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:	Ratheanna
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Announced
Date of inspection:	17 November 2021
Centre ID:	OSV-0002367
Fieldwork ID:	MON-0026967

About the designated centre

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

Ratheanna is a designated centre operated by St Michael's House located in North County Dublin. It provides a community residential service to five adults with a disability. The designated centre is a bungalow which consists of sitting room, a kitchen/dining room, five bedrooms – one of which is a staff office and two shared bathrooms. The centre is staffed by the person in charge and social care workers. Nursing support is provided through the provider's nursing manager on call system.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 17 November 2021	9:50 am to 5:10 pm	Jennifer Deasy	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with all residents on the day of inspection. In line with public health guidance, the inspector wore personal protective equipment (PPE) and maintained social distancing during all interactions with residents and staff. The inspector used conversations with residents and key staff, observations and a review of documentation to inform judgments on the quality of care in the designated centre. Overall, the inspector found that residents were living in a home which was striving to provide person-centred care and which was making efforts to come into full compliance with the regulations. There have been long-standing issues in relation to the premises of this designated centre and the impact that the space was having on residents' rights to privacy. At the time of inspection, the provider had committed to completing premises works by April 2022 in order to ensure that each resident had access to their own private bedroom. The provider had submitted a comprehensive service improvement plan which set out that these works were scheduled to begin in January 2022.

The inspector observed residents coming and going from their home during the day. Some residents attended day services. Day services for one resident had not resumed subsequent to the COVID-19 pandemic. Another resident had chosen to stay at home rather than return to their day service. Staff in Ratheanna reported that they had completed QQI training so they could provide modules as preferred by residents at home rather than in day service if that was their choice. The inspector saw that residents were supported to have meaningful days and engage in their preferred activities in their own time at home. Residents were observed painting, watching TV, listening to music and chatting with staff. Some residents went to the shop to purchase personal items during the course of the inspection. The inspector saw that these residents retained control of their money and were supported to manage their finances. The inspector saw residents sitting with staff to have their lunch. Staff were observed to engage with residents using multi-modal communication as per residents' assessed communication needs. Interactions between residents and staff were observed to be friendly, relaxed and caring with staff and residents observed sharing jokes and laughing.

Several residents told the inspector that they like living in Ratheanna. One resident said that it was a "good place to live". Another resident said that they were happy living in Ratheanna. This resident said that they can have good days and bad days, but when they had bad days, the staff were there to help them. Residents were also aware of the planned works to premises. Residents expressed uncertainty regarding moving out during the premises works, saying they would prefer to stay in their house but understood that the premises works were necessary.

The residents appeared to have good relationships with each other. Staff informed the inspector that the residents have lived together for approximately 17 years. Staff appeared to know the residents well and it was clear that the residents were comfortable with each other and with staff. While the residents appeared to get on

well together, the inspector noted that the communal living area was noisy when all residents were in the house. There was only one living area available to the residents. One resident told the inspector that they stay in their bedroom if they need a quiet space.

The inspector saw that the house was generally clean and tidy however it was in need of refurbishment. This will be discussed further in the quality and safety section of the report. Several residents showed the inspector their bedrooms. The inspector saw that one bedroom was shared by two residents. This shared bedroom arrangement had been known to the provider as being an issue since 2005 when plans had initially been drawn up to extend the building. There were open complaints in place in relation to this issue. This will also be discussed further in the quality and safety section of the report.

Overall, the inspector saw that the residents in this centre were supported to enjoy a good quality of life which was respectful of their choices and wishes. The person in charge and staff were striving to ensure that residents lived in a supportive environment. It was evident that the designated centre was a homely environment where residents were supported to have good relationships. There have been long-standing issues in relation to the premises and the impact of this on residents' rights. The provider was scheduled to commence premises works in January 2022 in order to address these issues at the time of inspection.

The next two sections of this report will present the findings in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of care in the centre.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and to inform decision-making for the renewal of the centre's registration. This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. The inspector found that this centre met the requirements of the regulations in many areas. There was evidence that the residents were receiving a person-centred service which was mindful of individual needs, preferences and wishes. However, there were long-standing issues with the provider's ability to respond to complaints in a timely manner which were impacting on the quality of this service.

The provider has known for many years that two residents shared a bedroom in the designated centre. There have been open complaints in relation to this issue since 2018. Residents' rights and premises have been identified as not compliant on several HIQA inspections. A restrictive condition was placed on the registration of the designated centre in 2019. This condition required the provider take action to

address non-compliances in premises and residents' rights by 30 April 2022.

At the time of inspection, the provider was making efforts to comply with the restrictive condition. A comprehensive time -bound plan had been submitted which detailed the actions that the provider was taking to address known issues. Regular updates to this plan were submitted to the Chief Inspector. Works to the premises were due to commence in January 2022. Residents spoken with were informed of these impending works and understood the reason for them.

There were effective governance and management arrangements in place that ensured the safety and quality of the service was consistently and closely monitored. A comprehensive annual review of the quality and safety of care of the service, as well as a bi-annual unannounced visit, were completed. These reviews were conducted in consultation with residents, their representatives and staff. Comprehensive action plans had been developed from these audits and actions were delegated to responsible individuals.

However, there was evidence that where issues were identified, there continued to be a failure on the behalf of the provider to address these in a timely manner. For example, a complaint had been lodged by residents that a velux window in a bathroom was not working in July 2021. This was reported to the maintenance department in July and was recorded on the unannounced visit completed in November. However, at the time of inspection the window had not been fixed. Staff and residents reported that this led to the shower room becoming uncomfortably hot. The bathroom was an internal bathroom with no windows. The inspector observed that the extractor fan in this shower room also did not work. This presented a risk to infection prevention and control.

There were clearly defined management structures in place. The centre was managed by a suitably qualified and experienced person in charge who was employed on a full-time basis. The person in charge had dedicated management hours and was supported in their work by a team lead who had their own delegated duties. The person in charge reported to a service manager and received regular supervision from them.

The staffing levels and skill -mix were appropriate to the assessed needs of residents. While the centre was not staffed by nurses, where residents required nursing care, this was made available to them from within the provider's own panel of nursing staff. Relief hours, when required, were provided from a small panel of regular relief and agency staff who were known to residents. This supported continuity of care for residents. A planned and actual roster was maintained which demonstrated that staffing allocations were as per the centre's statement of purpose.

A training matrix was maintained which demonstrated that staff generally had a high level of both mandatory and refresher training. Staff training records identified that all staff had up-to-date training in managing behaviour that is challenging, safeguarding, COVID-19, safe administration of medications (SAMs) and feeding, eating, drinking and swallowing (FEDS). A small number of staff required refresher

training in fire safety and first aid and had been booked to complete this training in the coming weeks.

All staff were reported to have received supervision, however, it was acknowledged by the person in charge that this was not completed as frequently as defined by the provider's supervision policy. This was attributed to the impact of COVID-19 on staffing attendance and the need for further dedicated management hours. The person in charge had received regular supervision from the service manager.

Regulation 14: Persons in charge

There was a suitably qualified and experienced person in charge who was employed in a full-time capacity. There were mechanisms in place to support the person in charge in having oversight of the designated centre. For example, there was a nominated staff member who took a lead role in reporting to the person in charge. The person in charge had allocated management hours and had access to their own supervision with the service manager. A review of the supervision records found that these took place regularly and that the content was appropriate to the needs of the person in charge.

Judgment: Compliant

Regulation 15: Staffing

A planned and actual roster was maintained. A review of the rosters found that the staffing levels and skill -mix were appropriate to the assessed needs of the residents and were in line with the centre's statement of purpose. Relief staff, where required came from a small panel of regular relief and agency staff. This supported continuity of care for the residents. One resident was undergoing assessment for nursing support. While the centre was not staffed by nurses, the provider had made arrangements to ensure a nursing staff was available to meet this resident's needs while the assessment was ongoing.

Judgment: Compliant

Regulation 16: Training and staff development

There was a system in place to evaluate staff training needs and to ensure that adequate training levels were maintained. A review of the training matrix

demonstrated that most staff were up -to -date in mandatory training. Some staff required refresher training in first aid and fire safety. Dates for these trainings had been secured for the coming weeks.

Improvements were required to the frequency of formal supervision for staff in the designated centre and to the maintenance of supervision records. Staff supervision had not occurred as frequently as set out by the provider's policy. Records of supervision with clear actions were not consistently maintained. However, it was clear from talking to staff that they felt supported in their roles and felt comfortable with escalating any concerns.

Judgment: Substantially compliant

Regulation 23: Governance and management

The centre was managed by a suitably qualified and experienced person in charge and was sufficiently resourced to meet the needs of residents. There was a clearly defined governance structure which facilitated the delivery of good quality care and support that was routinely monitored and evaluated. An annual review and a bi-annual unannounced visit were completed which clearly documented the views of residents in relation to their centre. There was evidence, through regular compliance plan updates, that the provider was actively attempting to address long-standing premises and rights' non-compliance. It appeared that the provider was on track to address these issues before 30 April 2022.

However, the provider had failed to respond to complaints and other premises related issues in a timely manner. For example, the velux window in the bathroom had been broken since July 2021 and had, at the time of inspection, not been fixed. The poor ventilation in this bathroom presented an infection prevention and control risk to residents and those staff who were supporting them.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

While it is acknowledged that the provider was in the process of taking measures to address long-standing complaints in relation to the premises, and in particular, the shared bedroom of two residents, there was evidence that the provider failed to respond to this and to other complaints in a timely manner.

At the time of inspection there were two open complaints in the centre. One related to the shared bedroom which was first logged as a complaint in May 2018.

The second complaint was logged in July 2021 and related to a broken velux

window. There was evidence that staff had escalated this complaint to the maintenance department and that it had been recorded on the provider's six-monthly unannounced visit. There was no evidence of measures taken to address this complaint. This demonstrated that the provider did not always respond to complaints in a timely manner.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the day-to-day practice within this centre ensured that the residents were safe and were receiving a quality service.

Individual assessments of need and personal plans were found to be in place for residents. These assessments were comprehensive in nature and detailed a wide variety of multi-disciplinary supports available to residents. Personal plans were written in a respectful manner and were person -centred. The personal plans were found to have been reviewed regularly, including when there was a change to residents' needs. There was evidence that residents were supported to attend a range of clinical appointments, as required. Where residents presented with a risk, such as a risk of falls, there was evidence of comprehensive assessments by relevant allied health-care professionals. Risk assessments were in place and clear guidelines were available for staff in order to mitigate against such risks.

Safeguarding plans were in place and were up -to -date for residents who required them. All staff had completed safeguarding training. Intimate care plans were also available and were up -to -date. Intimate care plans were written in a respectful manner. There was evidence that a trust in care investigation was completed in relation to an allegation made. This was notified to the respective authorities as required and an investigation was conducted. The investigation established that there were no grounds for concern, however, comprehensive support plans were implemented in order to safeguard the residents and staff from further allegations. These guidelines were signed off on by the staff team and relevant allied health professionals.

There was evidence that there were good local arrangements to support residents in exercising their rights and to ensure that residents were involved in the organisation of the designated centre. A review of the house meetings was conducted by the inspector. There was evidence that staff used visual supports and Lámh to assist residents in participating in meetings and to make meaningful choices. The residents' meeting agreement had also been visualised and made easy -to -read. A review of the minutes of these meetings found that information and decisions regarding the day-to-day running of the centre was discussed, including for example, house activities, health and safety and fire drills.

Improvements were required to the premises in order to ensure that each resident's

privacy and dignity was respected. The provider had committed to commencing building works on the premises in January 2022. The provider had plans in place to build an extension to the designated centre in order to ensure that each resident had their own bedroom. Residents spoken with expressed that this was a much needed extension. One resident stated that they have been frustrated for many years by not having their own bedroom.

There was a lack of private space in the centre for residents to receive visitors if they wished to do so. Residents had access to one communal sitting room and a kitchen. This space was noted by the inspector to be noisy when all residents were in the house. Residents told the inspector that they go to their bedrooms if they require some peace and quiet. The inspector was shown plans for the proposed extension to the premises. The purpose of this extension was to provide each resident with their own bedroom. The inspector noted that there was no additional living area in the reconfigured premises.

The premises required general maintenance throughout. While the provider had committed to adding an extension to the building, it was not clear if additional work would be completed to the upkeep of the rest of the building as part of this plan. The inspector identified that painting was required throughout the centre. The ceiling in the hall appeared to have been wallpapered over and this was peeling in some areas. The hallway, while painted in recent years, appeared dated and worn. There were several marks on the wall in the hallway from where screws and raw plugs had been removed. One of the bathrooms was noted to have a crack in the ceiling and paint was peeling. There were also cobwebs on the velux window and a pipe jutted out of the ceiling and into the room. The kitchen was observed to require maintenance; several drawers and doors did not close properly and the countertop was marked in places. One resident bedroom also had a frosted glass window. It was recognised that this was in place to ensure privacy as the window opened directly onto a neighbour's garden. However, it did not contribute to a homely or comforting feel in the bedroom.

A risk register was maintained for the centre which detailed known risks and provided an appropriate risk rating to each risk. There was evidence that the risk register was used as a working document and was updated regularly to include new risks. Individual risk assessments were on file where required. However, it was not demonstrated that the provider would be able to address all risks in a timely and appropriate manner. For example, there were several risk assessments which set out that residents could be at risk of falls due to narrow spaces, that there was lack of storage in the centre and that there was insufficient space for residents to receive visitors. These risks were all rated as red risks by the provider. However, there were no plans in place to mitigate against these risks as the proposed extension did not provide for wider spaces, storage facilities or additional living areas.

The provider had adopted a range of infection prevention and control procedures to protect residents from the risk of acquiring a healthcare -associated infection. The designated centre was observed to be clean. Staff were observed to wear personal protective equipment (PPE) and exercise physical distancing as far as was practicable. Temperature checks were completed on entry to the centre. Hand

sanitising gel was readily available throughout the service and there was easy access to sinks for hand washing. Staff were clear on their responsibilities when it came to preventing an outbreak of a healthcare -associated infection. The COVID-19 house plan detailed clear measures to be taken in the event of an outbreak.

Suitable fire detection, containment measures and fire fighting equipment were in place throughout the designated centre. Personal evacuation plans were up-to-date and were tailored to each resident. Fire doors were in place throughout the centre and were fitted with self-closing mechanisms. Fire drills had been completed and staff spoken with were aware of the procedures to be followed in the event of a fire. However, it was identified that one final exit required the use of a key and would not have been easy to open quickly in the event of a fire. Additionally, one resident had repeatedly refused to evacuate during fire drills and the measures in place to support this resident in the event of fire were insufficient to ensure their safety. The inspector was informed that the new extension would allow for a more efficient evacuation of this resident, due to the addition of a fire exit from this resident's bedroom directly to the back garden.

Regulation 11: Visits

There was a lack of private space in the designated centre in order for residents to receive visitors. Additionally the communal space was noted to be noisy and busy when all residents were in the designated centre. Residents told the inspector that they go to their bedrooms when they need a quiet space.

Judgment: Not compliant

Regulation 17: Premises

The premises required general maintenance both internally and externally. The provider had a comprehensive time -bound plan in place in order to extend the building and provide an additional bedroom to one resident. However this plan did not provide for further maintenance work to the building and other refurbishments. The premises areas which required addressing included:

- Walls and ceilings inside the house required painting and repair.
- The kitchen also required maintenance. Several drawers and doors did not close fully and the countertop was damaged in places.
- Blinds in the sitting room did not have draw cords.
- The velux window in the bathroom had been broken for some time.
- The extractor fan in the bathroom was also broken.

- Build up of cobwebs in the bathroom.
- The garden required some general maintenance to promote accessibility.
- A disused shed in the garden required removal.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had a comprehensive risk management policy in place and had systems in place to assess, manage and review risks. The risk register was observed to be up -to -date and accurately reflected the level of risk in the designated centre. However, it was not clear that the provider had systems in place to respond in a timely manner to known risks. For example, the risk of residents falling in the centre due to narrow spaces and cluttered furniture was rated as a red risk, however there were no plans in place to mitigate against this risk.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Standard precautions were in place in order to reduce the risk of residents contracting a healthcare -associated infection. It was clear that the designated centre had measures in place in order to mitigate against the risk of a COVID-19 outbreak. Staff were aware of their individual responsibilities in reducing the risk of a healthcare -associated infection and were aware of the procedures to be followed in the event of a suspected case of COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had arrangements in place against the risk of fire. There were adequate arrangements for detecting, containing and extinguishing fires. Personal evacuation plans were in place for residents and fire drills had been completed in line with the provider's policy. Fire equipment was noted to have been recently services. Self-closing mechanisms were observed throughout the centre.

However, there were insufficient procedures in place in order to ensure that one resident could be evacuated in the event of fire. The provider had plans to make changes to this resident's bedroom as part of the premises extension works in order

to ensure that this resident could be evacuated safely in the event of fire. A final exit at the rear of the house was found to be key locked. The inspector was told that this will also be addressed as part of the premises works. In the interim, a key was available in a break glass box beside that exit.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of need had been completed for residents. These had been reviewed within the last 12 months. Resident files documented support from clinical professionals as required.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a range of multi-disciplinary professionals, as required, based on their assessed needs. Comprehensive care plans were in place and were up -to -date for each assessed need.

Judgment: Compliant

Regulation 8: Protection

All staff had up -to -date safeguarding training. Staff spoken with demonstrated an understanding of safeguarding and the process to report concerns. Safeguarding concerns had been reported to the relevant authorities as required and had been investigated. Appropriate safeguarding plans were implemented and signed off on by staff and allied health professionals. Intimate care plans were up -to -date for those residents who required them and were written in a person centred and respectful manner.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence that staff, at a local level, were endeavouring to support

residents in exercising their rights. It was clear that residents were consulted with in a meaningful way and in their preferred mode of communication about the day -to - day running of the centre. Residents had also been informed of the impending premises works and could tell the inspector what this would involve.

At the time of inspection, two residents continued to share a bedroom. An issue which had been known to the provider for several years. The provider was in the process of implementing a time -bound service improvement plan in order to address this issue. The inspector was informed that premises works were due to start in January 2022 and would be completed in advance of 30 April 2022. Residents informed the inspector that they were very much looking forward to the works being completed.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ratheanna OSV-0002367

Inspection ID: MON-0026967

Date of inspection: 17/11/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • PIC to facilitate staff supervision in line with St Michaels House supervision policy. • PIC will develop an improved supervision schedule for the year and will prioritize supervision to ensure all staff receive 4 per year. • The minutes of supervision will contain improved detailed action plans that will be worked on by PIC/staff between supervision session and actions will be reviewed at each supervision meeting to support progress and accountability.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • PIC and staff to continue to provide regular updates to the residents in regards to their individual open complaints. • PIC and staff to continue to record and escalate complaints. • PIC/staff to continue to liaise with NAS. • Open complaints to be reviewed by PIC monthly and updates and other actions sought from the relevant parties in regards to steps required and progress made to a resolution. • All progress/updates of complaints to be logged in complaints folder. • Complaints to be discussed at team meetings. • PIC to highlight complaints to Service Manager at PIC support meetings. • Service Manager to highlight open complaints to Director of Adult Services.	

Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • Building works to commence in January 10th 2022. When complete the building works will resolve the current open complaints in regards to the shared bedroom. When the works are complete, associated complaints will be resolved and closed. • The Velux window will be assessed and fixed during the building works which will resolve the ventilation issue. • All current complaints are related to the premises. • When the building works are complete (April 2022 approx) all complaints will be resolved and closed. In the interim , the residents will be kept updated on progress and all progress will documented in the complaints folder.	
Regulation 11: Visits	Not Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: • Staff always support visits from family and friends and ensure residents have privacy to spend time with family if and when required.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The premises will undergo external and internal works that will commence on 10th January 2022 which will address all outstanding issues.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • A multidisciplinary risk review will be completed for all falls risks in the DC.	

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Building works to commence 10th January 2022 that will address the fire evacuation plan and enable all residents to be evacuated safely.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Building works are commencing on 10th January 2022. These works will resolve the ongoing complaints in regards to the right of the two residents who are currently sharing a bedroom.	

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 11(3)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident; a suitable private area, which is not the resident's room, is available to a resident in which to receive a visitor if required.	Not Compliant	Red	29/04/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	01/01/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Red	29/04/2022

Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Red	29/04/2022
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Not Compliant	Red	31/12/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Red	29/04/2022
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	Substantially Compliant	Yellow	21/01/2022

	to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	18/11/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	21/01/2022
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency	Substantially Compliant	Yellow	29/04/2022

	lighting.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	29/04/2022
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Red	29/04/2022
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Red	29/04/2022
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is 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.	Not Compliant	Red	29/04/2022