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:	Mulberry Lodge
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Offaly
Type of inspection:	Unannounced
Date of inspection:	05 February 2025
Centre ID:	OSV-0007413
Fieldwork ID:	MON-0046183

About the designated centre

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

Mulberry Lodge is a designated centre run by Nua Healthcare Services Ltd. The centre can provide residential care for up to four male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre can also cater for residents who require high behavioural support. The centre comprises of a main bungalow and four separate apartments. Each apartment provides residents with their own en-suite bedroom, living space and enclosed outdoor area. The main bungalow, comprises of a kitchen, staff office, bathroom, sunroom and hallway. Adjacent to the main bungalow, is a separate building comprising of laundry facilities and storage area. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 5 February 2025	09:30hrs to 16:15hrs	Anne Marie Byrne	Lead
Thursday 6 February 2025	09:45hrs to 16:30hrs	Anne Marie Byrne	Lead
Wednesday 5 February 2025	09:30hrs to 16:15hrs	Ivan Cormican	Support
Thursday 6 February 2025	09:45hrs to 16:30hrs	Ivan Cormican	Support

What residents told us and what inspectors observed

This was an unannounced inspection to assess the provider's compliance with the regulations, and was facilitated by the person in charge and the director of operations. Over the course of the two days, inspectors had the opportunity to meet with 10 staff members, the behavioural support therapist for the organisation, and with three of the residents, two of whom spoke briefly with the inspectors. Due to the communication needs of the third resident, they didn't engage directly with the inspectors, but did greet an inspector with a high-five, while they visited their apartment.

Overall, this inspection did find there were good systems in place supporting fire safety arrangements, consistent staffing levels were being maintained, suitable persons had been appointed to run and manage the service, and staff had been trained to carry out their duties. However, this was a centre where residents lived in a highly restrictive environment, which included the use of physical holds, that had been prescribed and sanctioned by the provider, and were frequently used in response to residents' behavioural needs and safety concerns. Giving due regard to this, the lines of enquiry into this inspection very much focused on the management and overall oversight of these restrictive practices. The findings of this inspection did identify that many aspects of restrictive practice management in this centre required considerable review, and significantly more oversight by the provider. These findings were also found to have an impact on the provider's risk and governance arrangements for this centre, and also residents' rights. This will be discussed in more detail throughout the next sections of this report.

At the time of this inspection, four adults resided in this centre, with each having their own apartment and transport. Many of them had complex behavioural support needs, assessed mental health needs, and some were identified with specific risks posing threat to their personal safety. They all had significant restrictions in place within the environment and surrounds of their apartments, and some were also prescribed physical restrictions, to include, physical holds. In response to the behavioural support and safety needs of these four residents, there was a high number of staff required to work in this centre at all times, which the provider had consistently maintained. For instance, one resident was assessed as requiring the support of three staff 24/7, another required three staff to support them during the day and two staff at night, while the two remaining residents each needed the support of two staff during the day and one staff each at night. When supporting these residents, staff were required to wear personal protective equipment for their own personal safety, and the provider had ensured a sufficient supply of this was maintained.

Upon inspectors' arrival both days, there was a calm and relaxed atmosphere, where residents were preparing to access their local community. Staff were observed to interact very warmly, friendly and casually with residents, and spoke confidently with inspectors about the individual care and support needs that residents had.

These residents enjoyed getting out and about; however, due to identified risks, staff were required to implement a number of safety precautions before and during some residents' social outings. For instance, where risks pertaining to community access had been identified, these residents' social activities were risk assessed so as to identify safe locations and times for their outings. There were very clear protocols in place for staff to adhere to when out in the community with these residents, which were regularly reviewed and updated. On both days, most of the residents were heading out for a drive with staff, with one going for a run in a local GAA park, and they planned to pick up a take-away on their return. This resident had recently begun swimming and staff stated that they were getting on well, and were enjoying this new activity. Another resident who required a lot of support from staff with regards to social interactions, was also heading out for a drive, but typically chose not to get out of the car. To encourage this resident more, staff had begun going for short walks with them and were supporting them to use some public facilities. One resident who met with an inspector, had a keen interest in music and had drums and a bongo in their bedroom. They loved to dress up and to get out and about, and had many photographs displayed in their apartment of the various costumes they had worn, and social outings that they had gone on. They planned to later head out to the local shop with staff to pick up snacks, and due to recent changes in their health status, staff were educating this resident around low sugar snack options. This resident took pride in their living space, and on the second day of this inspection, the provider was installing new flooring to their apartment. Some of these residents had spent time living in other countries and liked to speak some words in these languages. Over the course of the two days, staff were observed to facilitate this, and had educated themselves on some of the more commonly used words and phrased expressed by these residents. Staff had also begun cooking food from various other countries, and the person in charge had plans to expand on this further, so as to be able to give these particular residents a wider variety of dishes to choose from. Upon inspectors' departure on the last day of this inspection, staff were cooking some of these dishes for these residents, and the smell of home cooking gave a lovely homely feel to the centre.

This designated centre was located in the country side which had a large well-maintained garden, and many pleasant views. Along with the four apartments, the centre also comprised of a main bungalow, which contained a kitchen and dining area, sunroom, staff office and bathroom. At the rear of the centre, there was an additional building, which had a storage area and laundry facilities. Three of the residents could access the main bungalow at separate times, while supervised by staff. For the fourth resident, due to safeguarding risks identified by the provider, it had been assessed that it was unsafe for other residents, for that particular resident to access this area of the centre. Within the hallway of the main bungalow, there were two adjoining doors which gave access into two resident apartments, but these were not utilised and were only there to provide an additional fire exit from these apartments, if required. The third apartment also adjoined the main house; however, there was no access from this apartment directly into the main bungalow. The fourth apartment was located in a separate building adjacent to the main house. The layout of this centre provided each resident with their entrance and exit out of their apartment, meaning that they did not have to engage with one another as they came and went from the centre. Each apartment comprised on an en-suite

bedroom, a small hallway, and a living area. All four apartments had an outdoor area encased by high fencing, and access in and out was only via an electronic keypad lock. However, for two residents in particular, they lived in a highly restrictive environment which the provider had assessed as a requirement of their behavioural support needs, and associated safety concerns.

One of these two aforementioned residents had been admitted to the centre five months prior to this inspection. There were safety concerns relating to this resident in relation to them potentially leaving the centre without staff support, which the provider had named as an absconsion risk. They also were assessed with significant behaviours of concern, requiring the support of three staff throughout the day and night. Their apartment was fully surrounded by high fencing, had locked access points and window restrictions, and this resident was frequently physically restrained in response to behavioural related incidents. As part of their admission, the provider installed a 13ft high fence around the exterior of their outdoor area, to deter them from leaving the centre. However, this fence was found to be visually unpleasant and ineffective for its intended purpose. Both staff and management stated that since this resident's admission, they learned that the resident had a curious nature, loved to climb, and would seek every opportunity to climb this fence. Due to safeguarding concerns, this resident was not permitted access to the main bungalow. Subsequently, multiple incidents were reported, whereby, this resident scaled and climbed over this fence to try gain access to the main bungalow. At no time when these incidents occurred, was it reported that the resident made any attempt to leave the centre without staff support. It was however recorded, that these incidents had resulted on a number of occasions, where the resident was physically restrained by staff when they did attempt to climb this fence. In response to these incidents, the provider was in the process of raising the height of the fence by adding a large industrial pipe, with the aim of preventing the resident from getting a suitable hold in order to scale the fence. Inspectors found that this fence, which was initially installed to mitigate against an absconsion risk, now posed an additional significant safety risk for this resident should they fall from such a height. Furthermore, inspectors found that the fence itself was an unpleasant feature of this resident's living environment, and gave the resident no opportunity to enjoy the visual impact of the surrounding countryside.

This particular resident was also prescribed physical restrictive practices. Since their admission, numerous incidents were recorded where they had been physically restrained by staff, ranging from low to medium to advanced severity, some of which had been recorded to have been used for an extensive amount of time. Prior to this inspection, the provider submitted their quarterly notification returns to the Chief Inspector of Social Services, where they reported that this particular resident was physically restrained 25 times during the months of October, November and December 2024, with 13 of these reported to have been used in response to the resident attempting to climb their fence. Each physical hold was reported to have been of varying severity, with some notified to have been applied for significantly long periods of time. For example, three separate physical holds, each reported to have lasted 45 minutes for this resident, were notified to the Chief inspector as having occurred on the same day in December 2024. Upon request by inspectors, it was found that there was a incident where the resident was restrained for 35

minutes on that day; however, there were no records of the 45 minute holds which were notified, which raised concerns in relation to the oversight of these practices. Inspectors found that the reporting of recorded physical interventions was of a very poor standard, and did not provide sufficient detail to give context into each of these incidents which had left staff with no other option but to restrain this resident, as a last resort. Furthermore, multiple failings were found in relation to the provider's review process, oversight and response to these incidents, as well as giving due consideration to the rights of residents.

Following their admission, this same resident had enjoyed time in the kitchen area within the main bungalow, where they interacted well with staff, and had liked to both observe and help with the preparation of their own meals. Staff reported that this was had been a very pleasant time for the resident; however, the function of their behaviour changed over a period of time, with the resident no longer satisfied with just visiting the kitchen area, but also tried to forcefully gain access to two other residents' apartments that had adjoining doors into the main bungalow. One of these residents reported that they felt afraid when this had happened, and the provider responded swiftly to these incidents so as to safeguard both residents from this happening again. Although overall, safeguarding incidents were rare in their occurrence in this centre, from inspectors' discussions about safeguarding arrangements with members of management, it became apparent that the 13ft fence which had been installed due to an identified absconsion risk, had become an integral aspect of safeguarding arrangements in this centre. Inspectors found that significant work had gone into this centre in regards to facilitating these four residents to live together; however, for one resident it meant the use of a 13ft high fence, from which they could fall and sustain a significant injury from. Furthermore, this resident's desire to climb this fence had a significant impact on the number of times that they were subject to physical restraint, so as to safeguard the other residents from this resident attempting to gain access to their apartments.

An inspector reviewed the care arrangements for the second aforementioned resident, who had been admitted to the centre in 2023 and were supported by three staff during the day and two staff at night. They occupied the apartment which was adjacent to the main building, and they too lived in a highly restrictive environment. They had access to an outdoor area which was also bordered by a fence to deter them from leaving the centre. They also had locked access points into their apartment, with fixtures placed on some of their windows to discourage them from leaving without staff support, and to prevent property damage. Upon visiting this apartment, inspectors observed that this resident could only open one window in their apartment, and found that the bedroom area was stuffy and had no free flowing ventilation for fresh air. Inspectors were informed that the resident had recently attempted to kick open their bedroom window, which had restrictors in place, and maintenance personnel were waiting to fix this. In the meantime, the window frame had been screwed together, and to the wall with timber. Management of the centre told inspectors that the reason window restrictors were initially installed was because the resident was at risk of leaving the centre without staff support. However, the fence which surrounded their apartment prevented the resident from leaving the grounds of the centre, and inspectors found that the rationale for also restricting these windows required review to ensure that the least

restrictive option was utilised for this resident, at all times.

Although these two particular residents both lived in restrictive environments, their living areas were comfortable. One had photographs of themselves aswell as posters of their favourite movies displayed, both liked to use large bean bags to use to sit on, and visual aids of reference to them, were also left in a particular manner, as placed by them on counter tops. Staff who were supporting these residents were also very pleasant and they spoke about what each resident liked to do. It was clear that these residents were supported by a familiar staff team; however, they had each three staff with them constantly throughout the day in their apartment, which created a crowded home environment. For one of these residents, although three staff were required for safe community access, management of the centre could not clearly demonstrate the requirement of three staff to remain with this particular resident in their apartment at all times.

Overall, this inspection did find that considerable revision of the provider's review process, and system for managing and monitoring the use of restrictive practices was required. This was a highly restrictive environment in which residents lived in, and in particular where physical holds were being applied, inspectors found the provider had poor oversight of these and had failed to recognise and subsequently act on, the seriousness of restraining a resident for any period of time, not to mention for extended periods of up to 29 minutes and beyond. Multiple failings were also found in relation to the governance arrangements and of this aspect of the service, whereby, the provider was unable to clearly demonstrate that they had effectively assured themselves that the least restrictive practice was at all times used. This had a knock on impact on the overall effectiveness of the provider's risk management systems for this centre, which had failed to properly detect and manage risks associated with such a high use of restrictive practices. Finally, deficits were also found in the provider's ability to examine the overall effectiveness of their own oversight arrangements of this aspect of care, so as to ensure that residents' rights were to the forefront of care and actively promoted in this centre, at all times.

The specific findings of this inspection will now be discussed in the next two sections of this report.

Capacity and capability

As earlier mentioned, prior to this inspection, the provider submitted their quarterly notifications to the Chief Inspector, which informed of a high volume of restrictive practices which were implemented in this designated centre over a three month period. Due to this, the provider's processes for the oversight, review, and monitoring of restrictive practice management formed a large part of what both inspectors reviewed as part of this inspection. Overall, inspectors found multiple contributing factors which had resulted in many failings in this aspect of service, whereby, the provider had not used their own systems and processes, to urgently

review and respond to, the significantly high number of incidents of residents being physically restrained in their centre, despite this information being readily available to them.

At the time of this inspection, the person in charge had only recently returned to their position following extended leave. They were in the process of getting around to reviewing various aspects of the service, and had been responsive where they identified action needed to be taken, particularly in relation to staff support and training. Furthermore, upon their review of safeguarding related incidents that had occurred prior to their return, they had also taken action to address these, which had been effective in no further similar safeguarding incidents re-occurring. They had good support from the director of operations, and were in regular contact with them about any issues arising. There was a large staff team in place for this service, and regular reviews of this centre's staffing arrangement had ensured that there was consistency maintained in the number of staff rostered for duty both day and night, to support all four residents.

There were well established communication systems in place for this service, which included, regular staff team meetings as well as weekly senior management meetings. Ahead of weekly senior management meetings, local management compiled a report detailing how many times a physical restraint was used in this centre for the previous week, to inform this meeting. In more recent times, the provider had expanded this report, so that it now gave more information about the severity and time duration of the physical restraints applied. The information submitted ahead of a senior management meeting in December 2024 was reviewed by inspectors, which clearly indicated a considerable variation in the amount of physical restraints applied each week, with 22 physical restraints having been reported to have been applied on one particular week alone. Corresponding minutes of these management meetings were also reviewed by inspectors, whereby, there was no indication that this had been urgently discussed when these figures were flagged to senior management. When inspectors queried this further with those facilitating this inspection, they were informed that the consistent submission of this information to the provider on an on-going weekly basis, had not resulted in any robust review into restrictive practice management within this centre being requested, or carried out by the provider. In addition, failings in the provider's risk management system, also had a negative impact on ensuring incidents of physical restraint were being appropriately risk-rated to reflect the seriousness of the incident, so as to inform senior management meetings. Similarly, the monthly staff team meeting minutes from late December 2024 were also reviewed, and it was observed that this meeting was also not used to discuss the number of physical restrictions that had been implemented that month, despite it been reported to the Chief Inspector, that a resident was restrained for a substantial amount of time two weeks prior to this meeting.

Despite the many systems that the provider had in place for this centre, they had failed to act upon the information that they had consistently gathered and trended, that clearly highlighted that there had been a significant escalation in number of physical restrictions being implemented in their centre. Even though the provider did have processes for the local and multi-disciplinary review of these incidents, the

provider failed to question the effectiveness of their own review processes whereby despite these reviews, the use of physical restrictions, prescribed as a last resort practice, were continuing to have to be deployed on such a regular basis in order to care for these residents. Furthermore, they failed to effectively utilise their own risk, communication and monitoring processes to assure themselves that all times the least restrictive practice was be used, in recognition of the severity of any incident where any resident was subject to being physically restrained for any length of time.

Regulation 14: Persons in charge

The person in charge held responsibility for this service, and as this was the only designated centre operated by the provider in which they were responsible for, this meant that they had the capacity to be based full-time at the centre. They were supported in their role by a deputy, their staff team and their line manager in the running and management of the service. They had good knowledge of the residents' assessed needs and of the operational needs of the service delivered to them.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured there were sufficient staffing resources available to this centre, and this was maintained under regular review by local management. Although rare in occurrence, where the centre did require additional staffing resources, the provider had arrangements in place for this. There was also a well-maintained planned and actual roster for this centre, which clearly gave the names of staff and their start and finish times worked.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had arrangements in place to ensure all staff were provided with the training that they required to carry out their duties. At the time of this inspection, some additional training had been identified for staff, and the person in charge had scheduled this. All staff were also subject to on-going supervision from their line manager.

Judgment: Compliant

Regulation 23: Governance and management

This provider had many management systems in place to support them in the governance and oversight of this centre. This included regular local and senior management team meetings, and internal audits were frequently conducted. The provider was aware of the volume of restrictive practices prescribed for residents in this centre, and due to this, they had requested that information relating to the number of times a physical restriction was applied each week, was routinely submitted to inform weekly senior management team meetings. However, this it had not resulted in the provider taking urgent action when it was being consistently being reported to them that certain residents in their centre were regularly being subject to physical restraint for significant periods of time, given this practice was prescribed to be used only as a last resort.

The number of physical restraints used in this centre each week was trended by the provider and used to inform senior management team meetings. Inspectors reviewed a sample of this trending report, which gave a very clear overview of the amount of times physical restrictions were used in this centre for each month in 2024. This report, also clearly indicated significant fluctuations in the number of physical restrictions being used, particularly in the months leading up to this inspection. For example, in the second week of December 2024, 22 physical restrictions were reported to have been applied that week alone, in comparison to two physical restrictions being applied the week before. Information provided by the provider within their quarterly notifications to the Chief Inspector, reported that a resident was subjected to three separate 45 minute holds, of varying severity, with each having occurred on same day in this week. Despite the provider knowing that residents had been physically restrained for an extensive periods of time that week, some of which were reported to have been of advanced severity, and also given the considerable increase in physical restrictions reported on that particular week alone, this had not resulted in the provider urgently reviewing these incidents, so as to establish, robustly respond, and assure themselves as to the reason for this considerable increase in physical restrictions for that week. Similarly, the information provided for these weekly management team meetings also included the review of any red or orange rated-risks relating to this service. However, the current risk-rating of incidents in this centre was largely determined and calculated by the onset of injury or property damage. This meant that in the absence of both, many incidents which had warranted a resident to be physically retained in this service, were rated as low-risk incidents, and subsequently did not present for review as part of senior management meetings.

The provider did have identified monitoring systems in place, which they used to oversee the quality and safety of care within this centre. However, these were also found to be ineffective in identifying where specific improvements were required, particularly with regards to restrictive practices. For example, the last six monthly provider-led audit which was conducted in September 2024, did review many areas of care, to include, the use of restrictive practices. However, this visit primarily

focused on the policies and procedures guiding this aspect of service, staffing training and incident reporting of restrictive practices, with little emphasis placed on reviewing the quality and safety of the restrictive practices that were very regularly being implemented. For instance, the month prior to this visit, 20 physical restraints were reported to have been applied that month, which was a considerable increase in comparison to the months prior to this. However, the provider had not used this information available to them to inform the lines of enquiry for this six monthly provider-led visit, to monitor for this predominant area of care provided within their service.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had a system for the reporting, reviewing and monitoring of incidents occurring in this centre. They had ensured that all incidents were notified to the Chief Inspector of Social Services, as and when required.

Judgment: Compliant

Quality and safety

As mentioned throughout this report, residents who used this service had significant behavioural support and safety needs and there was an associated high use of restrictive practices. Considering the impact the provision of these practices had on residents' rights and experience of living in this centre, inspectors found that the oversight of some of these practices was of a poor standard. In particular, the provider failed to demonstrate that the use of physical holds was the least restrictive measure which could have implemented. In addition, the review of these restrictions practices, including physical and some environmental practices were of a poor standard and failed to identify significant concerns which were found on this inspection.

The provision of behavioural support is an integral aspect of care in this centre. Due to the high use of restrictive practices it was critical that this area of care was intensely monitored to ensure that the restrictions placed upon residents were required, and that the least restrictive option was employed at all times as to minimise the impact upon residents. An inspector reviewed an in depth behavioural support plan which gave a clear analysis of a resident's behavioural support needs. This plan sanctioned the use of physical restrictive practices in response to high level behaviours of concern. The plan also included an "opt out" sequence, which staff should deploy after the implementation of a physical hold lasting longer than

10 minutes. However, incident reports for physical holds reviewed by an inspector did not state that staff members tried to disengage at this 10 minute mark in all physical interventions. In addition, associated recording of these incidents was of a poor standard and did not give an accurate account of the physical hold itself, including which staff restrained particular body parts and for how long. Furthermore, the follow up review of these incidents failed to account for the poor record keeping and did not raise concerns on regards to the lack of implementation of the recommended "opt out" sequence. Although the person in charge had recently identified a deficit in how incident reports were being recorded and had organised additional training for staff in this area, a review of incidents previously submitted had not been prompted by the provider, in light of the extensive period of time that residents were reported to have been physically restrained.

There were two active safeguarding plans required in this centre which were implemented to prevent negative interactions between one resident and two others. Residents who used this service did not socialise or mix with each other. They had their own living areas and some residents used the communal kitchen area separately, for predefined periods of time. Recent safeguarding issues had occurred, whereby a resident had left their apartment area on several occasions and attempted to enter another resident's living area. As mentioned above, the 13 foot high fence was initially installed due to a perceived risk from one resident leaving the centre, but it ended up also being used as a secondary safeguarding measure following the above recorded incidents.

Although, residents were safeguarded in this centre, the presentation and use of this fence did have a negative impact on a resident's immediate environment. In addition, the primary use of this fence was to deter this resident from leaving the centre, and an associated risk assessment stated that the resident should be physically restrained, should they attempt to leave the grounds, which did impact on their rights. Despite this resident being admitted on a voluntary basis, and not showing any signs of intent to leave the centre without staff support, they were regularly physically restrained when they tried to climb this fence. In summary, the continued occurrence of physical restraint for this individual, along with the extensive measures required in order for four residents to live safely in this centre required review, to ensure that residents' rights were promoted and a good quality of life for all.

The oversight of risk in this centre also required significant review by the provider. A fundamental aspect of the service delivered to residents in this centre was behavioural support, which often resulted in physical restrictions being implemented; however, associated risk-rating of incident reports for the use of physical holds, failed to recognise the seriousness of these restrictions, particularly in the event of a resident being placed in a physical hold for a significant amount of time.

Regulation 26: Risk management procedures

The provider did have procedures in place to support the assessment, response and monitoring of risk in this centre; however, aspects of this system required significant improvement to ensure identified risks relating to this service were appropriately overseen.

The use of restrictive practices formed a large part of the care and support provided to these residents. Information pertaining to the implementation of these was readily made available to the provider on a weekly basis, which clearly indicated that incidents were occurring where a high number of physical restraints were being implemented. However, the provider had failed to appropriately review these incidents to assure themselves, that each restriction was applied as a last resort, and did not pose any potential risk to care and support of the residents in which they were intended for.

Considerable review was also required in relation to the risk-rating that was being calculated on incident reports where residents had been physically restrained. For instance, on associated incident forms that were reviewed by inspectors, it was observed that these were rated as 0 or 1, indicating a low risk-rating, for times when a resident was subject to a physical hold that was used for an extended period of time. These risk-ratings focused solely on property damage or injury, and failed to reflect the seriousness of the physical intervention that was used.

Where specific resident risks were identified, individual risk assessments were in place for these. However, some of these did require further review, to ensure better information was provided in relation to the specific control measures that the provider had put in place for these, particularly with regards to named absconsion and ligature risks. Furthermore, although the provider had a risk register in place, this also required review to ensure it gave due consideration to the specific risks that required on-going monitoring. For example, the risk assessment supporting the oversight of the use of restrictive practices in this service was rated as low, and had not considered the high volume of restrictions that were being implemented, or recognised the need for additional oversight measures to ensure this organisational risk was being robustly monitored.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had fire safety precautions in place, to include, fire detection and containment arrangements, regular fire safety checks were being carried out, all staff had up-to-date training in fire safety, and there were multiple fire exits in this centre which were maintained clear at all times. Regular fire drills were occurring, and records of these demonstrated that staff could support each resident to evacuate the centre in a timely manner. There was also a clear personal evacuation plan maintained for each resident, which guided on the specific support they

needed, should a fire occur. Upon a walk-around of the centre, it was observed that maintenance work was required to one fire door, and that the emergency lighting arrangements for one evacuation route required review, both of which the person in charge made arrangements to satisfactorily rectify by close of the inspection.

Judgment: Compliant

Regulation 7: Positive behavioural support

Although comprehensive behavioural support plans were in place, and restrictive practices were subject to review, for some residents these reviews were of a poor standard and ineffective in determining if the least restrictive option was employed at all times. Inspectors found that in particular, the use of physical holds in this centre required considerable review from the provider.

An inspector reviewed three separate incident notes whereby a resident was physically restrained for 30 minutes, 35 minutes and there also an unsuccessful attempted hold by five separate staff members, at intervals of two staff members at time, in an incident which was recorded to have lasted for 30 minutes. However, these notes failed to inform on what prior alternative strategies had been implemented, in order to avoid these holds in the first instance. In addition, the implementation of the "opt out" sequence, which was to be implemented after 10 minutes, with the aim of disengaging from the hold, was only evidenced in one separate incident report. The failure in providing adequate information around the context of these incidents, had a significant negative impact on this provider being able to demonstrate that the least restrictive option was in use at all times in this centre.

Both management of the centre and the behavioural support specialist were tasked with regularly reviewing these incidents, and the associated use of physical holds. An inspector found that these reviews did not examine if behavioural support plans were fully implemented, and also failed to determine if the least restrictive option was used at all times. Although the provider was aware of behavioural incidents and associated physical holds, suitable arrangements were not in place to question their use and the potential impact on residents' lived experience. In addition, the previously stated unsuccessful attempted hold by five staff members had not raised additional concerns by the provider in regards to the safety, consistency and delivery of care to this resident.

Environmental restrictive practices also required attention from the provider. Of concern to inspectors, was the use of a high fence to deter a resident from leaving their garden area. This fence had a negative impact on their immediate environment and also had presented them with an additional and significant risk of falls and serious injury. Inspectors found that the use of this fence required a significant review process to ensure it was the most suitable option for the delivery of care for

this resident.

This fence which was initially installed in response to safety concerns but had proved ineffective. In recent months, the fence had a secondary function in relation to safeguarding residents; however, the provider failed to recognise the extensive measures required in order for four residents to live together, and the impact these measures could have on a residents' safety, rights and overall well-being.

Judgment: Not compliant

Regulation 8: Protection

The provider had procedures in place to support staff in the identification, response and on-going monitoring of any concerns relating to the safety and welfare of residents. In response to safeguarding incidents which had occurred, there were two active safeguarding plans in place, which at the time of this inspection, had resulted in no further incidents of a similar nature re-occurring. Staff had received up-to-date training in safeguarding, and safeguarding arrangements were routinely discussed with staff as part of their meetings with the person in charge. As part of this inspection, inspectors did review the findings of a recent investigation into a safeguarding incident, which had been closed just prior to this inspection. Inspectors found that this required better detail was needed within this report into what steps were taken by the provider to inform this decision, as was outlined as a requirement within their provider's own safeguarding policy. This was brought to the attention of those facilitating this inspection, who were making arrangements for these documents to be updated with this information.

Judgment: Compliant

Regulation 9: Residents' rights

Residents in this centre lived in a highly restrictive environment, which the provider had assessed as a requirement for their care and support needs, as these residents could engage in behaviours of concerns that sometimes placed themselves or others at risk of harm or injury. Due to the extent of restrictions placed upon residents, significant oversight and review of these practices is required to ensure that residents' rights are not negatively impacted.

Although these practices were subject to review, these reviews were completed solely by those who were part of prescribing these practices to begin with, and were not subject to independent review to determine if residents' rights were to the

forefront of care at all times. In addition, a resident who was placed in the centre on a voluntary basis was prescribed a physical restrictive practice should they choose to leave, which was not in line with human rights. Although staff indicated that this would not occur and they would supervise their safety if they decided to leave, guidance from the provider was to restrict rather than to supervise and support this resident.
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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Mulberry Lodge OSV-0007413

Inspection ID: MON-0046183

Date of inspection: 06/02/2025

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	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

1. The Policy and Procedure "PLC007 – Policy and Procedure of Safety Intervention" is to be followed at all times by all Team Members and will be re shared with all the team members in the Centre and at the next Team Meeting.

Due Date: 30 April 2025

2. After any occasion of the use of an unplanned restriction, specifically a safety intervention, the Team Members involved will undertake a debrief to examine their perspectives in the situation and evaluate the strategies used prior to the safety intervention being applied with a member of the Centre Management. Learnings will be identified and shared with both the Team Members involved in the intervention and with the whole team as part of daily handovers for a specified period.

Due Date: 30 April 2025

3. A review of the Accident, Incident and Reporting System (AIRS) was discussed at the organisational Quality and Safety Committee Meeting on 27 March 2025. A full review of the AIRS system will be undertaken including how a safety intervention is recorded and documented, to further enhance our Governance and Management on the implementation of same.
Due Date: 27 June 2025

4. Centre specific training will be completed by relevant member/s of the training department and members of the multi-disciplinary team with Team Members which will focus on Individual Risk Management plans, Centre Specific Risk Registers and Restriction Passports. All training will be competency based and plans for Team Members

will be developed where required.

Completed: 26 February 2025

5. The Person in Charge (PIC) and the Quality Assurance Officer complete training with the Team Members on report writing and incident report writing. This is to ensure that Team Members can demonstrate in the incident report explicit details of the presenting incident and/or risk and what measures were implemented to respond to same including the proactive and reactive responses utilised in line with the plans pertaining to the Individual.
Completed: 26 February 2025

6. The PIC and the Shift Lead Managers (SLM's) will attend training in risk assessment and the management and ongoing review of risk.

Due Date: 25 April 2025

7. The Behavioral Specialist in conjunction with the PIC will complete a review of each incident within the Centre on a weekly basis to identify if there are additional strategies to support the Individuals and ensure that all relevant plans and documents specific to the Individual are updated where required. Identified learnings will be shared, trends monitored, and actions taken by way of a root cause analysis and review of the Behavioral Support Plan in place. This will be discussed and shared with the wider Multi-Disciplinary Team (MDT).

Completed: 18 March 2025

8. The PIC will conduct on the floor mentoring with Team Members to guide practice and enhance Team Members knowledge of strategies and the process of conducting debriefs with the Individuals in line with their assessed needs.

Due Date: 25 April 2025

9. A full review by the Occupational Therapist will be conducted on ID483's environment and any actions arising from the review will be implemented.

Due Date: 30 May 2025

10. The PIC in conjunction with relevant members of the Multi-Disciplinary Team will complete a full review of all Individuals Comprehensive Needs Assessments. Following this any additional recommendations will be implemented into Individual plans as required.

Due Date: 25 April 2025

11. PIC, DOO, Senior Behavioral Specialist and Behavioral Specialist will conduct a Restrictive Practice Review to ensure each restriction is only implemented following a revision of all alternative strategies being utilised and that they are been used as a last resort and for the shortest period of time.

Completed: 6 March 2025

12. Each week the DOO will review the Governance Matrix submitted by the PIC and will further discuss the intervention/s used and associated strategies and support utilized at the time. The DOO will document this review on the matrix that is discussed and published weekly. This review will indicate what further action is being taken including but not limited to, MDT review, Behavioural Support review and medical review as required.
Due Date 30 May 2025

13. The PIC and the Behavioural Specialist will complete a full review of each Individuals Multi Element Behavioural Support Plans (MEBSP) and/or section 4 of their Personal Plans.

Completed: 21 March 2025

14. The staff team will complete refresher training on Behaviour Support Plans and Restrictive practices within the centre. Following this training a Test of Knowledge (TOK) will be completed with all staff. The TOK will be reviewed by the PIC and Behavioural Specialist and an action plan developed for staff members where there is an identified skills gap.
Due Date: 25 April 2025

15. Behavioral Specialist in conjunction with the Person in Charge (PIC) will complete a review of all incidents in the centre on a monthly basis. In addition to this review the Behavioural team will produce a monthly trend analysis that is submitted to the PIC and Director of Operations (DOO). The trend analysis report must be accompanied by commentary regarding the action taken to mitigate risk or recommendations, and/or request for support to mitigate same.

Due Date: 30 May 2025

16. The PIC will escalate to the DOO all incidents where a physical intervention is used and where the opt out sequence is unsuccessful.

Completed: 28 February 2025

17. The DOO will raise at the weekly Governance Meeting instances of the use of a physical restraint where there is an increase in safety interventions used in week, regardless of severity or duration for the set period as per action plan.

Due Date: 30 May 2025

18. A Quality Assurance Officer will conduct an independent review of all the above actions with added focus on reviewing the quality and safety of the restrictive practices.
Due Date: 27 June 2025

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

1. Centre specific training will be completed with the Team Members by relevant member/s of the training department and members of the multi-disciplinary team which will focus on Individual Risk Management plans, Centre Specific Risk Registers and Restriction Passports. All training will be competency based and plans for staff will be developed where required.
Completed: 26 February 2025

2. PIC and Quality Assurance Officer to complete training with the Team Members on report writing and incident report writing. This is to ensure that Team Members can demonstrate in the incident report explicit details of the presenting incident and/or risk and what measures were implemented to respond to same including the proactive and reactive responses utilised in line with the plans pertaining to the Individual.
Completed: 26 February 2025

3. The PIC and the Shift Lead Managers (SLM's) will attend training in risk assessment and the management and ongoing review of risk.

Due Date: 25 April 2025

4. Behavioral Specialist in conjunction with the PIC will complete a review of each incident within the Centre on a weekly basis to identify if there are additional strategies to support the Individuals and ensure that all relevant plans and documents specific to the Individual are updated where required.

Completed: 18 March 2025

5. The PIC and Risk Officer to complete a full review of all Individual Risk Management Plans (IRMP's) and the Centre Specific Risk Register to review the risk ratings and controls in place and to ensure that the Individual risk rating is accurate and that the Centre Specific Risk Register matches the Individual's specific risk ratings.

Completed: 21 March 2025

6. Behavioral Specialist will meet with the PIC and management team at the Centre on a bi-weekly basis commencing the week of the 3rd March 2025 to review the Behavioral Support Plans where relevant or Section 4 of the Personal Plans for all Individuals. This will be underpinned by a Test of Knowledge (TOK) which staff will complete. If a staff member does not demonstrate competency, additional training will be provided to upskill them.

Due Date: 16 May 2025

7. PIC will review all incident reports daily and weekly to ensure that all proactive and reactive strategies were utilised proportionally to the presenting incident and or risk and that the least restrictive method of support was applied. Identified learnings will be shared, trends monitored, and actions taken by way of a root cause analysis and review of the Behavioral Support Plan in place. This will be measured through a monthly review between the Behavioural Specialist and PIC that will be minuted and shared with the wider Multi-Disciplinary Team.

Due Date: 30 May 2025

8. All the above actions will be discussed with the Team Members at the Centre Team Meeting to share learnings arising and to consistently reiterate the least restrictive approach.

Due Date: 30 May 2025

9. A Quality Assurance Officer will conduct an independent review of all the above actions with added focus on reviewing the quality and safety of the restrictive practices.
Due Date: 27 June 2025

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

1. PIC, DOO, Senior Behavioral Specialist and Behavioral Specialist will conduct a Restrictive Practice Reviews to ensure each restriction is only implemented following a revision of all alternative strategies been utilised and that they are been used as a last resort and for the shortest period of time.
Completed: 6 March 2025

2. The PIC in conjunction with the Behavioural Specialist will complete a full review of each Individuals Multi Element Behavioural Support Plans (MEBSP) and/or section 4 of their Personal Plans in consultation with relevant members of the Multi-Disciplinary Team.
Completed: 21 March 2025

3. The staff team will complete refresher training on Behaviour Support Plans and Restrictive practices within the Centre. Following this training a Test of Knowledge (TOK) will be completed with all staff. The TOK will be reviewed by the PIC and Behavioural Specialist and an action plan developed for staff members where there is an identified skills gap.
Due Date: 18 April 2025

4. Behavioral Specialist in conjunction with the Person in Charge (PIC) will complete a review of all incidents in the Centre on a monthly basis. In addition to this review the Behavioural team will produce a monthly trend analysis that is submitted to the Director

of Operations (DOO). The trend analysis report must be accompanied by commentary regarding the action taken to mitigate risk or recommendations, and/or request for support to mitigate same.
Due Date: 30 May 2025

5. The PIC, Behavioural Specialist and DOO in conjunction with other relevant members of the MDT will conduct a Restrictive Practice Review for the centre. This review will be completed in line with the Regulations and will include the identification of all alternatives tried to ensure that this is the least and most proportionate restrictive intervention available for the shortest period of time.

Due Date: 30 April 2025

6. PIC and Quality Assurance Officer to complete training with the staff team on report writing and incident report writing. This is to ensure that team members can demonstrate in the incident report explicit details of the presenting incident and/or risk and what measures were implemented to respond to same including the proactive and reactive responses utilised in line with the plans pertaining to the Individual.
Completed: 26 February 2025

7. All the above actions will be discussed with the staff at the centers team meeting.

Due Date: 30 May 2025

8. The PIC will escalate to the DOO all incidents where a physical intervention is used and where the opt out sequence is unsuccessful.

Completed: 28 February 2025

9. For each occasion where a physical intervention is used the PIC will complete a root cause analysis to review the antecedents that led to a restraint having to be utilised to ensure that this was as a last resort and for the shortest period of time. This review will be sent to the DOO for oversight and shared with the relevant members of the MDT.
Completed: 21 March 2025

10. A review of the Accident Incident Review System (AIRS) will be undertaken to ensure it captures all areas to be reported and that the impact to an individual is considered.
Due Date: 30 May 2025

11. A full review by the Occupational Therapist will be conducted on ID483's environment and any actions arising from the review will be implemented.

Due Date: 30 May 2025

12. Where a physical intervention is attempted with an Individual but is unsuccessful, a full review will be undertaken by the PIC and shared with the DOO and MDT for learnings.
Due Date: 30 April 2025

13. A Quality Assurance Officer will conduct an independent review of all the above actions with added focus on reviewing the quality and safety of the restrictive practices.
Due Date: 27 June 2025

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

1. PIC to apply for an independent advocate for resident ID483 and resident ID234.

Completed: 19 March 2025

2. The PIC in conjunction with the DOO will work with the independent advocate/s to ensure that all support provided is in line with their assessed needs, preferences and that any restrictions are proportionate to the presenting risk.

Due Date: 30 May 2025

3. The PIC, Behavioural Specialist and DOO in conjunction with other relevant members of the MDT will conduct a Restrictive Practice Review for the Centre. This review will be completed in line with the Regulations and will include the identification of all alternatives tried to ensure that this is the least and most proportionate restrictive intervention available for the shortest period of time.

Due Date: 30 April 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.	Not Compliant	Orange	27/06/2025
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.	Not Compliant	Orange	27/06/2025
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's	Not Compliant	Orange	27/06/2025

	behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	27/06/2025
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.	Not Compliant	Orange	27/06/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/05/2025