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:	18 May 2021
Centre ID:	OSV-0005232
Fieldwork ID:	MON-0032288

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 is comprised of three separate ground floor apartments in an apartment complex. Two residents have their own apartment and, two residents share an apartment. Each apartment provides residents with their own bedroom, some en-suite facilities, a bathroom, and a combined kitchen and living area, the latter being shared in the shared living arrangement. The provider aims to support a broad range of needs in the service, the model of care is social and, a staffing presence is maintained in each apartment at all times. The night time staffing arrangement is a sleepover duty. The centre is managed and operated as one unit with management and oversight of the centre delegated to the person in charge supported by a social care worker.

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
Tuesday 18 May 2021	09:45hrs to 16:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken to follow-up on the findings of the last inspection of the service by the Health Information and Quality Authority (HIQA) completed in July 2020 and, regulatory engagement with the provider in the interim. The findings of this inspection were unaltered. While there were positive outcomes for residents, residents also had needs that were not always compatible in the context of the compact, shared living arrangement they were provided with in this centre. This impacted on each residents' quality of life. Neither resident had the space and privacy that they needed and, the proximity in which they lived resulted in sleep disturbance and, disturbance and upset by day. The circumstances in which these two residents lived limited the quality and safety of the service provided to them, impacted on them individually but also negatively impacted on their relationship that was positive on many levels. The provider has a plan to address this, but confirmed to HIQA that it does not have the resources required to deliver on this plan so as to improve the safety and quality of life for both residents.

This inspection was undertaken in the context of the ongoing requirement for measures to prevent the accidental introduction and onward transmission of COVID-19. COVID-19 has resulted in changes as to how centres are inspected so that they can be inspected in a way that is safe for residents, staff and inspectors. In the context of COVID 19 and the required infection prevention and control measures, in consultation with the provider it was agreed that the inspector would complete the review of records and, meet with the social care worker and the person in charge in nearby locations. The inspector then spent a short period of time in one of the three apartments.

These arrangements and, the individual routines of residents on the day meant that the inspector only met with one of the four residents living in the centre. The inspector has previously met and spoken with three residents. The inspector was mindful that this was a time of personal sadness for a resident. The inspector was also aware that two residents had in recent months met with an independent consultant. The consultant was engaged by the provider to establish the understanding, will and preference of both residents in relation to their current and desired living arrangements. The inspector therefore did not open a discussion again about these living arrangements; the facts and, the voice of both residents have been captured and established. Further discussion with residents under the circumstances may have led to further unnecessary upset. The resident spoken with applied a face-mask without prompting prior to engaging with the inspector. The resident spoke of their sadness, but said that they were ok and feeling a little better as they had a visit from family at the weekend and, had also played some of their favourite music to lift their spirits. There was some discussion of COVID-19, the need to be careful but not afraid and, the hope that vaccination brought to returning to a more normal way of life. The resident told the inspector that they felt fine after

their first vaccination and, knew that they had to wait some weeks for their second dose.

The completion of the annual review of the quality and safety of the service for 2020 was delayed, but resident and representative feedback had been gathered and, was reviewed by the inspector. The person in charge confirmed that the challenges arising in the shared living arrangement had been discussed with resident's representatives at the personal planning meetings. This was documented in the personal plan reviewed and in the most recent internal review of the service. The feedback provided did not refer directly to these matters or raise any concerns about proposed solutions including moving from the current location. The feedback was focused on the day-to-day service provided and, particularly referenced the quality of the support provided to residents in the context of COVID-19, the ensuing restrictions and lock-downs. The feedback was positive with respondents acknowledging how staff had kept residents safe but also ensured that they coped with and, had the resilience to accept challenges such as the loss of and, restricted contact with family, peers, work and day-services. Residents said that they had good control in their daily lives such as planning their meals and would speak with their family or the person in charge if they were unhappy.

This feedback would concur with the findings of this and previous HIQA inspections. There were many positive outcomes for residents, but these were overshadowed and limited by the unsuitability of the shared living arrangement. For example, the inspector saw from records and observations on the day that residents were supported to have safe access to family and peers and, access was increasing with vaccination and, the reduced incidence of community transmission. One resident was on a short visit to home supported by staff on the afternoon of this inspection. Residents had been supported to increase their skills in using technology and video applications, for example to participate in the provider's advocacy forum. Residents were supported to safely access their local community and safe outdoor amenities. Conversely, the review of narrative notes, risk assessments and, incident records demonstrated an ongoing pattern of needs that disrupted sleep, disrupted the shared living space and caused upset. This was not intentional or targeted, very simply residents had different needs, required different levels of support and, were not suited to living together in such a compact, shared living arrangement.

Overall, there was evidence of infection prevention and control measures, contingency and outbreak plans that have been effectively implemented in this centre. Staff had supported residents to develop their knowledge and, understanding of how to protect themselves from the risk of COVID-19. However, based on the records provided and observations during this inspection, there were staff that needed to complete training on the correct use of personal protective equipment and, further guidance and monitoring on the consistent, correct use of face-masks was needed. Again based on records seen and discussed with the social care worker, there were other deficits arising in the completion of refresher training particularly in relation to fire safety and, training in responding to behaviour of risk.

The inspector saw that staff monitored resident overall health and well-being and, ensured that residents had continued access to the services and clinicians that they

needed for their health and well-being. The personal plan had been reviewed and, was framed within the challenges and constraints of living with COVID-19.

Risk was identified and managed, the inspector saw that corrective actions were taken and, accidents and incidents that had occurred were taken into consideration when reviewing risks and their control. For example, there was evidence of physiotherapy input and advice where moving techniques in resident care was a concern. However, the process of managing and reviewing risk was inconsistent and fragmented. For example, the inspector was not assured that all incidents were accurately logged and, a better balance was needed when monitoring and reviewing incidents. Because of the unsuitability and the risk created by the shared living arrangement, the emphasis was focused on measuring the impact on peers, the level of disturbance and upset. However, the review of each incident also needed to reflect on each incident and its management so as to measure possible cause and, to ensure there was a consistent, therapeutic response.

The primary issue arising in relation to the premises itself is the unsuitability of the shared living arrangement in one of the three apartments. The location facilities ready access to a broad range of services and amenities and, contact and visits from peers in nearby services. Each apartment is well-maintained and, while part of a larger complex and large residential area, the inspector noted that it was pleasant and quiet. Staff said that other residents were welcoming and inclusive and, no further issues or complaints had arisen since the last HIQA inspection. The inspector did note however, that the extent of the emergency lighting provided in each apartment was limited to one in the main entrance hallway. Potentially this level of lighting may not sufficiently illuminate possible escape routes particularly with doors closed.

At verbal feedback of the inspection findings the inspector discussed with the person in charge (who is also the regional manager) the imperative of resolving the unsuitability of the shared living arrangement in the context of the provider's application seeking renewal of registration of this centre. HIQA has to be assured that residents are at all times protected by the consistent receipt of safe, quality supports and services. The person in charge confirmed that there was consensus amongst all parties that this was not an appropriate, safe or quality living arrangement for either resident in the context of their needs, the amount of space that they shared and, the amount of time that they spent together. The provider had identified alternative accommodation in the same complex in an apartment that is already registered by HIQA. This arrangement would give each resident the space, privacy, psychological safety and, security that they needed while allowing them to meet and spend time together if and when they so choose. The person in charge told the inspector that the provider did not have the financial resources needed to staff the apartment and, had escalated the matter to its funding body, the Health Service Executive (HSE).

The next two sections of this report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how

these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

As discussed in the opening section of this report, the primary finding in relation to the governance of this centre was the provider's failure to provide to HIQA a fully-funded, time-bound plan to address the unsuitability of the shared living arrangement. This failure meant that residents did not consistently receive a safe, quality service that was appropriate to their individual and collective needs. The provider advised the inspector that while it had identified alternative suitable accommodation it did not have the financial resources to staff the service. There were other findings of this inspection that indicated that in general, the provider needed to strengthen its governance and oversight of the service, for example in relation to risk management systems, the review of incidents and, staff attendance at refresher training.

Ordinarily the local management structure consists of the person in charge supported by a social care worker. There had, since the last HIQA inspection, been both planned and unplanned changes to the management structure of this service. This change potentially contributed to some gaps in oversight and monitoring and, some findings of this inspection. However, there was continuity of management in the appointment of the regional manager as person in charge in response to an unexpected absence. The regional manager was very familiar with the service, the residents, the need for a solution and, the progression and escalation of the plan to resolve the difficulties arising from the shared living arrangement. The inspector saw that the social care worker had management and leadership skills and, was implementing systems that supported effective management and oversight. For example, the inspector saw records of staff meetings with good staff attendance and, detailed relevant discussion of resident, staff and, general management issues. Each meeting had an action plan and identified responsible persons. The inspector tracked some of these actions such as the review needed of the positive behaviour support plan and, of the protocol for the administration of as needed medicines; both of these actions were completed.

There was insufficient evidence for the inspector to conclude that staffing levels and arrangements were not suited to the number and assessed needs of the residents. Each apartment was staffed and, ordinarily there was one staff on duty at all times in each apartment. Residents generally received a wraparound type service where staff provided both a residential and a day service; there was a sleepover staff on duty in each apartment at night. The provider continued to monitor the adequacy of this sleepover arrangement given the possibility for disturbance at night and, the risk of its unsuitability to staff had been recently increased. The suitability of this staffing arrangement will require ongoing and effective monitoring by the provider. The provider was facilitating a staffing resource four days a week for a day service

for one resident. This arrangement gave space to both residents living in the shared apartment and, limited the amount of time that they had to spend together in the apartment with a shared staff. However, this arrangement was not evident from the staff rota and, while there was a separate rota, neither record clearly identified the staff on duty at all times or the hours that they worked be that in the residential or in the day element of the service.

At the time of the last HIQA inspection the inspector noted that refresher training was due for a number of staff and had not been scheduled due to the impact of COVID-19 restrictions on facilitating training. At that time there was a plan to recommence the rescheduling of this training in conjunction with the completion of on-line training where possible. The social care worker had devised a overall training matrix and discussed the complexities of completing some on-line training such as MAPA (management of actual or potential aggression). However, notwithstanding the challenge of ensuring ongoing training for staff during the pandemic, the training records indicated there were a number of staff overdue refresher training in fire safety and, MAPA training.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted a complete and valid application seeking renewal of the registration of this centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was an experienced senior manager who had assumed the role of person in charge as an interim measure in response to an unexpected absence. The person in charge had previously fulfilled the role and, understood the scope and responsibilities of the role. This arrangement did not disrupt individual roles, responsibilities, reporting relationships or the working of the overall governance structure. The social care worker confirmed she had good access, support and, direction from the person in charge.

Judgment: Compliant

Regulation 15: Staffing

The staff rota did not clearly identify the staff on duty at all times or the hours that they worked be that in the residential or day service aspect of the service.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider was facilitating online training for staff in lieu of practical training. The training records indicated that there were a number of staff overdue refresher training in fire safety and MAPA training.

Judgment: Substantially compliant

Regulation 22: Insurance

With the application seeking renewal of the registration of this centre, the provider submitted evidence of having appropriate insurance.

Judgment: Compliant

Regulation 23: Governance and management

The provider failed to provide to HIQA a fully-funded, time-bound plan to address the unsuitability of the shared living arrangement. This failure meant that residents did not consistently receive a safe, quality service that was appropriate to their individual and collective needs. The provider advised the inspector that while it had identified alternative suitable accommodation it did not have the financial resources to staff the service. There were other findings of this inspection that in general indicated the the provider needed to strengthen its governance and oversight of the service, for example in relation to risk management systems, the review of incidents and, staff attendance at refresher training.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose submitted with the application seeking renewal of registration contained all of the required information such as details of the service and facilities provided and, how to make a complaint.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider had notified HIQA of the absence of the person in charge and, of the arrangements for the management of the service during the unplanned absence.

Judgment: Compliant

Quality and safety

In this centre residents had good opportunity to integrate with the local community and, to maintain close contact with family and peers. However, as discussed in the previous two sections of this report, the quality and safety of the service residents received and experienced was inconsistent and, was negatively impacted by the incompatibility of residents needs specifically where they were required to live in a shared living arrangement. The shared living arrangement limited the ability of the provider and staff to provide each resident with a service and support that was appropriate to and, adequately met their individual and collective needs.

The facts to support this finding have being well established by repeat HIQA inspections, the provider's own reviews of the service, its monitoring systems such as logs of incidents and, a recent external review commissioned by the provider. Seeking external review demonstrated the provider's overall desire to provide an appropriate, safe and quality service and, ensure that the residents' voice was reflected in decisions about where they lived, who they lived with and, any plans about such decisions. However, there was consensus across all reviews and findings that the provider did not have the arrangements in the designated centre to meet the assessed needs of each resident.

The inspector again reviewed records such as narrative notes completed by staff and, incident logs and found that there was no substantive change on previous inspection findings. There were individual resident needs that were incompatible in this shared living arrangement. This impacted negatively 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, their right to a good nights sleep. Neither resident had the space and privacy that they needed when periods of anxiety developed, escalated and were expressed

through behaviour. Records seen demonstrated that the possibility of such events occurring was likely, they were at times intense based on the descriptors used by staff and, required the administration of a prescribed medicine to assist in the regulation of emotions.

The provider did attempt to provide each resident with the support that they needed. Residents had clinical support from psychiatry, behaviour support and, psychology. Staff had access to a detailed positive behaviour support plan that had been reviewed again since the last HIQA inspection in consultation with the behaviour therapist. The protocol that guided the use of medicines when supportive interventions did not work had also been reviewed and updated since the last inspection. However, the inspector was not assured that the shared living arrangement facilitated the provision of the best possible individualised and, most appropriate behaviour support. The plan and staff always had to consider the impact on peers and the impact of recommended strategies on peers. For example, the possibility of allowing sometime to see if a resident settled rather than responding immediately was limited as was the opportunity to allow and give some space.

In addition on reviewing the log of incidents and other records, the inspector found that there was some inconsistency and, was not assured that all incidents were accurately recorded on the incident system. The focus of review was on the overall incidence and, the impact on peers; a better balance was needed. Individual and collective reviews also needed to establish possible cause and, review how each event was responded to by staff so as to assure the response was consistent, in line with the plan, person-centred and therapeutic.

It was evident from the risk register that the primary risks presenting in the centre were identified, controls to manage the risk were implemented and, the risk and its control were kept under regular review. However, there was an increased and high level of residual risk associated with the impact of the shared living arrangement; this would continue as long as it remained unresolved by the provider. In addition the inspector found inconsistencies and fragmentation in the process of risk management. For example, a resident with a previous good history of independently evacuating, had recently not evacuated during a simulated evacuation. The risk assessment for the resident's ability to safely spend time alone in their apartment was to be reviewed and amended, but was not. In addition, the residual high risk for the risk posed by behaviour of risk had been increased in response to a pattern of incidents but linked risks such as the monitoring risk assessment for the shared living arrangement had not increased.

Overall, there was evidence of good day-to-day fire safety practice but the provider did need to review the effectiveness of its fire safety arrangements. The fire safety register reviewed by the inspector was well maintained. The 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. However, on visual inspection the inspector noted that each apartment had only one emergency light located in the main hallway. This may not provide the recommended level of illumination of escape routes. Staff undertook simulated 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. Any challenges arising were reported but overall adequate evacuation times were achieved. Corrective actions that were needed have been referred to above in the context of risk management. Overdue refresher training for staff in fire safety is addressed in Regulation 16: Training and staff development.

The provider continued to review and implement policies, procedures and, practice designed to manage the risk of the accidental introduction and onward transmission of COVID-19. For example, the inspector saw an overarching risk assessment that was regularly reviewed and updated as national guidance and, the status of COVID-19 in the general community fluctuated. Staff were diligent in ascertaining inspector well-being in the areas visited by the inspector. Staff sought to support residents to learn how to stay safe, for example by using a face mask and completing hand-hygiene. Staff had supported residents to understand the benefit of and, to avail of vaccination. There was a contingency plan for responding to any suspected or confirmed COVID-19 and these plans included the residents in the shared apartment. The social care worker described spot-checks of adherence to controls. However, the training records in place indicated that training on the correct use of PPE for a small number of staff was not complete. Based on these inspection findings action was needed to ensure that the importance of using face-masks correctly was clearly understood and, consistently implemented.

Regulation 11: Visits

The provider recognised the importance of family to overall resident health and well-being. There was broad range of arrangements in place that were responsive to the risk that presented. For example, visits outdoors, phone and, video calls were facilitated. Visits from family and short visits home had recommenced with the continuation of infection and prevention controls to make these arrangements as safe as possible.

Judgment: Compliant

Regulation 17: Premises

The amount of space available in the shared apartment was equivalent to that provided to residents who lived on their own. The space, layout and, the proximity in which residents lived was not suited or appropriate to the circumstances of residents.

Judgment: Not compliant

Regulation 20: Information for residents

The residents guide was presented in an user friendly format and, contained all of the required information. For example, a summary of the terms and conditions attached to living in the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

There was some inconsistency and fragmentation in the process of assessing risk. The inspector was not assured that all incidents while recorded, were recorded on the incident system. Individual and collective reviews of incidents needed to establish possible cause and, review how each event was responded to by staff so as to assure the response was consistent, in line with the plan, person-centred and therapeutic. The inspector found that the inconsistencies in the process of risk management created a potential for risk that was not adequately reviewed and controlled.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The training records in place indicated that training on the correct use of PPE for a small number of staff was not complete. Based on these inspection findings action was needed to ensure that the importance of using face-masks correctly was clearly understood and, consistently implemented.

Judgment: Substantially compliant

Regulation 28: Fire precautions

On visual inspection the inspector noted that each apartment had only one emergency light in the main hallway. This may not provide the recommended level of illumination of escape routes.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider did not have the arrangements in the designated centre to meet the assessed needs of each resident. There were individual resident needs that were not compatible in the shared living arrangement. This impacted negatively on residents' rights; their right to privacy, their right to a safe and secure environment and service that promoted their well-being and development; their right to personal space other than their bedroom when they were upset or anxious.

Judgment: Not compliant

Regulation 6: Health care

Staff continuously 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

Residents had the clinical support that they needed from psychiatry, behaviour support and psychology. Staff had access to a detailed positive behaviour support plan that had been reviewed again since the last inspection, in consultation with the behaviour therapist. The protocol that guided the use of medicines used when supportive interventions did not work had also been reviewed. The inspector found that the constraints of the shared living arrangement and the requirement to consider peers, potentially limited the opportunity for maximising an individualised approach. This is addressed under Regulation 5 above.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Ralahine Apartments OSV-0005232

Inspection ID: MON-0032288

Date of inspection: 18/05/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: PIC will update Staff Rota to identify staff on duty at all times in both the residential and day service aspect of the service Completed 27/05/2021	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: PIC will ensure that all staff overdue refresher in Fire Safety and MAPA complete refresher training PIC will ensure all staff have reviewed Site Specific Fire Evacuation Plans and a Site Specific Fire Evacuation Self Declaration Form is filed locally. PIC will ensure staff due MAPA refresher will complete the online module followed by attendance on the MAPA virtual classroom element to receive certificate of completion. All staff due refresher in PPE Training will complete BOCSI Donning & Doffing of PPE video followed by AMRIC PPE on HSEland.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Each incident of night time disturbance will be recorded on OLIS and reviewed by PIC in compliance with our OLIS procedures.
Incidents logged on OLIS relating to disturbances will record impact on both individuals in the apartment
Each incident will be reviewed to ensure the management of incidents reflects on possible cause of each incident to ensure consistent and therapeutic response.
The monitoring and reviewing of OLIS reports will be directed by OLIS line of authority procedures.

PIC will ensure that attendance of refresher training as outlined in actions for Regulation 16 are completed. PIC will ensure that all actions detailed under Regulation 26 Risk Management of this compliance plan are completed.

The Provider has updated a time bound plan to address the unsuitability of the shared arrangement. It outlines both the long term plan involving a move for one individual to alternative suitable accommodation and short term plan to support this move in the interim whilst awaiting funding. This will result in a safe and quality service for both individuals

PROVIDER ULTIMATE PLAN
BOCSI Clare Region to support a move for one individual, by 20th January 2022, to a similar nearby apartment, by providing residential supports funded by the funder. This apartment is currently registered as a location in the designated centre, Rineanna OSV 0005527.

PROVIDER SHORT TERM PLAN
Whilst awaiting for funding for full time residential supports, The Brothers of Charity propose to support one individual to receive residential supports in Shannon Adult Respite. It is proposed to commence this initially for four nights from June 15th with progression to full seven nights on recruitment, induction and training of staff by end of August. Below details the Actions Needed to achieve this desired outcome.

1.Agreed to support one individual to receive residential supports in Shannon Respite whilst awaiting residential funding from the funder.
Limited respite service will be provided where compatibility assessment are completed for those who will share the accommodation.

2.Discuss proposed plan with individual to identify how best to support the transition to Shannon Respite.

3.Discuss proposed plan with family of individual. Following consultations with family members, issued raised by family have been addressed and agreement reached. Family

have been provided with assurances by the Registered Provider, regarding a quality service being to the resident, while residing in the respite house.

4.Review and Update Statement of Purpose for Shannon Respite. Registered capacity of Ralahine, will be reduced from 4 to 3, commencing September 1st 2021

5.Commence and document transition to receiving residential supports in Shannon Respite starting June 14th 2021. In consultation with individual, their family and staff

6, Discuss the proposed plan to support one individual to receive overnight support in respite with the staff team

7. In consultation with Shannon Respite PIC identify individuals requesting respite that would be compatible with the individual availing of residential supports.

8.Complete compatibility assessments for each individual identified to ensure compatibility

9. Mentor, induct and train newly recruited staff prior to extending to seven-day service in Shannon Respite

10. Reviewed and submitted business plan to ensure adequate supports can be provided as part of the ultimate plan to move to the new home in Rineanna DC.

11. The BOCSI Clare services will arrange a meeting with the funder with regard to the allocation of funding for the residential supports in the new home in Rineanna DC 0SV 0005527

12. Prepare and document a transition plan for the move from Shannon Respite to Rineanna DC.

Start transition June 14th and complete actions by Aug 31st 2021

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider has updated a time bound plan to address the unsuitability of the shared arrangement. It outlines both the long term plan involving a move for one individual to alternative suitable accommodation and short term plan to support this move in the interim whilst awaiting funding from the funder. This will result in a safe and quality service for both individuals

PROVIDER ULTIMATE PLAN
BOCSI Clare Region to support a move for one individual, by 20th January 2022, to a

similar nearby apartment, by providing overnight supports funded by the funder. This apartment is currently registered as a location in the designated centre, Rineanna OSV 0005527.

PROVIDER SHORT TERM PLAN
Whilst awaiting for funding for full time residential supports, The Brothers of Charity propose to support one individual to receive residential supports in Shannon Adult Respite. It is proposed to commence this initially for four nights from June 14th with progression to full seven nights on recruitment, induction and training of staff by end of August. Actions outlined under Regulation 23 Governance & Management

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Ensure that all incidents are recorded by staff on OLIS System. PIC will discuss with staff team at the next staff team meeting on June 3rd.
Ensure any corrective action indicated in response to the incident is reflected in the risk assessment and risk register and control measures are taken into account when reviewing and assessing the risk score
Ensure any documentation such as PEEP, CEEP, Evacuation Plan associated with the relevant risk assessment is updated to reflect any new control measures
Each incident will be reviewed to ensure the management of incidents reflects on possible cause of each incident to ensure consistent and therapeutic response.
The monitoring and reviewing of OLIS reports will be directed by OLIS line of authority procedures.

Ensure when reviewing and updating risk assessments that all linked risks are reviewed and updated accordingly to reflect any change to control measures and scoring of risks

Complete risk assessment regarding individual staying in the respite house or apartment on their own for short periods of time.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:

All staff due refresher in PPE Training will complete BOCSI Donning & Doffing of PPE video followed by AMRIC PPE on HSEland.

PIC will discuss IPC Measure and Controls in Management and Prevention of Covid 19 at team meeting to include the importance of appropriate wearing of masks.
Any further issues of noncompliance adhering to IPC Measures will be discussed at individual Staff Support and Supervision session.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Emergency lighting will be installed in hallway outside bathroom and bedroom.

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:
The Provider has updated a time bound plan to address the unsuitability of the shared arrangement. It outlines both the long term plan involving a move for one individual to alternative suitable accommodation and short term plan to support this move in the interim whilst awaiting funding from the funder. This will result in a safe and quality service for both individuals

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Actions outlined under Regulation 23 Governance and Management.

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	27/05/2021
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	14/06/2021
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	Not Compliant	Orange	20/01/2022

	number and needs of residents.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/08/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/08/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	30/06/2021
Regulation 27	The registered provider shall ensure that residents who may	Substantially Compliant	Yellow	14/06/2021

	be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	14/06/2021
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	20/01/2022