Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Ralahine Apartments
Name of provider:	Brothers of Charity Services Ireland
Address of centre:	Clare
Type of inspection:	Announced
Date of inspection:	28 and 29 May 2018
Centre ID:	OSV-0005232
Fieldwork ID:	MON-0021966

About the designated centre

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

This designated centre is comprised of three separate ground floor apartments in an apartment complex in a residential area. A maximum of four residents are accommodated; two residents share one apartment while one resident lives in each of the other two apartments. Each apartment has its own team of social care staff led by the social care worker. The social care worker assists the person in charge in the management of the centre.

Residents are in receipt of residential services with some day service also delivered in and from their home. There is some variation in the support and service provided based on individual resident requirements but ultimately the provider aims to provide each resident with a safe, positive environment and to support them individually to achieve a valued and meaningful life connected to peers, family and community.

The following information outlines some additional data on this centre.

Current registration end date:	29/09/2018
Number of residents on the date of inspection:	3

How we inspect

To prepare for this inspection the inspector or 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
28 May 2018	09:15hrs to 18:30hrs	Mary Moore	Lead
29 May 2018	09:15hrs to 16:30hrs	Mary Moore	Lead

Views of people who use the service

Four residents live in the centre; the inspector met with three of the residents, one resident was at home with family.

Engagement with residents was directed by residents and their particular needs and choices and was both verbal and non-verbal. The inspector was greeted with a warm smile and a gentle handshake while other residents engaged in easy conversation about their life and life in the centre. Residents also completed the questionnaires provided by HIQA (Health Information and Quality Authority); two residents completed their own questionnaire.

Residents spoke about what was good about life in the centre but also used the opportunity of the inspection to talk about what was not so good and what they would like to see changed to make life better.

Residents clearly described the positive aspects of living in the centre. Residents spoke of the opportunities they had for meaningful engagement with peers and family and with the local community. Residents spoke with pride of their role in forthcoming national sporting events, of their work experience with a local employer and an upcoming religious pilgrimage to Lourdes with the local diocese. Residents described how they had control in their daily routines such as doing the grocery shop on line and travelling independently on the local transport scheme.

Residents said that they had a great staff team that they could and would talk to and it was evident to the inspector that the person in charge was well known to the residents.

Where such comprehensive verbal feedback was not possible the inspector noted through resident general demeanour that residents were comfortable in their environment, with their routine and with the staff on duty. Staff also recorded in records seen how resident choice and preference was expressed and respected.

However, residents also used the HIQA questionnaire and the inspection to raise the aspects of the service that they did not like and to describe the impact that this had on them; this related to the shared living experience in one apartment. The inspector also saw the challenges involved in the shared apartment over the course of the inspection; these observations concurred with what residents said.

Capacity and capability

Overall the inspector found that there was a management team committed to ensuring that residents received safe, quality supports. However, the inspector also found that more robust and timely recognition and response was required where issues impacted on the quality and safety of the service received.

There was a clear management structure comprised of a social care worker, person in charge and a regional manager; there was clarity on individual roles, responsibilities, reporting relationships and individual accountability.

The person in charge was employed full-time and had responsibility for two designated centres. The person in charge held suitable qualifications in disability nursing and management and had established experience in a supervisory capacity. On a day to day basis the social care worker supported the person in charge in the administration and operational management of both centres. On speaking with them, both described how they agreed and allocated work and responsibilities while retaining clarity on accountability.

Based on the evidence available the inspector found that there was sufficient staff to meet the number and needs of the residents living in the centre; ordinarily there was one staff present in each apartment at all times. The night-time staffing arrangement was a sleepover staff; there was evidence of intermittent occasions where residents did get up at night-time. The provider was monitoring this and had currently not identified a requirement for waking staff. Staffing levels and arrangements should however be included in the required multi-disciplinary review of each resident and their current supports as discussed in the next section of this report.

Staff were provided with the training needed to meet mandatory training requirements and that equipped them with the skills required to meet resident's needs. Staff attendance at training was monitored; any training required including refresher training was planned or booked.

Staff were provided with support and individual staff performance was appraised through the staff supervision process.

The statement of purpose, a record the provider is required to produce and that describes the centre, the service provided and the aim of the service was reviewed by the inspector. The record was current and contained most but not all of the information required. A revised statement was submitted based on the verbal feedback provided, the revised document contained the required information.

While residents spoke openly during the inspection and were seen to engage freely with the person in charge the inspector found that further discussion, explanation and clarity was required on what constituted a complaint and the purpose of complaints, particularly as a valuable source of information to make improvements in the service provided. Clarity was required on formal and informal complaints whether complaints were received verbally or in writing. The inspector was advised that a concern had been raised in relation to the shared living arrangement and that the particular issue had been addressed to the satisfaction of the complainant. This concern was not however viewed, managed or recorded as a complaint. It is also

reasonable to conclude based on these inspection findings that while there was discussion of a possible solution, the matter was not satisfactorily resolved.

The provider had arrangements for the completion of the annual and six-monthly unannounced reviews of the service required by the regulations. The inspector saw that the reviews sought and incorporated feedback from residents and their representatives and did identify both good practice and areas where improvement was required. For example in the guidance available to staff on supporting residents to manage behaviours of concern. However, overall the inspector found that all information available to the provider including but not exclusively the findings of these reviews did not result in a robust and timely explicit plan to address the inconsistency in the quality and safety of the service. This plan was required to ensure that the provider had clear objectives and plans for the delivery of consistently person-centred, safe and effective services and supports with a focus on improved outcomes for all residents effectively and efficiently.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted in a timely manner a complete application for the renewal of registration of the centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge had sound knowledge of the residents and their needs and of the general operation and administration of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were appropriate to the assessed needs of the residents. The inspector reviewed the staff rota and saw that residents received continuity of care

and supports from a team of regular staff.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had completed mandatory training within the specified timeframes; refresher training was scheduled. Staff had also completed training that supported them to safely meet resident's needs.

Judgment: Compliant

Regulation 21: Records

The inspector found that the records listed in part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were in place. The required records were retrieved for the inspector with ease; the required information was retrieved from the records with ease; the records were well maintained.

Judgment: Compliant

Regulation 22: Insurance

There was documentary evidence that the provider was insured against injury to residents and against other risks in the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

The management structure was clear and there was clarity on roles, responsibilities, reporting relationships and individual accountability. However, quality and safety were not consistent and all information available to the provider did not result in a robust and timely explicit plan that addressed this.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Each resident was provided with a contract for the provision of services. The contract was seen to be specific to each residents circumstances and agreed with the resident and/or their representative. The contract detailed the terms and conditions of living in the centre including the applicable charges and services that a resident may wish to avail of but were not included in the basic fee.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider maintained and made available in the centre a copy of the current statement of purpose. The record did not however contain all of the required information; in addition greater detail was required of the specific care and support needs that the provider intended to meet in the designated centre. These changes were made based on the verbal feedback provided.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The provider was aware of the requirement to notify HIQA of absence of the person in charge where that absence was of a continuous period of 28 days or more. The inspector confirmed that there had been no such absence. The provider had suitable arrangements in place for the management of the centre in the absence of the person in charge.

Judgment: Compliant

Regulation 34: Complaints procedure

Based on these inspection findings further discussion and explanation was required in the centre on what constituted a complaint and the purpose of complaints,

particularly as a valuable source of information to make improvements in the service provided. Clarity was required on formal and informal complaints whether complaints were received verbally or in writing.

Judgment: Substantially compliant

Quality and safety

Overall the inspector found that residents were supported to live a full and meaningful life. However, the inspector also 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. This conclusion on both the positive and negative aspects of the service concurs with what residents said about life in the centre.

The inspector saw that the completed assessment of resident needs was comprehensive; the support plan was based on the assessment findings and multi-disciplinary team (MDT) recommendations and the plan was subject to review by the staff team. Residents had input into their plan and one resident retained a copy of their plan. It was evident from the plans that the provider sought to ensure that each resident had the support that they required across a broad range of identified needs. Given the complexity of residents needs, their plan of care and support was strongly informed by the recommendations of the MDT such as occupational therapy, speech and language therapy, dietitian and behavior support. However, while the requirement for and benefit of MDT review was discussed during this inspection these reviews had not occurred.

There was some lack of clarity as to the format of the support plan which did not provide assurance that there was one succinct plan of support that collated all of the information and recommendations and guided consistent practice on a daily basis. Some inconsistent guidance was noted by the inspector for example in relation to dietary and speech and language recommendations and the administration of medicines on a PRN (as required) basis. These inconsistencies could impact negatively on residents in that recommendations and prescribed medication may not be delivered as prescribed.

The inspector saw the many ways by which the provider demonstrated how residents were consulted with and participated in the organisation of the service and how resident's rights were respected and promoted. For example the inspector saw that residents and/or their representatives participated in their own personal plan. Residents had access to and participated in the advocacy programme; an independent advocate had also visited the centre and met with residents. Residents who wished to vote were supported to vote and religious observance was facilitated in line with resident's choice. Regular house meetings were convened where staff and residents discussed matters such as meal choices, activities and planned social

events. There was clear guidance for staff on non-verbal cues that residents used to communicate their likes and dislikes; staff were seen to record these cues in the daily narrative notes, when reporting how resident choice was expressed.

On a daily basis residents had access to a broad range of meaningful activities and engagement including off-site day services and day services delivered from the centre. Residents enjoyed swimming, bowling, art, horse-riding, meeting peers and socialising. Access to education, training and employment was supported in line with and as appropriate to resident's wishes.

However, the inspector found that while the service was person-centred, 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 at all times, to personal space, to choose where they wished to live and whom they wished to live with. This was evidenced directly during this inspection; it was also evidence in records seen including feedback from residents, assessments and behaviour support plans that highlighted the lack of and desire for personal space and the inability to secure time alone.

The provider did have systems that sought to protect residents from harm and abuse, for example staff had all attended safeguarding training and education was provided for residents so as to raise their awareness and their skills for self-protection; there was ready access to the designated officer. The inspector was satisfied that the provider responded appropriately and implemented its safeguarding procedures when any concerns were brought to their attention.

Residents required staff support to prevent and manage behaviours that posed risk to the resident themselves or to others including other residents and staff. The internal provider review of January 2018 had found that the local management team requested further input into the plans for positively supporting behaviours. The inspector saw that guidance for staff was in place in the form of both positive and reactive plans; those seen were clear and referenced the role of behaviours in the context of supporting all aspects of the resident's daily routine. For example in relation to expressing choice and refusal and providing personal care. The plans were evidence based and informed by the analysis of incidents and/or psychology review. However, given the behaviours that presented, their current impact and past incidents and recommendations, there was a lack of timely provision of positive behaviour support plans.

There was a lack of clarity as to what constituted a restrictive practice; consequently there were therapeutic interventions in use including the use of audio monitors, devices to hold open doors including a bedroom door and movement alarms. While there was a rationale for their use, for example to alert staff to ensure resident safety in the event of seizure activity, these interventions had not been viewed, agreed, sanctioned or reviewed as restrictive on residents rights including their right to privacy and freedom of movement. A review of their use was required to address their restrictive component, to ensure that their use was warranted and where devices were used concurrently, for example both a bed and floor based alarm, that

this was the least restrictive procedure possible.

The person in charge maintained a register of work-related and resident specific risks, their assessment and the controls required to manage and reduce the risk. Some of the residual risk-ratings were still high as the likelihood, for example of certain behaviours was high; these particular assessments were supported further by protocols for staff to adhere to so as to reduce the risk of harm and injury.

There were policies and procedures for recording and reporting incidents and accidents that occurred; as mentioned above one purpose of these was to inform the development of the behaviour support plan. However, the inspector found that the incidents and consequently their review did not adequately consider and capture the impact of incidents on other residents so as to accurately inform the actions required to improve the safety of the service provided.

Residents were supported to enjoy good health. Staff facilitated residents to access their choice of General Practitioner (GP) and pharmacist. There was evidence that staff and families worked collaboratively when liaising with healthcare services. Records seen demonstrated that residents were referred to other healthcare services including optical, dental, chiropody, psychiatry, occupational therapy and speech and language therapy. Some referrals and reviews sought to further inform the support needed, for example sensory needs in the context of behaviours. There was evidence of a health promoting ethos to care such as regular blood-profiling and seasonal influenza vaccination. Staff monitored resident body weight as an indicator of health and encouraged residents to make healthy lifestyle choices.

The provider had measures in place that ensured residents were protected by safe medicines management practices. Staff had attended training; prescriptions were current and legible; staff maintained a record of each medicine administered to residents. There were systems for reporting and responding to any medicines related incidents; records viewed indicated that these were generally of a documentary nature.

There was evidence of good fire safety practice. Fire action and fire evacuation notices were prominently displayed; the emergency lighting, fire detection system and fire fighting equipment were inspected and tested at the prescribed intervals and most recently in April 2018. All staff had completed fire safety training and undertook simulated evacuation drills with residents; records of these drills indicated that there were no obstacles to evacuation and good evacuation times were achieved.

Regulation 10: Communication

Records seen and practice observed reflected an understanding of how residents communicated their needs, preferences and choices particularly

where communication was not verbal. There was a good understanding between exhibited behaviours and communication; staff were provided with strategies such as visual props and guidance on how to interpret resident actions so that communication with and between residents and staff was effective.

Judgment: Compliant

Regulation 13: General welfare and development

The inspector found that resident's personal objectives were delivered. On an individualised basis residents had access to a broad range of meaningful activities and community engagement; this was evident from records seen and from speaking with residents. Residents were supported to maintain and develop personal relationships with peers, family and the wider community.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had policies and procedures for promoting the health and safety of residents, staff and others. The person in charge maintained a comprehensive register of risks. There were arrangements for the identification, reporting and review of accidents and incidents. However, incident management did not adequately capture the impact of incidents on other residents so as to accurately and adequately inform the actions required to improve the safety of the service provided.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider ensured that there were effective fire safety management systems in place including arrangements for the safe evacuation of residents.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had medication management policies and procedures in place that complied with legislative and regulatory requirements. Staff adhered to the procedures for the safe administration of medication; medication was administered as prescribed. Records were kept to account for the management of medicines including their administration

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed three of four personal plans and found them to be detailed *and* supported by good referral and access to the MDT. However, there had been no MDT review of each plan to assess and assure its effectiveness. This was of particular significance given the findings in relation to the incompatibility of residents needs in the context of a shared living arrangement.

There was some emerging lack of clarity as to the format of the support plan; this did not provide assurance that there was one succinct plan of support that guided consistent practice on a daily basis.

Judgment: Substantially compliant

Regulation 6: Health care

The provider had arrangements in place including staff that were attuned to and responded to any changes in the residents presentation, to ensure that residents were supported to enjoy good health.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was evidence of understanding and a positive evidence based approach to the

management of behaviour of concern. However, there were deficits in the context of the needs of this particular cohort of residents and this service, specifically the timely provision of positive behaviour support plans.

There was a lack of clarity as to what constituted a restrictive practice; consequently there were therapeutic interventions that had not been viewed, agreed, sanctioned and reviewed as restrictive.

Judgment: Substantially compliant

Regulation 8: Protection

The inspector found that the provider had measures to protect residents from harm and abuse and did take appropriate action in response to any concerns raised.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to safely exercise independence, choice and control. Residents were consulted with and participated in their person plan, residents had access to advocacy and were facilitated to exercise their civil rights and engage in religious observance if they so wished. However, there were resident needs that were not compatible in the context of a shared living arrangement; this incompatibility impacted on each residents right to privacy, to adequate and appropriate personal space and to a safe suitable living arrangement.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ralahine Apartments OSV-0005232

Inspection ID: MON-0021966

Date of inspection: 28 & 29/05/2018

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • By 31/10/2018 PIC will have completed; • BOCSI Clare Region Comment, Compliment and Complaints procedure will been fully implemented. • All staff in Ralahine Apartments will be using the standardized approach of the 'On Line Information System'(OLIS) to accurately and adequately capture any impact of incidents and accidents, especially on other residents. • All Discovery documents and Personal Plans are being reviewed and updated by PIC and PPIM to ensure one succinct plan of support is used to guide consistent practice on a daily basis. There will be MDT reviews of plans at annual Individual Planning Meetings in Ralahine Apartments. • Compatibility assessments will be carried out for all future living arrangements within Ralahine apartments. • All therapeutic interventions being used in Ralahine Apartments as restrictive practices have now been identified, agreed, sanctioned and have 3 monthly review dates.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • PIC will ensure staff fully understand and implement BOC Clare Region 'Comment, Compliment and Complaint Procedure' in Ralahine Apartments. At staff team meetings PIC and PPIM will read through and explain BOC Clare Region 'Comment, Compliment and Complaint Procedure'. Team discussion and policy sign off will also take place to ensure all staff members are fully aware of official process in place to manage a complaint. 'Comments, Compliments and Complaints' will also be included as a standing agenda item at all team meetings	

in Ralahine Apartments to ensure learning and improvements are made in the service. This will be completed by 14/09/2018.

- Key workers will meet with all residents and go through and explain the easy read 'COMPLAINTS PROCEDURE FOR PEOPLE WHO ARE SUPPORTED BY Brothers of Charity Clare Services'. Residents will be given their own copy of complaints procedure to access at all times, adding to the copy already on display in each house. This will be completed by 14/09/2018.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
As per BOCSI Clare Region 'Risk Management Procedure' all incidents and accidents will be recorded by staff using the standardized approach of the On Line Information System(OLIS) to accurately and adequately capture any impact of incidents and accidents, especially on other residents. The Regional Manager/PPIM and PIC will conduct an audit every six months to identify and proactively manage risk. Incidents & Accidents have been included as a standing agenda item at all team meetings in Ralahine Apartments to ensure they are used as a learning opportunity to improve service delivery for all residents. This process is in place as of 20/07/2018.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All Discovery documents and Personal Plans are being reviewed and updated by PIC and PPIM to ensure one succinct plan of support is used to guide consistent practice on a daily basis. This will be completed by 14/09/2018.

There will be an MDT review of each plan at all upcoming annual Individual Planning Meetings in Ralahine Apartments. All annual plan reviews will be complete by 31/10/2018.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Positive Behaviour Support Plans are being reviewed by BOC Psychologist and Positive Behaviour Support Specialist and will be completed by 31/08/2018.

All therapeutic interventions being used in Ralahine Apartments which are restrictive practices have been identified, agreed, sanctioned and have 3 monthly review dates. This process will be fully complete by 30/07/2018.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: 2 plans have been put in place due to the incompatibility, at times, of residents in a shared living arrangement in Ralahine Apartments.

Medium Term Plan:
Alternative accommodation has been identified for one resident during crisis incident/s. Such incidents are rare but the resident will be supported to stay at the local respite house. The resident is very familiar and comfortable with this accommodation having used the house for years on a very regular basis. This will be in place as of 27/07/2018.

Long Term Plan:

- Identify a new designated centre where resident can live.
- If this involves sharing with others then a compatibility assessment will be completed to assess if the individuals are compatible.
- Register the new designated center by 31/12/2018

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.	Substantially Compliant	Yellow	31/10/2018
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	31/08/2018

Regulation 34(1)(a)	The registered provider shall provide an effective 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.	Substantially Compliant	Yellow	31/07/2018
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	14/09/2018
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall	Substantially Compliant	Yellow	31/10/2018

	be multidisciplinary.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	31/10/2018
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	31/07/2018
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	11/09/2018
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is	Not Compliant	Orange	31/12/2018

	respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			