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:	Auburn House
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Offaly
Type of inspection:	Unannounced
Date of inspection:	22 July 2025
Centre ID:	OSV-0005253
Fieldwork ID:	MON-0047760

About the designated centre

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

Auburn House is a designated centre operated by Nua Healthcare Services Ltd. The centre provides residential care for up to five male and female residents, who are over the age of 18 years and who have a range of complex needs including, intellectual disabilities and mental health needs. The centre comprises of one two-storey house, where residents have their own bedroom, en-suite facilities, shared bathrooms and communal use of a sitting room, kitchen and dining area, sensory room, utility and conservatory area. A large garden to the front and rear of the centre, is also available for residents to use, as they wish. An apartment, occupied by one resident, which is adjacent to the main building, provides the resident with their own bedroom, kitchen, sitting room, bathroom and separate entry and exit point, independent of the main building. Staff are on duty both day and night to support the residents who live in this centre.

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 (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 22 July 2025	09:00hrs to 16:30hrs	Jackie Warren	Lead
Tuesday 22 July 2025	09:00hrs to 16:30hrs	Anne Marie Byrne	Support

What residents told us and what inspectors observed

This was an unannounced inspection carried out following receipt of unsolicited information to the Chief Inspector of Social Services. This information pertained to concerns regarding the use of physical restraints in this centre, and in relation to staff training in relation to the use of these. Overall, this inspection did find that improvements were required in relation to aspects of restrictive practices and risk management, with considerations to be given to the provider at a governance level in relation to how they were overseeing these aspects of their service. These will be discussed in more detail later on in this report.

Given the nature of the information provided within the unsolicited information, the lines of enquiry for this inspection solely focused on the care and support needs of the resident that this related to. The inspection was facilitated by the person in charge and the director of operations for the service, who were both very knowledgeable of the needs of all residents and of the operational needs of the service delivered to them. Inspectors also had the opportunity to briefly meet with two residents, and with some staff on duty. Due to the assessed communication needs of the two residents that the inspectors met, they were unable to speak to them directly about the care and support that they received.

This centre was home to five residents, who had all lived together for a number of years, and primarily required care and support in relation to their behavioural support needs. Some residents also required the use of restrictive interventions, others had assessed health care needs, some required a certain level of support with their personal and intimate care, and each resident needed staff support so that they could get out and about to do the activities that they liked. In response to negative peer-to-peer interactions which had previously occurred, there were also specific safeguarding measures that staff had to routinely adhere to each day, so as to ensure residents' safety. Overall, these were an active group of residents, who enjoyed active lifestyles. Some liked to have frequent overnight stays with their families, attended yoga classes, went horse riding, shopping, liked to go swimming, and some were involved in Special Olympics. The provider had ensured that there was sufficient transport at the centre to facilitate residents' activities and outings, and had also ensured that a sufficient level of staff was at all times on duty to support residents to take part in these activities.

Upon inspectors' arrival to the centre, one resident was up and about, while the other four were having a lie on for themselves. There was a very calm and homely atmosphere in the centre, while staff were going about their duties before the rest of the residents got up. The centre comprised one two-storey house, that included one self-contained apartment that was home to one resident, and was located a few kilometres from a town in Co. Laois. In the main house, residents had their own bedrooms some of which were en-suite. There were shared bathrooms, a conservatory area, a sitting room, utility, and large kitchen and dining area. The apartment which wasn't visited by inspectors, comprised of a kitchen and living

area, bedroom and bathroom. To the front and rear of the property, there were large and well-maintained garden areas that residents could use and enjoy. The house was very spacious, light and bright, and was well-maintained.

Following a change in the presentation of a resident in recent months, this centre experienced an increase in the number and severity of behavioural incidents occurring, and in the number of physical holds that were being used in response to these. This had also resulted in an increase in negative peer-to-peer interactions between some residents, which at the time were subject to review both locally and by the designated safeguarding officer, which had resulted in this centre not experiencing any further incidents of this nature in over a month. Furthermore, following multi-disciplinary reviews of a resident's care, this had also resulted in a decline in the number of behavioural related incidents occurring at the time of this inspection.

As part of this inspection, inspectors specifically focused on regulations relating to governance and management arrangements, risk, behavioural management, safeguarding, assessment of need, complaints management, and staff training. While there were good practices found in a number of these areas, there were some areas for improvement that the provider was required to address. These specifically related to the accuracy of the information that was being gathered around the use of physical holds, and in how these incidents, where these holds had been required, were being risk-rated.

The next sections of this report present the inspection findings in relation to governance and management in the centre, and how it impacted on protecting residents from harm and supported them to manage behaviours that challenged.

Capacity and capability

Based on the findings of this inspection, overall, there were good levels of compliance with regulations relating to how residents lived their lives, how their rights were supported, and how they were protected from any form of harm. The person in charge and staff in this service were very focused on ensuring that residents had information about being safe, were supported to communicate effectively, had comfortable and safe living environment, and were aware of their rights. However, improvement to aspects of behaviour support including oversight of restrictive interventions and risk associated with the use of these restrictions.

There was a clear governance structure with defined roles and responsibilities identified to manage the centre. Residents were safeguarded through consistent care and support which was provided by a suitably trained staff team. The management systems in place ensured that the provider's commitment to safeguarding was appropriate, and had a positive impact on the lives of residents. There was a suitably qualified and experienced person in charge was also responsible for the management of another designated centre, and split their time

equally between the two centres. The person in charge was very familiar with the care and support needs of residents who lived in this centre and focused on ensuring that these residents would receive high quality of care and support. The person in charge was supported in the day-to-day management of the service by both a deputy person in charge and a shift lead manager. One these managers was allocated for duty when the person in charge was not present which ensured a management presence in the centre at all times, including at weekends.

The provider had ensured that the staff numbers and skill mixes were in line with the assessed needs of the residents and appropriate to meet their leisure, behaviour support and safeguarding needs. The inspector noted that, on the day of inspection, there were adequate staff on duty to support residents.

There were processes and resources in place to ensure the safe delivery of care and support to residents. These included accessible complaints and advocacy processes, communication systems to provide information and choice to residents and maintenance of a safe and comfortable living environment. Resources also included transport vehicles, and adequate numbers of suitably trained staff.

Improvement was required, however, the the oversight and risk management of restrictive interventions used for behaviour support and also to staff guidance on the use of these interventions. Some improvement to complaints management was also required. Overall, the complaints management process was satisfactory and complaints were being taken seriously and were being investigated. However, some improvement to recording of outcomes of complaints was required. For example, where a complaint had been raised about a concern having occurred on three separate occasions, the response was in respect of how this area of care was being managed overall, and there was no information available to view to demonstrate whether or not each of the three events of concern had been investigated separately.

Regulation 15: Staffing

Adequate staffing levels were being maintained in the centre to provide appropriate care to residents, and to ensure that they were safe.

An inspector viewed the staffing roster and found that planned and actual rosters were maintained. Rosters showed that sufficient staff were consistently being rostered to meet the wellbeing, assessed needs and safety needs of residents. Due to their support needs, some residents were assessed to need to need two-to-one staff support, while others were assessed to need one-to-one support. There were always seven staff on duty during the day to meet these needs, and this was evident on the day of inspection. Nursing support was also available to residents as required.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that staff who worked in the centre had received training to support them to provide suitable care to residents and to ensure that residents were protected from harm.

An inspector viewed the staff training records which showed that staff had received mandatory training in fire safety, behaviour support, and safeguarding, in addition to other training that was relevant to the needs of the residents who lived in the centre. These included training in safety intervention, risk assessment, autism and aspergers syndrome, providing intimate care, and three modules of intellectual disability training. Training records viewed, also confirmed that the provider had provided a range of human rights training which was relevant to the support and safeguarding of residents. Rights based training that staff had taken part in included; human rights in health and social care, good communication in upholding human rights, positive risk taking, putting people and human rights for healthcare professionals.

Judgment: Compliant

Regulation 23: Governance and management

Based on the findings of this inspection, overall, there were good levels of compliance with regulations relating to how residents lived their lives, how their rights were supported, and how they were protected from any form of harm. The person in charge and staff in this service were very focused on ensuring that residents had information about being safe, were supported to communicate effectively, had comfortable and safe living environment, and were aware of their rights. However, some improvement to safeguarding interventions and complaints recording was required.

There was a clear organisational structure in place to manage the service, which included a suitably qualified and experienced person in charge. There were arrangements in place for management support at weekends and when the person in charge was not on duty, and these arrangements were clearly communicated to staff. Further managerial support was provided by a deputy person in charge and a shift lead manager who both supported the person in charge with the day-to-day management of the service and provided management cover in the centre when the person in charge was not available. The person in charge also worked closely with their line manager. The person in charge, their line manager and the deputy person in charge were present on the day of inspection and all demonstrated a very clear

knowledge of the residents, their care and support needs, and the provider's processes.

The centre was suitably resourced to ensure the delivery of safe care and support to residents. During the inspection, inspectors observed that these resources included the provision of suitable, safe and comfortable accommodation and furnishing, transport, Wi-Fi, television, and adequate levels of suitably trained staff to support residents' safety, preferences and assessed needs.

The service was subject to ongoing monitoring and review. A range of audits and reviews were being carried out, including unannounced audits on behalf of the provider. From review of information and records, inspector found that oversight of safeguarding and residents' rights was important to the management team. There were processes in the centre to oversee behaviour support, risk, safeguarding and residents' rights. However, improvement to oversight of risk management, restrictive interventions, including holds, and the complaints process was required to ensure that these processes were fully effective..

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Any complaints or concerns that were received were taken seriously by the provider and there were systems in place for the management and resolution of complaints. However, improvement to the investigation and resolution of specific aspects of a complaint were required.

There was a complaints process in the centre to enable residents or their representatives to raise any complaints or concerns. There was a complaints policy to guide practice. The complaints procedure was clearly displayed in the centre and there was easy-read information to inform residents about how to raise a complaint and or to avail of an advocacy process either through the provider's system or externally. An inspector viewed the complaints management process and found that it generally met the requirements of the regulations. Some concerns had been brought to the attention of provider and an inspector viewed how these had been managed. The management team explained that the complaints process was managed by combined involvement of the management team in the centre, the organisation's complaints officer who was based external to the centre, and where appropriate issues identified through the complaints process were also referred to the provider's safeguarding team for their assessment.

Records of some aspects of complaints management were not available to view as they were retained elsewhere by the provider's complaints officer. An inspector read the complaints register that was available in the centre and reviewed how complaints were investigated and resolved. Overall, the complaints management process was satisfactory. There were records of the concerns received, and these

had been referred to the complaints officer for investigation. The outcomes of complaints had been communicated to the complainant. The outcomes of investigations were also recorded in the centre's complaints register, including whether or not the person who made the complaint was satisfied with the outcome. Where various examples of information was received as part of one complaint, records viewed indicated that each subject of complaints was investigated and explained separately in the outcomes. However, where a complaint had been raised about a concern having occurred on three separate occasions, the response was in respect of how this area of care was being managed overall, and there was no information available to view to demonstrate whether or not each of the three events of concern had been investigated separately.

Judgment: Compliant

Quality and safety

The provider had ensured that residents' needs were regularly assessed, and that multidisciplinary input was sought as part of these reviews, as and when required. There were also good arrangements in relation to safeguarding, which had been put in place in response to a number of negative peer-to-peer interactions that had occurred in recent months. However, this inspection did find that there was improvement required to restrictive practice management, and also in relation to aspects of risk management.

The provider had arrangements in place to safeguard residents from any form of harm. These included safeguarding processes, and systems to support residents to manage behaviours of concern as required. The size and layout of the centre, sufficient staffing levels to support residents and access to sufficient transport vehicles were also factors in the safeguarding of residents from any negative peer-to-peer interactions. Due to the nature of the unsolicited information received, the lines of enquiry for this inspection into restrictive practices were solely focused on the use of physical holds for one resident in this centre. There had been an increase in behavioural related incidents for this resident in recent months, which resulted in an increase in the number of times this resident had been subject to a physical hold during that time. However, at the time of this inspection, these behavioural incidents had recently declined in occurrence, and this had also resulted in a decline in the number of times physical holds were implemented. There were some good practices observed in relation to the use of these, to include, debriefing was carried out with this resident and staff following each physical hold, regular multidisciplinary assessments relating to their use was occurring, and along with daily body charts already being completed for this resident additional body charts were also being completed after each physical hold to observe for any injury. However, improvement was required in relation to how information was being gathered around the number, type, and duration of these holds. There was also improvement required to the guidance available to staff on the appropriate use of these holds, and in how

restrictive practice review meetings were overseeing the use of these physical holds.

A resident's risk assessments viewed by an inspector were of good standard and clearly stated very specific controls with regards to staffing levels, environmental considerations, social activities, and de-escalation techniques, in response to their identified risks. It was evident that these were kept up to date, and were regularly discussed with staff as part of daily handovers. There was a good incident reporting culture in this centre, with most of these relating to behavioural incidents that were regularly trended to inform residents' behavioural support reviews. However, improvement was required to how these incidents were being risk rated. The provider's current system for doing so, was calculated on the basis of whether or not injury or property damage had occurred during the incident. Despite this centre having encountered some very challenging behavioural-related incidents for staff to manage, which warranted them to implement last resort physical holds, all incidents relating to these were risk rated as low. Although these incidents were presented weekly to senior management in narrative format, this system for risk rating significantly diluted the impact and severity of these individual incidents to be accurately calculated, so as to highlight any potential or increasing risk to the service.

Regulation 26: Risk management procedures

The incidents that were reported in this centre were primarily behavioural related, and in the two month period prior to this inspection there had been an increase in these due to heightened presentation of a resident during this time period. A number of these were reviewed by inspectors, some of which detailed very challenging circumstances that staff had to respond to, whereby, their own personal safety and the safety of a resident was at risk, and last resort physical holds had to be implemented to support a resident back to baseline. However, despite the challenging nature of incidents where staff had to use these last resort measures, all incidents reviewed by inspectors in relation to such incidents, each were risk rated as low. For example, one behavioural incident detailed how a resident had engaged in significant self-injurious behaviour, that had warranted two physical holds to be applied with an attempt to apply a third hold not successful due to the presentation of the resident at the time, and clearly outlined the potential threat to staff safety while trying to support this resident back to baseline. This incident along with many others, was risk rated as low, with this calculation solely based on whether or not property damage or injury had occurred. This system of risk rating failed to give due regard other considerations relevant to the context of individual incidents, so that accurate risk rating could be calculated based on the actual incident that happened, irrespective of whether or not that incident had resulted in injury or property damage.

At the time of this inspection, the main organisational risks that the person in charge was maintaining regular oversight of pertained to staffing levels, behavioural support, potential threats to staff safety, restrictive practices and safeguarding

arrangements. However, the risk register required review, so as to ensure it accurately reflected the specific measures that were in place to oversee these specific organisational risks.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Comprehensive assessment of the health, personal and social care needs of each resident had been carried out, and individualised personal plans had been developed for all residents based on their assessed needs. These were of good quality, were up to date' and were informative.

The provider had ensured residents' needs were re-assessed for on a regular basis, and that personal plans were then developed to guide staff on what care and support was required to be provided to meet their needs. Residents' and their representatives were regularly engaged with, which informed any updates required to re-assessments, and the person in charge maintained good oversight in relation to all updates required. Furthermore, where residents regularly experienced unexplained bruising, they were subject to daily body chart assessments to monitor for this aspect of their care.

Upon review of one resident's assessment of need, an inspector did observe that it would benefit from minor updating, so as to include more specific information around what the resident required particularly in regards to safeguarding and their behavioural support arrangements. This was discussed with the person in charge, who was making arrangements to have these updates included before close of the inspection.

Judgment: Compliant

Regulation 7: Positive behavioural support

Due to the assessed needs of some residents, they were prescribed physical holds in response to their behavioural support needs. Upon arrival to the centre, inspectors requested specific information relating to the use of these, to include, an overview of the number of, nature and duration of these physical holds. There was multiple information gathered around these holds, to include trending reports and graphs, incident reports, and monthly and weekly data analysis charts, which were made available to inspectors. However, there were some discrepancies in the information provided, which impacted the provider's ability to have clear baseline information around the exact number, nature, and duration of the physical holds that had been used in this centre. For example, on one document totalled five physical holds for

May 2025; however, the weekly governance report totalled that ten physical holds were used in May 2025. When an inspector completed their own review of incidents for May 2025, it was found that six physical holds were reported. Another record outlined that ten physical holds in total were used in June 2025; however, a weekly governance report that was made available to inspectors totalled eight physical holds for that month. This failure to have clear and concise baseline information around the number, type and duration of all physical holds used in this centre, greatly impacted the provider's ability to have accurate information so to assurance themselves, that the least restrictive practice was at all times being used.

The guidance provided to staff on how to appropriately apply physical holds also required review. The guidance reviewed referred to a dynamic risk assessment that staff were required to complete prior to any physical hold being implemented. However, no information was provided to guide staff of what considerations needed to be given to this assessment, when completing it for the specific resident that the physical hold was intended for. Furthermore, for one resident, their guidance outlined six different types of physical holds that could be used. However, there was no guidance afforded in relation to how staff would determine which of these six holds was the one that was appropriate and proportionate to use, based on the outcome of the dynamic risk assessment. When physical holds were applied, staff completed an incident report, with improvements also found to be required to these. For instance, a number of such incidents reports reviewed by an inspector failed to identify the body part held by which staff member during the hold, and there were also a number of inconsistencies in the recording of the exact duration of individual physical holds.

There were monthly restrictive practice review meetings occurring, and these were attended by a member of local management and by the behaviour support specialist. The purpose and function of these reviews was to provide an increased level of scrutiny and oversight into the use of restrictive practices. The most recent meeting occurred in July 2025 and reviewed the restrictive practices that had been implemented in this centre in May 2025. As per the incident reports for that month, six physical holds had been implemented, arising from three separate behavioural related incidents involving the same resident. These three incidents were reviewed by an inspector and it was found that there were gaps in key information, such as, the duration of each individual hold wasn't consistently recorded, and many failed to indicate which staff member held which body part during each application. Furthermore, when the inspector reviewed these incidents in conjunction with the person in charge, it was also identified that there was some information that needed further clarification around the alternatives that were trialled before these physical holds were applied. The record of this restrictive practice review meeting gave limited information around the level of scrutiny these six physical holds had been subject to, with the outcome of the review concluding that all physical holds had been implemented as a last resort, despite the aforementioned gaps in key information that would have been required to determine and assure of this.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had good systems in place to safeguard residents from any form of harm and to ensure that residents were safe.

The provider had good systems in place to safeguard residents from any form of harm and to ensure that residents were safe. Although there were no identified safeguarding issues in the centre, the provider's systems continued to keep residents safe, ensure that they knew about safeguarding, and provide for the management of safeguarding concerns should this be required.

Inspectors reviewed the arrangements in place in the centre to safeguard residents from harm. These included development of intimate care plans and missing person profiles, and access to a safeguarding process. Information was also made available to residents in user friendly formats to increase their awareness and understanding of safeguarding. Inspector saw that information about safeguarding was presented to residents in appropriate formats that they could understand.

There was an up-to-date policy to guide practice. A safeguarding team was available in the local area to support residents and staff, and all staff had attended safeguarding training.

Inspectors found that a number of safeguarding incidents had previously occurred, where negative peer-to-peer interactions had taken place. These incidents were subject to local management and by the designated safeguarding officer, which observed key trends and patterns. In response to this, a number of safeguarding plans had been developed, and the effective implementation of these had resulted in no further incidents occurring. For residents who regularly presented with unexplained bruising, there was also a protocol in place to establish if there were any grounds for safeguarding concerns.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Auburn House OSV-0005253

Inspection ID: MON-0047760

Date of inspection: 22/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The Person in Charge (PIC) in conjunction with the Director of Operations (DOO) and Centre's Behavioural Specialist will conduct a full review of the processes in place that oversees risk management, restrictive interventions, including holds to ensure they are appropriately implemented, least restrictive and effective. Due Date: 30 September 2025 2. The PIC will complete a review of all documentation pertaining to risk management, behavior support and restrictive procedures to ensure information is clearly documented and guidance is consistent. Due Date: 15 September 2025 3. The Person in Charge and Director of Advocacy and Safeguarding will ensure all feedback received is reviewed in line with the Policy and Procedure on Comments Compliments and Complaints [PL-Ops-002] to ensure appropriate process is followed. Due Date: 30 September 2025	
Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The Person in Charge (PIC) will conduct a full review of the Centre Specific Risk Register and ensure adequate control measures reflect the measures actively in place in the Centre.

Due Date: 15 September 2025

2. The PIC in conjunction with the Centre's Behavioral Specialist will conduct a full review of all risk ratings within plans and ensure they are in line with the Risk Management Policy and Procedure [PL-OPS-003].

Due Date: 15 September 2025

3. Following the above actions being completed, the Individual Risk Management Plans and Centre Specific Risk Register will be discussed at the Team Meeting.

Due Date: 30 September 2025

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. The Person in Charge (PIC) in conjunction with the Centre's Behavioural Specialist will conduct a full review of Safety Interventions during the restrictive practice meeting and ensure the meeting minutes include a detailed rationale, justification and the review of the restriction to demonstrate extensive process undertaken.

Due Date: 30 September 2025

2. The PIC and Director of Operations (DOO) will ensure that all occasions of Safety Intervention are detailed consistently in all documents such as incident registers, incident reports, graphs and meeting record review minutes.

Due Date: 30 September 2025

3. The PIC in conjunction with the Centre's Behavioral Specialist will conduct a full review of Multi Element Behavior Support Plan (MEBSP) to provide further updates and guidance in relation to the application of Safety Intervention.

Completed: 28 August 2025

4. The PIC will provide training to Team Members through supervision, on-the-floor mentoring, daily handovers and Team Meetings regarding detailing all proactive measures utilised and exhausted during an incident of challenging behavior prior to implementing a restrictive procedure.

Due Date: 31 October 2025

5. The Policy on Report Writing and Record Keeping [PL-OPS-004] will be discussed at the Team Meeting.

Due Date: 30 September 2025

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	30/09/2025
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	31/10/2025
Regulation 07(1)	The person in charge shall ensure that staff have up to date	Substantially Compliant	Yellow	31/10/2025

	knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	31/10/2025