incompatibility but the plan to provide alternative accommodation more suited to the needs of both residents had not progressed as planned by the provider.

Capacity and capability

The primary finding in relation to the governance of this centre was the providers failure to progress its quality improvement plan in line with the timeframes previously committed to and submitted to HIQA. This plan related to the longterm resolution of the fact that residents have different needs and do not always live compatibly together; the living arrangements in one of the apartments are not suited to their individual and differing needs and this impacted on the quality and safety of residents lives.

The management structure was clear as was individual roles and responsibilities and the escalation of matters that were beyond individual roles to manage and resolve. The input of and the oversight of the person in charge was evident. For example the person in charge while exercising their responsibility for the management of the service, liaised and advised their manager of matters that impacted on the quality and safety of the service that residents received and the action taken in response to address this, such as a pattern noted in medicines management errors. There was also documentary evidence that in turn management escalated unresolved matters internally within the governance structure and externally to other stakeholders such as the funding body, for example the incompatibility of needs and the unsuitability of the living arrangements that the centre offered. Ultimately however, the providers plan to source and provide alternative accommodation so that all residents were in a receipt of a service that was suited to their individual and collective needs, that was consistently safe, that eliminated anxiety and unpredictability for residents had not been progressed within previously committed to timeframes. In addition records seen indicated that proposed solutions altered in line with challenges and obstacles that were encountered by the provider when seeking to find a resolution. A defined and agreed solution based on the holistic assessed needs and wishes of residents and not just the issue of night-time disturbance was needed, a plan that was consistently progressed and had a defined implementation timeframe. For example it was not clear how it was established that a continued shared living arrangement but with more space was the best solution that would promote the best possible outcomes for both residents.

The provider had completed its own recent review of the quality and safety of the service; the report was in draft but was shared with the inspector. This review and report was transparent and acknowledged what was good, where improvement was needed but also that there were matters that the provider had not resolved and that still required resolution, that is the unresolved quest for alternative accommodation. The findings of that internal provider review and this HIQA inspection are therefore similar in terms of what is still required of the provider so as to ensure the provision of an appropriate safe and quality service for each resident.

Based on the evidence available to the inspector staffing levels and arrangements were suited to the assessed needs of the residents and the design and layout of the centre. There was evidence that the provider had through recruitment addressed reliance on relief staff and the staff rota indicated that a team of regular and relief staff now worked in the centre; this promoted consistency and familiarity for both residents and staff. The night-time arrangement was a sleepover staff in each of the three apartments; residents did at times require support from staff. The person in charge discussed how the suitability of this arrangement was monitored and

corrective actions were described such as reducing the number of sleepover duties allocated to staff. The inspector reviewed records pertaining to the past three months and these indicated good resident sleeping patterns in that time-frame. The staff rota was well maintained and was seen to be made available to residents so that they knew what staff were due to come on duty. The person in charge confirmed that formal staff supervisions were all on schedule.

Like the staff rota the record of the training completed by staff was clearly presented and from it the inspector established that all staff had completed baseline mandatory, required and desired training such as safeguarding, fire safety and medicines management. Refresher training was due for a number of staff and had not been scheduled due to the impact of COVID 19 restrictions. There was a plan to recommence the rescheduling of this training in conjunction with the completion of on-line training where possible. The training programme was responsive and included a suite of training relevant to the skills and knowledge needed by staff to respond effectively to the risk of COVID 19 such as hand hygiene and the correct use of personal protective equipment (PPE). The training record was complete for the majority of staff but much of this learning was self-directed and certificates needed to confirm and verify the completion of this important training were not all evident. Verification was however provided and submitted to the inspector post the inspection by the person in charge.

Improvement was needed in how the provider responded to and monitored its response to complaints to ensure and satisfy itself that its response was timely and effective. Residents and their representatives knew how to and did use the complaint procedure when they were dissatisfied with an aspect of the service. Residents were supported by staff to make a complaint, develop their skills for self-advocacy and were hoping to commence formal education on human rights. There was evidence of actions taken by the provider in an attempt to address and resolve complaints. However, the issue and impact of incompatible needs and living arrangements was formalised to the provider in 2018 through the complaints procedure and was still unresolved for the complainant, a resident. The complaint log indicated that the resident had complained on a further two occasions in 2019. The provider needed to consider given that the complaints process had not resolved this issue if it was the most appropriate process by which to progress the residents concerns.

Regulation 14: Persons in charge

The person in charge worked full-time and met the requirements of the regulations in terms of qualifications, skills and experience. The person in charge took responsibility for the management of the centre taking into account their role in the management structure. The person in charge was supported in the day to day management of the centre by the social care worker. The provider had also recently

reduced the person in charge scope of responsibility so as to better support the capacity of the person in charge to effectively manage each of the designated centres. The input of and oversight by the person in charge was evident on inspection.

Judgment: Compliant

Regulation 15: Staffing

Based on the evidence available to the inspector staffing levels and arrangements were suited to the assessed needs of the residents and the design and layout of the centre. There was evidence that the provider monitored the adequacy of these arrangements and made changes so as to best support residents, for example the recruitment of regular staff, additional staffing to support residents during the COVID 19 pandemic and the monitoring of the night-time staffing arrangements.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to the education and training that they needed so as to provide residents with a safe and effective service.

Judgment: Compliant

Regulation 23: Governance and management

The providers plan to source and provide alternative accommodation so that all residents were in a receipt of a service that was suited to their individual and collective needs, that was consistently safe and that eliminated anxiety and unpredictability for residents had not been progressed within the committed to time-frames. In addition records seen indicated that proposed solutions altered in line with challenges and obstacles that were encountered by the provider when seeking a solution and this did not support timely resolution. A defined and agreed plan based on the holistic assessed needs and wishes of residents and not just the issue of night-time disturbance was needed, a plan that was consistently progressed and had a defined implementation time-frame.

Judgment: Not compliant

Regulation 31: Notification of incidents

Based on the records seen in the designated centre there were arrangements that ensured that events and incidents that were to be notified to HIQA such as the use of any restrictive intervention were notified.

Judgment: Compliant

Regulation 34: Complaints procedure

Improvement was needed in how the provider responded to and monitored its response to complaints to ensure and satisfy itself that its response was timely and effective. The provider needed to consider given that the complaints process had not resolved this issue if it was the most appropriate process by which to progress the issue and impact of incompatible needs and living arrangements.

Judgment: Substantially compliant

Quality and safety

Residents living in this centre presented with a broad range of needs and abilities and there were many positive outcomes for residents who lived in this centre. Residents enjoyed the experience of living in their own home while being provided with the support that they needed from staff, residents had good opportunity to integrate with the local community and to maintain close contact with family. However, the inspector again found that the quality and safety of the service was negatively impacted at times by the incompatibility of residents needs specifically where there was a shared living arrangement.

Based on their assessed needs two residents lived in their own apartment and had a staff support at all times. The apartments are however part of a much larger complex and challenges directly related to the overall design and layout of the complex had arisen in the months prior to this inspection. The inspector was advised that this necessitated the relocation of a resident to an alternative property and that a suitable property had been identified. The proposed move was, based on records seen a very recent development, a transition plan had not yet been developed but the inspector was told that the relocation had been discussed and agreed with the residents representatives. This situation highlighted the requirement for the robust assessment of residents needs in relation to existing and future placements to ensure that the arrangements offered by apartment living were suited to those

assessed needs.

As was found at the time of the last HIQA inspection, the service was person-centred but it needed to be more individualised. There were individual resident needs that were incompatible in a shared living arrangement. This impacted negatively at times on residents' rights, their right to privacy, their right to a safe and secure environment that promoted their well-being and development; their right to personal space other than their bedroom and to reasonably choose where they wished to live and whom they wished to live with. This individuality of needs was compounded by the limited space that was available with two residents and the staff on duty sharing the open plan kitchen, dining and communal space. This living arrangement, the challenge it posed and the impact on resident quality of life was the subject of a repeat complaint made by a resident in 2018 and 2019 as referenced in the first section of this report. Neither resident had the space and privacy that they needed when periods of anxiety developed, escalated and were expressed through behaviour. During this HIQA inspection a resident described to the inspector how they felt upset when such periods of anxiety occurred and described how they would lie in bed and pull their bedclothes over their head to block the noise. In the complaints that were made by the resident, this upset was cited again as was loss of sleep and consequent tiredness and a sense of a lack of fairness at their situation was perceived by the resident. Staff confirmed in records the upset of the resident as witnessed by them.

While the episodes may not be regular, they were at times intense and required the administration of a prescribed medicine to assist in the regulation of emotions. While not regular there was an unpredictability, the element of not knowing that needs to be factored into the impact of this incompatibility. In addition the assessment of compatibility and impact needs to be broader that the issue of night-time disturbance as this living arrangement works primarily because one resident ordinarily spends their day out of the apartment. In the context of COVID 19 additional staff support was needed to compensate for the closure of day services so that this living arrangement worked. As stated in the first section of this report while there was evidence of efforts made by the provider since the 2018 HIQA inspection to secure alternative accommodation this matter was not resolved and there was no defined pathway to resolution.

The provider did try to reduce the occurrence and manage the impact. Residents had the clinical support that they needed from psychiatry, behaviour support and counselling. Staff had access to a detailed positive behaviour support plan that was, based on records seen reviewed in consultation with the behaviour therapist in February 2020 and a protocol that guided the use of medicines when supportive interventions did not work. Other actions taken by the provider included the introduction of a call-bell for seeking staff assistance and the offer of alternative accommodation to afford the space needed by both residents during these times of distress.

The person in charge had systems for monitoring the quality and safety of the service such as staff meetings, staff supervisions and maintaining a presence on site; residents clearly knew the person in charge. All staff had completed

safeguarding training and there were no reported obstacles to reporting concerns for resident safety. There was access as needed to the designated safeguarding officer. A resident spoken with told the inspector that they knew the safeguarding officer. While the resident told the inspector that they were not afraid, the impact on the resident, the protection and safeguarding of their psychological well-being given the reported upset, needs to be considered in the assessment of risk associated with needs that are incompatible and shared living arrangements.

Staff monitored resident well-being and records seen demonstrated that residents were referred to services such as medical (their General Practitioner (GP)), optical, dental, chiropody, psychiatry, occupational therapy, physiotherapy and speech and language therapy. Some referrals and reviews sought to further inform the support provided, for example occupational therapy review to assess the capacity and safety of residents accessing the bathroom without staff assistance. During the COVID 19 pandemic staff continued to seek advice and support from these clinicians as needed. Staff were seen to encourage residents to make healthy lifestyle choices.

While there was scope for improvement, overall the inspector concluded that there was a good understanding of the identification and management of risk. The sample of risk assessments seen were clear on what the risk was, the controls that reduced the risk to resident and staff safety and any additional controls that were needed. For example, the risk assessment for times when a resident may be unsupervised in their apartment clearly set out the resident skill-set that made this an appropriate arrangement and the controls that assured safety such as access to a phone and staff from an adjoining apartment. Staff had recently tested one such control; resident response and ability to evacuate should the fire alarm sound. Accidents and incidents were reviewed and analysed so that patterns and contributing factors were identified and corrective actions to ensure and assure resident safety were put in place. This review was also seen to inform the review of already assessed risks such as a risk for falls. However, the inspector also found that improvement and better consistency was needed in the identification and assessment of risk. For example while the risk of incompatible resident needs was identified and there were existing and additional controls (securing alternative accommodation) the overall risk rating was not assessed on the records seen by the inspector. The need to secure alternative accommodation was however described by the provider as urgent. While the adequacy of the staff sleepover arrangement was monitored, a risk assessment that logged the possibility of risk that it was not and that set out how monitoring controlled that risk and informed any action that may be needed was not in place. In addition though good and safe practice was described to the inspector, COVID 19 specific risk assessments individualised to each resident as they started to reengage with family and the wider community were not in place so as to best guide and support practice.

The provider had responded effectively and implemented measures to protect residents and staff from the introduction and onward transmission of COVID 19. The response was led by a national team so that there was consistency in systems and processes and to ensure that changes to national guidance were monitored and disseminated. Adherence was monitored locally and monitoring of COVID 19 preventative controls was included in the recent internal provider review. The

inspector saw these controls such as the training completed by staff, temperature checks, the availability and use of PPE and sanitising products. Staff had in line with the each residents assessed needs and abilities, supported residents to understand the risk posed and how to protect themselves through hand-hygiene, physical distancing and using a face mask as needed.

There was evidence of good fire safety practice. A fire safety register was maintained in each apartment; the register reviewed by the inspector was well maintained. The recent internal provider review had looked at all three registers and the findings provided assurance that practice was consistent across the three apartments. This HIQA inspector saw that the emergency lighting, fire detection system and fire fighting equipment were inspected and tested at the prescribed intervals and all inspections were up to date. All staff had completed fire safety training and undertook evacuation drills with residents. Records of these drills indicated that the drills were convened so as to simulate different scenarios such as night-time evacuation, there were no reported obstacles to evacuation and good evacuation times were achieved.

Regulation 13: General welfare and development

Pre COVID 19 residents had access to off-site day services, community based programmes or received an integrated type service from their home. With the required cessation of day services, the provider had enhanced staffing levels so that each resident had a staff support by day. Staff had sought to ensure that residents coped with the loss of contact with family, friends and the wider community; contact was facilitated by phone, visual or physical distancing in times of crisis such as bereavement. It was evident to the inspector that being able to see family and attend ceremonies eased and helped residents cope with their loss. Residents spoke of how they were re-engaging with family and communities and returning to more normal routines as national restrictions eased.

Judgment: Compliant

Regulation 26: Risk management procedures

Overall the inspector concluded that there was a good understanding of the requirement to identify and manage risk so that residents received a safe service. However, the inspector also found that improvement and better consistency was needed so as to inform and assure the safety of the support provided. For example while the risk for the needs of residents that were incompatible was identified as were controls including the overall objective of securing alternative accommodation,

the overall risk impact on residents was not assessed. There were other potential risks that were not included in the register of risks and that would, if put in place better support and guide practice, such as the monitoring of the staff sleepover arrangement and supporting residents to safely re-engage with and navigate the reality of COVID 19 in the community.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had implemented policies, systems and measures to protect residents and staff from the risk of the introduction and onward transmission of COVID 19.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had effective fire safety procedures including procedures for the evacuation of residents from the designated centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were individual resident needs that were incompatible in a shared living arrangement. This impacted negatively at times on residents' rights, their right to privacy, their right to a safe and secure environment that promoted their well-being and development; their right to personal space other than their bedroom, to reasonably choose where they wished to live and whom they wished to live with. This individuality was compounded by the limited space that was available with two residents and the staff on duty sharing the open plan kitchen, dining and communal space. While there was evidence of efforts made by the provider since the last HIQA inspection to secure alternative accommodation it was not resolved and there was no defined pathway to resolution. Further challenges had also arisen and the learning from this highlighted the requirement for the robust assessment of residents needs in relation to existing and future placements to ensure that the arrangements offered by apartment living were suited to their assessed needs.

Judgment: Not compliant

Regulation 6: Health care

Staff assessed and monitored resident well-being and ensured that residents had access to the services that they needed. Clinical reviews and recommendations were incorporated into the personal plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were times when residents were challenged to cope positively with events and anxieties. Residents had the clinical support that they needed from psychiatry, behaviour support and counselling. Staff had access to a detailed positive behaviour support plan that was, based on records seen reviewed in consultation with the behaviour therapist in February 2020 and a protocol that guided the use of medicines used when supportive interventions did not work. The inspector found that there was greater clarity on what constituted a restrictive intervention and a reduced reliance on such interventions.

Judgment: Compliant

Regulation 8: Protection

The provider had policies and procedures to protect residents from harm and abuse. However, the protection and safeguarding of resident psychological well-being given the reported upset, needs to be explicitly considered in the assessment of risk and the plan for resolving needs that are incompatible in a shared living arrangement.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ralahine Apartments OSV-0005232

Inspection ID: MON-0029753

Date of inspection: 15/07/2020

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To arrange a planning meeting with HSE, PIC and Managers • To review impact of current living arrangements on both individuals. Address issues of incompatibility, get input from stakeholders and list recommendations to be actioned. • To review accommodation options that will come available in Shannon and Newmarket on Fergus at end of 2020. Also, options through Banner Housing or Clare Co Council. • To decide whether the plan to live together in a larger house is a feasible option given housing stock available locally and wishes expressed by both individual. • To address funding issues with HSE that would assist with sourcing appropriate accommodation and additional staff support as needed. • To provide a plan on above items with realistic timeframes for the implementation of agreed actions To be completed by Oct 30th 2020	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Complaints Officer • To close the complaint and address the issues regarding the quality of service experienced by individual tenant in her individual plan, reviews, audits and HIQA inspections.	

• To communicate this to tenant, family advocate, Clare Service Manager and HSE. To be completed by Sept 30th 2020

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: To review all risks identified for both individuals and staff who work in the apartment To identify additional controls that can be put in place to help manage risks. To be completed by September 30th 2020	

Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Review support for both tenants holistically to ensure supports are both person centered and individualised. • To complete planning meetings for both individuals that include input from MDT, PIC, SCW, Regional Manager and family member. • To develop recommendations and actions that address issues raised in HIQA report. • To continue to develop and respond to issues that arise in a timely manner as a result of incompatibility of tenants while alternative arrangements are being worked on.	

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 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	30/10/2020
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	30/09/2020
Regulation 34(1)(a)	The registered provider shall provide an effective	Substantially Compliant	Yellow	30/09/2020

	complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	30/09/2020
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	30/09/2020
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/10/2020