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

Issued by the Chief Inspector

Name of designated centre:	Ravens Hill
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	03 November 2023
Centre ID:	OSV-0008204
Fieldwork ID:	MON-0041849

About the designated centre

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

Ravens Hill is located in rural setting in County Westmeath. It can support up to three adults both male and female. The property sits on a large site surrounded by a large garden. The centre comprises of a large bungalow that has been subdivided into three self-contained apartments. Each apartment consists of a kitchen/ sitting room, a bedroom and en suite bathroom. Each apartment leads onto a small enclosed garden. There are also two communal areas including a large kitchen and sitting room. The staff team include scial care workers and assistant support workers on a 24/7 basis. Transport is provided in the centre should residents want to go on trips further afield. The supports provided in this centre include a range of allied health professionals including an occupational therapist, behaviour support specialist and psychologist.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Friday 3 November 2023	09:00hrs to 17:15hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

This unannounced risk inspection was conducted to review notifications submitted to the Chief Inspector regarding adverse incidents, safeguarding, a number of restrictive practices and the receipt of unsolicited information, which related to safeguarding concerns and residents rights.

Overall, the inspector found that significant improvements were required to the governance and management's arrangements in this centre along with staffing and resident's rights. Some improvements were required in safeguarding, complaints, restrictive practices and risk management.

During the inspection, the inspector met two of the residents, three staff, the person in charge, a deputy manager and the director of operations.

The centre is divided into three apartments, each apartment has a kitchen/sitting room, bedroom, en-suite bathroom and a small enclosed garden. There is also a sitting room and large kitchen that residents can use should they wish to meet up.

The centre was clean and two of the residents' apartments had been personalised to their individual preferences. For example; one resident who liked the colour pink had their room decorated in this colour. The inspector spent some time with this resident who showed the inspector their apartment and was happily looking at their electronic tablet when the inspector was there. The resident was supported at all times by a staff member and the interactions between the resident and the staff member was observed to be warm and friendly. This resident was getting ready to go home for the weekend and was looking forward to this. The staff member supporting the resident informed the inspector that, the resident did not like to engage in many activities but they were trying to introduce new things that the resident would enjoy.

Another resident who showed the inspector their bedroom, reported that they did not like the bed they slept in. The inspector followed this up with the person in charge who said that the resident had not raised this as a concern before today and agreed to follow it up with the resident after the inspection.

The resident also spoke about a complaint they had made the day before the inspection regarding anxieties they had in relation to some behaviours of concern exhibited in the centre. The resident said that these behaviours were impacting on their anxiety levels and at times they felt unsafe. The resident said they had complained about this before and that some measures had been taken to address this, but it had not resolved all of the issues. One of the measures in place meant that the resident pulled down the blind in their living area which restricted their view and the resident stated they did not like to do this.

Notwithstanding this the resident said that they liked living in the centre and found

the staff very nice and they discussed some of the supports that had been put in place to manage their anxiety. They spoke about volunteering at a local dog shelter and stated they were due to complete a course on pet care in the coming weeks. The resident also spoke about being supported to meet family and about some of the allied health support personnel they attended. On the day of the inspection the resident went out bowling and told the inspector they enjoyed this activity when they returned to the centre.

The inspector did not get to formally meet the third resident but visited their apartment for a short time to talk to staff. Over the preceding few months there had been a number of incidents resulting in property damage in the residents' apartment and other areas of the centre, the required repairs had not been completed at the time of the inspection. However, the inspector acknowledged that this was difficult for the registered provider to complete given that the resident found it difficult to have staff or strangers in their environment a lot of the time.

Staff spoken with, including senior management stated that, since this resident had transitioned to the centre they had engaged in episodes of behaviours of concern. As a result of this the person in charge said that an additional staff member was required on night duty to ensure safe staffing levels. However, this was not in place at the time of this inspection, the inspector sought written assurances from the senior manager on the day of the inspection that appropriate staffing levels would be in place going forward.

A number of complaints had been recorded in the centre since January 2023, and as discussed one resident had made a complaint the day before the inspection about the impact that behaviours of concern was having on their mental health. This was in progress at the time of the inspection. However, the inspector found that improvements were required in other records relating to complaints.

Notwithstanding, the inspector also observed a record of some compliments that had been recorded from family and residents representatives. For example; one family noted that they were very happy with the service being provided to their family member in the centre.

The inspector reviewed some records that demonstrated how residents were supported to raise concerns in the centre for example, key worker meeting records. The inspector found that these records for May, August and September 2023 contained the same information and therefore were not in any way meaningful.

The inspector also followed up some of the information that had been notified to the Chief Inspector regarding safeguarding concerns and restrictive practices. For example; the provider had stated that on each occasion when a physical safety intervention had been used, a debrief was conducted with the resident, however, there were no records to support that this was happening.

In addition while the provider was responding to safeguarding measures in the centre, some of the measures employed were impacting on residents' rights. Examples of this included, a resident was required to keep the blinds down in their apartment during the day, another resident was confined to their apartment and

could not use the communal kitchen and sitting room and had limited access to the large garden. The enclosed garden they did have was small and did not provide much space for this resident even though their behaviour support plan stated that they needed to be engaged in physical activities to manage their anxiety.

The next two section of the report present the findings of this inspection in relation to the governance and management arrangements and how these arrangements impacted the quality of care and support being provided to residents.

Capacity and capability

Overall, the inspector found that significant improvements were required to the governance and management's arrangements, staffing and resident's rights, and some improvements were required in safeguarding, complaints, restrictive practices and risk management.

As stated earlier unsolicited information had been received prior to this inspection where concerns were highlighted about safeguarding incidents and residents' rights and the inspector found that some of these concerns were substantiated. The Chief inspector had also been notified of a significant number of occasions where physical safety interventions had been employed in the centre and the provider had outlined certain measures taken post these interventions however, the inspector found that some of the measures were not being done.

The inspector found the governance and management arrangements in the centre at the time of the inspection were not adequate as the centre was not appropriately resourced with staff on night duty or managers every day in the centre to ensure a safe quality service to the residents living here. As a result, the inspector had to seek written assurances from the director of operations on the day of the inspection that, additional staff would be put in place at night time to support residents.

In addition, findings from the inspection demonstrated that the oversight in the centre was not adequate to ensure the safety and welfare of the residents living there. A new person in charge was appointed on 12 September 2023 and they were also in charge of another designated centre under the remit of the provider. Given the complex needs of the residents in this centre and the proximity of the two centres (one hour forty minutes distance apart), at the time of the person in charges appointment, the registered provider was contacted by HIQA seeking assurances around the governance and oversight of this centre. The provider submitted assurances to include that the centre would have supernumerary management (meaning in excess of the normal staff numbers) on-site Monday to Friday. This was not in place every day at the time of the inspection. The inspector found that the governance and management arrangements in the centre at the time of the

inspection were not effective based on the findings of this inspection.

The person in charge and a deputy manager (who was assigned some days to work in this centre) facilitated the inspection both of whom demonstrated a person centred approach and a good knowledge of what was required to ensure that the quality and safety of care was to a good standard. However, they were not in the centre every day and this was impacting on the oversight arrangements in place. This was evident on the day of the inspection when the inspector reviewed available information and found that, some improvements were required which included supervision had not been completed with staff, some actions from audits were not completed, records in relation to the management of restrictive practices were not managed effectively and issues in relation to safeguarding were negatively impacting on residents' rights in the centre.

The registered provider had a complaints policy which outlined the way in which complaints should be managed. Residents were informed about their right to make a complaint. However, as discussed in the previous section of this report, improvements were required in the management of some complaints.

Regulation 15: Staffing

The registered provider had not ensured that the number of staff on duty at night was appropriate to meet the needs of residents at night. The person in charge had identified that an additional member of staff was required on duty at night to support a resident due to behaviours of concern, without this additional staff there was a safety risk to the resident. This had not been implemented at all times at the time of this inspection and a review of the planned rota for the next week showed significant gaps in the rota to have this shift filled. As a result the director of operations was required to submit written assurances that these shifts would be covered going forward until such time that it had been assessed by the management team (which included multi-disciplinary team) to reduce this need.

At the time of the inspection there were three staff vacancies, additional shifts to fill these vacancies were being completed by regular staff to ensure consistency of care to the residents. The person in charge informed the inspector that the registered provider was actively recruiting to fill these vacancies and there two staff were due to commence in the coming weeks.

There was a planned and actual staff rota, maintained in the centre.

Personnel files were not reviewed at this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

A review of the staff training matrix showed that staff had completed mandatory training in safeguarding vulnerable adults, basic life support, fire safety, behaviours of concern, autism, the safe administration of medicines and risk management. The person in charge was also planning some refresher training for staff to ensure that their skill were kept up to date.

Judgment: Compliant

Regulation 23: Governance and management

At the time of the inspection the designated centre was not resourced to ensure the effective delivery of care and support as discussed under regulation 15 staffing. In addition, the person in charge appointed on 12 September 2023 was also in charge of another designated centre under this provider. At the time of this appointment, the registered provider was contacted by HIQA to seek assurances around the fact that the person in charge would be responsible for two designated centres. At that time the registered provider submitted assurances to include that the centre would have supernumerary management personnel (meaning in excess of the normal staff numbers) on-site Monday to Friday. This was not always in place at the time of the inspection.

The inspector found that the governance and management arrangements in the centre at the time of the inspection were not effective based on the findings of this inspection which included:

- supervision of staff was not up to date
- reporting procedures were not always followed. An incident recorded on a residents night report on the 24 October 2023 had not been reported to the person in charge until 27 October 2023 and had not been reported to the operations manager up to the time of this inspection. In addition there was no incident report recorded at the time of this inspection for this incident.
- Debriefs were not been completed with staff each time a physical safety intervention was used in the centre
- The provider had recorded in the notifications to HIQA that each time a restrictive practice was employed that the resident's individual risk management plan was updated. There was no evidence of this review in the plans reviewed.
- There was inconsistencies in the records maintained for when a physical safety intervention was required in the centre. For example; when the inspector reviewed the daily handover staff log, the restrictive practice register and residents daily records some of the information did not match.
- Records in the centre such as residents key working meetings were not meaningful and some appeared to be carbon copies of each other.

- Some actions from audits had not been completed. For example; it had been identified in a recent audit that some records were not in place around the management of complaints. This was still an issue at the time of this inspection.
- Safeguarding measures implemented to protect residents needed to be reviewed as they were impacting on the rights of residents. In addition a review of a sample of records showed that all safeguarding concerns had been notified to the Health Information and Quality Authority where required. However, on 31st October 2023 a resident had raised a complaint which suggested that more safeguarding concerns could have occurred. While the inspector acknowledges that this was only received the say before the inspection, given the inconsistencies in some of the records already noted this needed to be fully reviewed by the provider.

Judgment: Not compliant

Regulation 34: Complaints procedure

A number of complaints had been recorded in the centre since January 2023 and one had only been recorded the day before the inspection from a resident who was not happy about some aspects of the service. This was in progress at the time of the inspection. The inspector found that, where a complaint was raised it was investigated and responded to. Residents were informed about their right to make a complaint and easy to read information was available throughout the centre about how residents could make a complaint.

One resident had been supported to contact an advocacy services to ensure that they were supported with some of their concerns in the centre. This was still in progress at the time of the inspection. This resident spoke to the inspector about some complaints they had raised and actions taken to address these concerns. However as discussed and referenced under regulation 9 of this report some of those actions impacted on the rights of the resident.

However, in respect of two complaints raised there were no records on one of the complaints recorded to demonstrate whether the complainant was satisfied with the outcome of the complaint. And in another complaint a recommendation to follow up with a resident in a few weeks about issues contained in the complaint had not been done.

Judgment: Substantially compliant

Quality and safety

Overall the inspector observed positive interactions between two of the residents and staff and found examples of how residents were supported to have meaningful activities and be included in decisions around their care and support. However, due to safeguarding issues in the centre, significant improvements were required in residents rights. In addition, as outlined in the previous section of this report improvements were also required in risk management, safeguarding and positive behavioural support.

All staff had been provided with training and ongoing guidance from allied health professionals around how to support and manage behaviours of concern for residents. For example; a positive behaviour support specialist and an occupational therapist visited the centre once a week to support staff and review support plans. Staff were knowledgeable about the supports in place to manage residents behaviours of concern and were aware of the physical safety interventions to be employed as a last resort. However, improvements were required in the records and management of restrictive practices.

All staff had been provided with mandatory training in safeguarding vulnerable adults according to the training records reviewed and the inspector was also informed that additional refresher training was also being provided.

Safeguarding plans had been developed to protect residents when such incidents occurred. However, the inspector found that some safeguarding plans were not reviewed to ensure that they were effective and to ensure that the resident felt safe. For example, a safeguarding plan for a resident did not include details of measures in place to ensure the residents' psychological needs were being met and to assure that the resident felt safe. This was particularly important, as this resident had raised a number of concerns in the centre. Some of the safeguarding measures in place were also impacting on residents' rights in the centre as discussed under regulation 9.

Risk management systems were in place in the centre, however, some improvements were required in reporting incidents and updating risk management plans.

Regulation 26: Risk management procedures

The registered provider has policies and procedures in place around the management of risk. Not all aspects of risk management were reviewed at this inspection. However, as identified a risk in relation to staffing levels had not been mitigated at the time of this inspection as actioned under staffing.

An incident that occurred in the centre had not been reported in a timely manner and an incident report form had not been completed for this incident.

The provider had also indicated in their notifications to the office of the Chief

Inspector that after a restraint was used in the centre the residents individual risk management plan was reviewed. However, this review was not recorded on the risk management plan.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

All staff had been provided with training and ongoing guidance from allied health professionals around how to support and manage behaviours of concern for residents. This included training on the management and de-escalation techniques used to support residents. The staff spoken with were knowledgeable around these safety techniques and were aware of the dangers associated with some physical safety techniques. For example; staff were aware that if a resident was on the floor they had to disengage from any physical safety techniques to ensure that the resident was not at risk of being injured. This was also clearly outlined in the residents 'multi element behaviour support plan'. The use of prone restraint or physically restraining a person on the floor was not permitted. This plan also outlined alternatives that should be tried before a restrictive practice was used.

One resident went through some of the supports they had in place to manage their anxieties and it was evident that the resident was included in decisions around their care.

However, a review of some measures related to the use of restrictive practices was not available in some instances. For example; there were no records to show that a debrief had occurred with staff or the resident after a physical safety intervention was employed even though this was a measure that the registered provider had in place. In addition, as discussed under regulation 23 governance and management some physical safety intervention records were poorly recorded and conflicting information was included in the records viewed.

Judgment: Substantially compliant

Regulation 8: Protection

All staff had been provided with mandatory training in safeguarding vulnerable adults according to the training records reviewed. The inspector was also informed that, additional refresher training was also being provided. A review of some records found that the registered provider had instigated an investigation where a safeguarding concern had been raised in the centre and relevant authorities had been informed. The residents were informed about their right to feel safe and who

to report concerns to.

Safeguarding plans had been developed to protect residents when such incidents occurred. However, the inspector found that some safeguarding plans were not reviewed to ensure that they were effective and to ensure that the resident felt safe. For example, a safeguarding plan for a resident did not include details of measures in place to ensure the residents' psychological needs were being met and to assure that the resident felt safe. This was particularly important, as this resident had raised a number of concerns in the centre. Some of the safeguarding measures put in place were also impacting on residents rights as discussed under regulation 9.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The inspector found that there were a number of forums in place for residents to be consulted and participate in the organisation of the designated centre. There were also forums for residents to be informed of their rights and to be included in decisions about there care and support. However, some of the forums that the registered provider had in place were not meaningful. For example; the inspector found that records in May, August and September of 2023 contained the exact same information and therefore was not in any way meaningful.

The registered provider had also outlined that after each incident when a physical safety intervention was used that a debrief would be completed with the resident. There were no records to demonstrate this at the time of the inspection.

As discussed under regulation 8, the inspector found that some of the measures implemented to safeguard residents were impacting on residents' right to their freedom to exercise choice and control in their daily lives. For example, one resident said they were required to have their window blinds pulled down in their apartment as a safeguarding measure. The resident reported to the inspector that they were not happy with this measure. Another resident was confined to their apartment area only and had no access to the communal kitchen and limited access to the large garden area. The small garden area that this resident did have access to, was not very inviting with limited activities available to them. This was very important, as the resident did not like to engage in community activities on a regular basis in line with their personal preferences. These required review to ensure that residents' rights were being respected in this centre.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ravens Hill OSV-0008204

Inspection ID: MON-0041849

Date of inspection: 03/11/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
To demonstrate that the Designated Centre is in line with regulation 15 the Person in Charge shall ensure that there are adequate staffing levels maintained at all times as per Service User's assessed needs.

1) The open vacancies in the Centre to be filled to ensure skill mix maintained as per the Statement of purpose (Due Date: 31/01/2024).

2) The Director of Operations/PIC to meet Recruitment weekly to place focus on filling current vacancies (Due Date: 31/01/2024).

3) Contingency Risk Assessment on staffing levels to be reviewed by the PIC to ensure it identifies arrangement in the event of staff absences (Completed).

4) Skills gap analysis to be completed for all team members in the Centre to identify areas for further upskilling/ training (Due Date: 22/12/2023).

5) Centre Management to complete a weekly review of the roster of the coming week to ensure that all shifts are covered in line with assessed needs of Service Users. Centre Management will immediately escalate any shifts requiring cover to the Director of Operations (Due Date: 31/01/2024).

6) Centre Specific Training plan for Centre team will cover the following areas for this regulation:

- Positive Behaviour Support
- Service Users Plans
- Report Writing to include Incident Reports and Debriefs
- Safeguarding
- Complaints
- Rights

· Risk Management
· Use of Safety Interventions/ Safety Pod training.
· Use of PRN medication in line with Service User's Plans.
(Due Date: 15/01/2024).

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To demonstrate that the Designated Centre is in line with regulation 23, the Provider shall ensure that there are appropriate measures in place to ensure there is adequate Governance and Management of the Centre.

1) A daily check in to be completed by Centre management to include confirmation a review of all daily notes for Service Users has been completed and signed off (Due Date: 18/12/2023).

2) The PIC to brief all team members that all incident report forms are completed when incident occurs (Due Date: 08/12/2023).

3) A Governance Improvement / Compliance Plan has been implemented in the Centre and will be overseen by the PIC /Director of Operations (Due Date: 31/01/2024).

4) Supervision to be completed by Management with all team members to ensure the Centre is in line with Supervision Policy (Due Date: 20/12/2023).

5) PIC to ensure HIQA quarterly notifications are reviewed prior to submission to ensure that they capture accurate information relating to the use and review of restrictive practices (Due Date: 30/01/2024).

6) Monthly key working sessions to be reviewed by the PIC to ensure that they are meaningful and accurate of discussions held with Service Users (Due Date: 08/12/2023).

7) PIC to ensure all complaints raised by Service Users are reviewed and Safeguarding referral will be submitted through pathway as required (Due Date: 07/12/2023).

8) Nua's Designated Safeguarding Officer will visit the Centre on a fortnightly basis commencing week beginning 04 of December to review all Safeguarding Plans with PIC and meet with Individuals, where available and to review the effective of the current Safeguarding Plans in place (Due Date: 22/12/2023).

9) A QA Officer will be assigned to the Centre 1 day a week on a fortnightly basis for 8-week period (Due Date: 31/01/2024).

10) A Behavioural Specialist will attend the Centre on a weekly basis to complete on the floor mentoring of MEBSP and Section 5 of the Personal Plan (Due Date: 11/12/2023).

11) Behavioural Specialist in conjunction with the PIC will complete a review of each incident within the Centre from June 2023 and incidents on a weekly basis as part of the Governance Improvement / Compliance Plan to identify additional strategies to support Service Users (Due Date: 31/01/2024).

12) PIC,DOO, Behavioural Specialist and Behavioural Specialist Manager will conduct bi-weekly 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. Following this review all Personal Plans, Behaviour Support Plans and Risk Management Plans will be updated to reflect any changes that occur, and minutes of meetings will be on file showing clear rational for any restrictions (Due Date: 31/01/2024).

13) A Multi-Disciplinary Team meeting will take place to discuss all three (3) Service Users plans with all key disciplines in attendance. The Purpose of this meeting will be to review supports required for each Individual and collectively and ensuring their engagement in their Personal Plans, Goals and Safeguarding (Due Date: 22/12/2023).

14) Team meetings will take place fortnightly for an 8-week period, upon when the frequency of same will be review (Due Date: 30/01/2024).

15) Incident report to be completed regarding the incident which occurred on the 24th of October (Due Date: 10/11/2023).

16) Behavioural Specialist will complete a review on the most appropriate method of debrief to be utilised with each Service User, and this is to be recorded on Service Users Personal Plan, where appropriate to do so (Due Date: 18/12/2023).
17) Centre Management to ensure Personal Plans, MEBSPs [where relevant] and IRMPs for each Service User is to capture the Behavioral Specialist recommendations regarding debriefs (Due Date: 22/12/2023).
18) Complaint received prior to the inspection to be reviewed in line with the safeguarding pathway as per the Safeguarding policy (Due Date: 10/11/2023).

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
To demonstrate that the Designated Centre is in line with regulation 34, the Person in Charge shall ensure that there are appropriate measures in place to manage complaints.

1) PIC to conduct a weekly review of the complaints register to ensure that it contains information on updates and the satisfaction of the person raising the complaint (Due Date: 18/12/2023).

2) Centre Management to complete training on complaints, inclusive of the complaints process and documentation relating to same (Due Date: 22/12/2023)

3) Each team member to attend Centre Specific Training on the Complaints Policy and

Procedure to ensure all team members are competent in the application of the process (Due Date: 15/01/2024).

4) Key working session on the complaints process to be completed with all Service Users in the Centre (Due Date: 11/12/2023).

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
To demonstrate that the Designated Centre is in line with regulation 26, the Person in Charge shall ensure that there are appropriate measures in place to manage risk.

1) Contingency Risk Assessment on staffing levels to be reviewed by the PIC to ensure it identifies arrangements in the event of staff absences (Completed).

2) A daily check in with the DOO to be completed by Centre management to include confirmation a review of all daily notes for Service Users has been completed and all relevant information updated as required including Individual Risk Management Plans (IRMPs) (Due Date: 11/12/2023).

3) Risk Manager to visit Centre in December and January to support PIC to complete a full review to all IRMP's to further enhance the control measures are in place for all Service Users (Due Date: 31/01/2024).

4) PIC will review all quarterly notifications when they are been submitted to the Authority to ensure that they are reflective of current controls and information is accurate of current practice (Due Date: 31/01/2024).

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
To demonstrate that the Designated Centre is in line with regulation 7, the Person in Charge shall implement the following actions to ensure adequate positive behavior support is in place to meet the needs of Individuals.

1) Behavioral Specialist will complete a review on the most appropriate method of debrief to be utilised with each Service User, and this is to be recorded on Service Users Personal Plan, where appropriate to do so (Due Date: 18/12/2023).

2) The Behavioural Specialist will conduct a trend review on restrictive practices within the Centre, identifying potential areas for further reductions (Due Date: 12/01/2024).

3) A Behavioral Specialist will attend the Centre on a weekly basis to complete on the floor mentoring of MEBSP and Section 5 of the Personal Plan (Due Date: 31/01/2024).

4) Behavioral Specialist in conjunction with the PIC will complete a review of each incident within the Centre from June 2023 and incidents on a weekly basis as part of the Governance Improvement / Compliance Plan to identify additional strategies to support Service Users (Due Date:31/01/2024).

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
To demonstrate that the Designated Centre is in line with regulation 8, the Person in Charge shall ensure that there are appropriate measures in place to safeguard Individuals from abuse.

1) Nua's Designated Safeguarding Officer will visit the Centre on a fortnightly basis commencing week beginning 04 of December to review all Safeguarding Plans with PIC and meet with Individuals, where available and to review the effective of the current Safeguarding Plans in place (Due Date: 22/12/2023).

2) Monitoring to be implemented to capture potential psychological impact, the monitoring to be reviewed weekly by the Behavioral Specialist and PIC (Due Date: 22/12/2023).

3) Centre specific classroom-based training will be completed with the team which will focus on Safeguarding and Protection. This refresher training will cover identifying and recognising all types of abuse, reporting, and documenting all concerns and escalation of any potential concerns to Nua’s Safeguarding Team. This training will be competency based and scenario-based training (Due Date: 15/01/2024).

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To demonstrate that the Designated Centre is in line with Regulation 9, the Person in Charge shall ensure that there are appropriate measures in place to support Resident’s rights.

1) Behavioral Specialist in conjunction with the PIC will complete a review of each incident within the Centre from June 2023 and incidents on a weekly basis as part of the Governance Plan to identify additional strategies to support Service User (Due Date: 31/01/2024).

2) The Safety Intervention Trainers will conduct a review of each occasion where physical restraint was implementation since June 2023 to identify the learnings for the staff team on ensuring their adherence to Safety Intervention Training in relation to the use of restraint as a last resort and used for the shortest period of time (Due Date: 20/12/2023).

3) A member of management will chair the Individual Service Users forums in line with the communication needs of the Service User to ensure that the Service Users are consulted on key aspects of the running of the Centre (Due Date: 22/12/2023).

4) Person In Charge (PIC), DOO, Behavioural Specialist and Behavioural Specialist Manager will conduct bi-weekly 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. Following this review all Personal Plans, Behaviour Support Plans and Risk Management Plans will be updated to reflect any changes that occur, and minutes of meeting will be on file showing clear rational for restriction (Due Date: 31/01/2024).

5) Restriction reduction plans in place to undergo review by the PIC in consultation with the Behavioral Specialist (Due Date: 23/12/2023).

6) Service Users to be educated on the National Advocacy Service and supports they provide (Due Date: 16/12/2023).

7) Centre Specific Training to be completed which will focus on importance of Individual Rights and ensuring that consultation with Individuals is completed (Due Date: 15/01/2024).

8) Behavioural Specialist, PIC and Keyworkers to ensure that all Service Users have been consulted with in relation to the proactive and reactive strategies within their Personal Plans - Section 5 and Behavioural Support Plans and that this is documented (Due Date: 20/12/2023).

9) Comprehensive needs assessment review to be completed inclusive of their enclosed garden and access to activities with input from the relevant MDT members (Due Date: 17/01/2024)

10) Monitoring to be implemented to capture potential psychological impact, the monitoring to be reviewed weekly by the Behavioral Specialist and PIC (Due Date: 22/12/2023).

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/01/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/01/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	31/01/2024

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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	31/01/2024
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	15/01/2024
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify	Substantially Compliant	Yellow	31/01/2024

	and alleviate the cause of the resident’s challenging behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	15/01/2024
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	31/01/2024
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	31/01/2024