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:	Ravens Hill
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	04 June 2025
Centre ID:	OSV-0008204
Fieldwork ID:	MON-0046583

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 is located on a large site which includes a large garden, parking area and driveway. The property is a large bungalow that has been subdivided into three self-contained apartments. The three apartments consists of a living area, 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 social care workers and assistant support workers who provide support 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 includes 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
Wednesday 4 June 2025	13:30hrs to 20:30hrs	Anna Doyle	Lead
Thursday 5 June 2025	10:40hrs to 16:40hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

Overall, over the course of this two day inspection, the inspector found from talking to one resident and observing some practices that staff in the centre were kind, patient and treated residents in a respectful manner. Some improvements were also observed in the quality of life for two of the residents living in this centre. However, this was not as evident for another resident and as such required improvements in the governance and management, risk management, personal plans and records retained within the centre.

This inspection was unannounced and was carried out for a number of reasons to include following up on actions from the last inspection in August 2024, due to changes in the management structures in the centre. It was also carried out after the receipt of some notifications received by the Office of Chief Inspector and unsolicited information received since the last inspection.

On arrival to the centre, two of the residents were out doing activities and one of the residents was preparing to go for a drive. Over the course of the inspection, the inspector met with several staff members while observing practices. This included a shift lead manager, a deputy person in charge, the director of operations and the registered provider representative (over the telephone). The inspector also reviewed a sample of records in residents' personal plans and records pertaining to the governance and management of the centre.

Over the course of the two days, there were maintenance personnel on site carrying out maintenance work in the property. Some of this work had been identified by the provider previously and one issue needed to be addressed because of observations by the inspector on the first day of the inspection. This issue will be discussed further under risk management of this report.

The inspector met all three residents. Two were met with informally while they were engaging in activities and one resident met with the inspector to talk about what it was like living in the centre. The resident said that they thought the centre was okay, the staff were nice, but they really wanted to progress their goal to move to a more independent setting. The resident said that they were still progressing with this goal and both the director of operations and the registered provider representative updated the inspector on this goal for the resident. It was evident from talking to everyone that the resident was very near to realising this goal. Since the last inspection the resident informed the inspector about some positive things that had happened, which included more visits home which the resident was very happy about. They had also taken up horse riding, which they were really enjoying. The inspector found from talking to this resident that their goals were progressing and the resident was happy with this. They also informed the inspector about a recent birthday celebration they had in the centre, which they said they enjoyed.

The inspector met another resident in their apartment on the second day of the inspection. They were relaxing on the couch and appeared to be enjoying interacting with staff. Since the last inspection they had gone back swimming which they said they liked. They had also had some murals painted in their back garden which the resident appeared to like. They also talked about going home to visit family.

The third resident was heading out for a drive on the first day of the inspection and was out for most of the day. This was something that the resident liked doing, particularly when the weather was good. The inspector observed the staff interactions with the resident, who communicated using non verbal gestures and some signs. The staff were observed encouraging the resident to use the signs they knew, and the resident gave the thumbs up sign to the inspector. This indicated that they were feeling good. From talking to staff however and reviewing this residents personal plans, the inspector was not assured that the care and support provided to the resident was consistently implemented. This matter will be discussed in more detail under Regulation five: individual assessment and personal plans.

The centre was divided into three self contained apartments and also had a large kitchen and dining room that two of the residents used and, another larger sitting room.

One of the residents only had access to their own self contained apartment. The inspector found that the premises were for the most part clean, well maintained and decorated to a high standard. One of the apartments, (while reasonably clean), presented with a malodour (caused by a resident continually blocking the toilet). This meant that on regular occasions, the maintenance team had to unblock the toilet (as was the case on the first day of this inspection). However, the maintenance team could only access this areas when the resident was not in the apartment. The director of operations informed the inspector that the registered provider was going to address this, by moving the location of the toilet, which should address the maintenance team being able to address the blocked toilet in a more timely manner.

The property is situated on a large site which comprises of parking areas and a large garden. Each apartment also, lead on to a small enclosed garden that each resident could access. It had been observed on previous inspections that the enclosed garden area for one resident was small and the resident was limited in accessing the large garden area.

At the time of this inspection, the registered provider had applied for planning permission to increase the size of the resident's garden area. This project would take approximately 6 months to complete. This would address the size of the garden for the resident going forward. Since the last inspection, the resident had more access to the larger garden area, a new football goal post had been purchased and an overground swimming pool. The staff informed the inspector that the resident had liked the swimming pool at first, but was not using it on a regular basis. The

staff said that this may be because the water was cold and the provider was investigating ways to get equipment to have the water heated.

It had been highlighted on previous inspections, that the suitability of the self contained apartment for this resident was a concern due to its size and the supports the resident required. The inspector was still concerned about the size and layout of the apartment at the time of this inspection as this resident did not like going outside when it was raining, meaning they stayed in their apartment where they were supported by three staff.

In the resident's personal plan, it was recommended that they should have activities that would expel energy. These activities included using a trampoline, a rowing machine and exercise ropes. It had also been recommended to develop indoor activities for the resident on days when it was raining.The inspector asked a staff member to demonstrate what activities the resident engage in when it was raining.The staff member showed the inspector, how they encouraged the resident to run from one wall and then to the window. The staff member also said that they encouraged the resident to play ball inside and do some exercises like squats. They also said that the resident liked watching television some days and would do this with staff.

However, the inspector was not assured from speaking to staff, observing the size of the apartment and looking at the recommendations in the residents plan that the living area in the apartment was suitable in terms of its size and layout as it had limited space to engaging in recommended activities.

Additionally, on the first day of the inspection, it was unclear from speaking to staff and the director of operations, how the resident should be supervised by staff in their apartment when staff were not in the apartment. The apartment was surrounded by an enclosed garden, with high walls and with the provision of one exit gate. Outside and to the side of the exit gate there were two chairs which staff said they used sometimes (when the resident did not want them in their apartment or garden area). When asked how they observed the resident, staff informed the inspector that they looked through the window (which was half covered in patterned window film) to observe the resident. The inspector observed however, that the resident's living area could be seen from here, but not their bedroom area.

The inspector then asked the director of operations to walk them through how the resident was supervised when staff left the apartment and stayed in the enclosed garden area. However, when the inspector and the director of operations stood in this area, it was not possible to see inside the apartment through the windows. The inspector was therefore not assured that the supervision of the resident was adequate during these times.

There was also conflicting information recorded on the resident's risk management plans and what was written in their behavioural support plan and what staff were saying.The inspector sought clarity from the director of operations around this. The director of operations consulted with the behavioural support specialist, who drew

up a clear guide on the second day of the inspection that staff were to implement consistently.

The inspector also observed that a piece of equipment (which resembled a very large bean bag) was required to be used on occasion when the resident engaged in behaviours of concern. This piece of equipment was stored outside in a garden shed and when the inspector observed this storage area, it was not water proof, and when the bean bag was taken out it was wet. This was not suitable for use in its observed state. The director of operations agreed to get the maintenance team to address this, which they did on the second day of the inspection.

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 centre was well resourced to support the needs of the residents. However, at the time of the inspection the inspector found that one resident was not being provided with a consistent service to ensure a safe, quality service to this resident. As a result, improvements were required in risk management, the implementation of the resident's plan, the management of records and the governance and management arrangements in place in the centre.

There were adequate staff numbers in place to support the residents in line with their assessed needs.

The staff had been provided with training which the provider had assessed as being mandatory to support the residents needs in the centre.

There were governance and management arrangements in place in the centre, however, improvements were required.

The storage of records in the centre also required review, this has been an ongoing issue in this centre . The inspector however, was assured from speaking to the registered provider representative, that they were taking steps to address this issue.

In addition, the registered provider had notified the Chief Inspector regarding allegations of misconduct by staff members. The inspector followed up on these and found that the provider had taken actions to address this.

Regulation 15: Staffing

The residents were supported by a team of assistant support workers, shift lead managers and a deputy person in charge who worked 9-5 Monday to Friday. Due to the changes in the management structure, the director of operations also spent one day each week in the centre to ensure effective oversight. Each resident had an assigned number of staff each day and at night to support their assessed needs. This meant there were seven staff on duty during the day and at night five staff were rostered to work.

The inspector looked at a sample of the worked rotas for one week in January 2025, May 2025 and the current weeks roster and found that the staffing levels were maintained in line with the needs of the residents as outlined above. At the time of the inspection, there was 2.5 staff vacancies. The provider had employed consistent relief staff to cover these vacancies.

The registered provider had an induction system in place for new staff starting in the centre which included training, a review of pertinent policies and residents plans. There was also on site mentoring for staff on behaviour support plans in the centre.

Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had been provided with a suite of in service training modules. The training records for all staff were maintained on an electronic database which was provided to the inspector. A review of a copy of this printed database showed that all staff had completed required training and there were dates in place for refresher training to be completed when required.

The training provided included:

- Fire Training
- Safety Intervention
- Manual Handling
- Safeguarding
- Risk Assessment
- Basic First Aid
- Fire Safety Awareness
- Hand Hygiene
- Infection Control
- Food Hygiene
- Protection & Welfare of Vulnerable Adults & Children
- Intimate Care
- Supporting a person with Autism and Aspergers
- Blood Pressure Monitoring

- Personal Protective Equipment
- Safe Administration of Medicines.
- Positive Behaviour Support
- Self-harm.

Some staff were provided with additional training in fire marshall training and first aid responder to support them in their roles.

As well as this, the behaviour support specialist had provide on site mentoring and guidance to staff around the specific behaviour support plans for residents. The clinic nurse had also attended a staff meeting to provide guidance and support around medicine management practices.

Judgment: Compliant

Regulation 21: Records

The inspector found as with previous inspections that the management of records required review in this centre. There were several times over the course of the inspection where documents could not be located in a timely manner, or were not the most up to date records for the resident. For example, on the first day of the inspection the inspector requested the most up to date positive behaviour support plan for a resident. However, after reading this document, the inspector was informed that this was not the most up to date version. As well as this, some daily reports from April 2025 were not easily retrieved as they were waiting to be archived. There were several occasions whereby the inspector had to revert back to the shift lead manager, deputy person in charge and the director of operations for accurate and complete records. The inspector also observed that the staff members in question spent a considerable amount of their time trying to retrieve records for the inspector. This did not provide assurances around effective information governance systems in the centre.

The registered provider representative who spoke with the inspector on the second day of the inspection, informed the inspector that the provider had implemented an organisation wide improvement plan to address this going forward. This had started circa January 2025 and was still ongoing at the time of this inspection. As the provider was addressing this, this was taken into consideration when assigning a regulatory judgement.

In advance of this inspection the registered provider has notified the Office of the Chief Inspector regarding allegations of misconduct by a staff member. The investigation into these allegations by the provided had resulted in disciplinary actions for some staff. At the time of this inspection, some of the investigations were still ongoing and one staff members employment had been terminated. This

provided assurances that the provider has systems in place to address any identified deficits in the centre and address those in a proactive timely manner.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that the service was well resourced and that residents had access to a range of allied health professionals to support their assessed needs. However, at the time of the inspection there were difficulties with providing a consistent service to one of the resident's to ensure they received a safe, quality service. As a result, improvements were required in risk management and the implementation of the resident's personal plan.

Since the last inspection, there had been a number of changes to the governance and management of the centre. The arrangements for the person in charge had changed three times since January 2025. One person in charge had left at short notice, and the provider had to advertise for this position which took some time to fill. In the interim, the registered provider had appointed a named manager to deputise as the person in charge.

The director of operations was also involved in the governance of the centre and attended the centre for a full day each week. At the time of this inspection, the director of operations and the registered provider representative informed the inspector that a new person in charge had been appointed and they were completing their induction to the organisation.The registered provider representative also informed the inspector that the new person in charge would be supported in their role by the current named manger and the director of operations to assure effective oversight during their induction and for the next few months. This provided assurance to the inspector around the governance arrangements particularly in relation to the consistent approach required to support the residents in this centre.

Additionally, the registered provider had provided on site mentoring with staff about one resident's behavioural support plan. The director of operations told the inspector that this had recently informed the need for more regular meetings with staff so as to ensure they understood the importance of consistently implementing the strategies included in this resident's plan. This would also enable staff to raise concerns or discuss strategies that they felt were not working for the resident. The director of operations stated that this review would commence on a weekly basis and would be attended by the behavioural support specialist. This provided assurances to the inspector that some of the improvements in relation to the residents personal plan would be addressed with these regular meetings.

The registered provider had systems in place to review and audit the care being provided in the centre. This included an unannounced quality and safety review of the centre which had been completed in February 2025. Additionally, an annual

report of the service had been completed in April 2025. This was bringing about some changes to the quality of care being provided. For example; it highlighted improvements with medicine management practices some of which related to the storage of unused medicines.The inspector followed up on this and found that this issue had been addressed.

The inspector also followed up on the actions from the last inspection in relation to this regulation and found that the following had been completed. A full review of medicine management practices had been conducted by a clinic nurse and the report was available to the senior managers including the provider representative and the director of operations. This had been completed on 27 August 2024 and recommendations had been drawn up in this report. The clinic nurse had also agreed to attend staff meetings to discuss medicine errors occurring in the centre and this had been completed in September and October 2024. In addition, the behavioural support specialist had developed behavioural strategies, providing on site training to staff on best practices and was involved in the review of the residents personal plan. This had been an action from the last inspection.

Overall the inspector found that the centre was adequately resourced, and was being audited and reviewed as required by the regulations. However, the management of records, risk management procedures and the oversight of the care and support of one resident was not being managed effectively on the day of the inspection.

Judgment: Substantially compliant

Quality and safety

Overall the inspector observed that two of the residents were supported to engage in activities and there were positive improvements observed in their quality of care since the last inspection. However, one resident's care and support needed to be reviewed so as to assure that the service was safe, suitable to meet their assessed needs and that interventions recommended to meet their needs were being consistently implemented.

As stated in section one of this report, the Office of the Chief Inspector had received unsolicited information prior to this inspection in relation to the use of vehicles and their road worthiness. The inspector found no evidence to substantiate this information at the time of this inspection from the records made available on the day of the inspection.

Residents had personal plans to inform the care and support they required. However, the inspector found that for one resident, the interventions outlined in their plans were not always consistently implemented. The inspector was also not

assured that the design and layout of the premises was adequate to meet the assessed needs of this resident.

The registered provider had systems in place to manage risks in the centre. However, the inspector observed over the course of the inspection that improvements were required in the management and review of risks, the implementation of required control measures and the identification of one hazard in the centre.

The registered provider had systems in place to safeguard residents in the centre. Where required, investigations had taken place to address concerns raised.

The inspector also followed up on actions from the last inspection concerning the general welfare of residents in the centre and found they had been addressed.

Regulation 13: General welfare and development

At the last inspection, there had not been enough drivers employed to drive the vehicles available in the centre. At that time, this impacted on the residents' ability to go on outings. The inspector found that this had been addressed and more drivers were now employed in the centre.

The residents were supported to keep in touch with family and friends. The staff supported the residents with this by driving them to and collecting them from their family home. This was very important to two of the residents and meant that they got to see their family on a regular basis.

Two of the residents spoke about new hobbies they had taken up since the last inspection. One had started horse riding which they said they really liked and another had started swimming.

Notwithstanding, and as discussed under Regulation five: individual assessment and personal plan, the inspector was not assured that one resident had adequate access to participate in meaningful activities.

Judgment: Compliant

Regulation 26: Risk management procedures

At the last inspection the provider had outlined that they would conduct a thorough review of each residents personal plan to ensure it aligned with controls and recommendations in their individual risk management plans and their multi-element behaviour support plan.

The inspector found that the individual risk management plans had been updated. However, the inspector was not assured from reading the individual risk management plans and the mutli-element behaviour support plans that the control measures were being implemented in practice at all times. The inspector also found on the first day of the inspection, that the storage of a safety pod for a resident was inappropriate and needed to be addressed in a timely manner.

As outlined in the first section of this report, the inspector observed that the supervision arrangements for one resident in the centre needed to be reviewed. The inspector found from talking to staff, the director of operations and reading the risk management and behaviour support plans for one resident, that it was not clear what this should look like in practice. As an example; the staff were required to observe a resident from a distance through a window. However, when the inspector and the director of operations stood there, the inside of the apartment was not visible.

The inspector also observed on the first day of the inspection that the storage of a safety pod for a resident was not suitable as the area was not waterproofed. When the inspector observed the pod it was wet and had debris from the garden on it. The floor in the storage shed was wet also. This was addressed on the second day of the inspection by maintenance personnel. However, this hazard had not been identified prior to this inspection.

There were systems in place for assessing and managing risk but reviews were not ongoing. For example, a risk assessment in place for one resident was risk rated red, meaning it was considered a very high risk. One control measures stated that staff should remain in an observation shed, however this shed had been removed. Another risk assessment for physical aggression stated that staff should maintain a visual on the resident at all times and re-engage every 15 minutes however, as observed on the first day of the inspection this could not be achieved at all times. Therefore it was not clear how staff implemented some control measures pertaining to some risks at the time of this inspection.

Another risk assessment for property damage indicated that there were high staff supervision levels for the resident. However, this was not always the case as the resident regularly asked staff to leave their apartment where they were not always in the line of vision of staff. The inspector found that the supervision of this resident had not always been maintained in the centre through incidents notified to the Office of the Chief Inspector (as stated under Regulation 21: records).While the registered provider had put systems in place to address this, they were still not clear in some plans and some of the controls did not provide assurances.

As an example; after some incidents the registered provider had implemented a system whereby staff had to fob into the apartment every ten minutes when there were no staff with the resident (for example when the resident was in bed). These records were available on a computer. However, there was no record maintained of the exact times that the resident was left on their own in the apartment to inform when staff were to start completing the fob checks every ten minutes.

The inspector found that the vehicles used to transport residents are regularly serviced, insured, and roadworthy at the time of this inspection. The registered provider had a system in place whereby staff conducted weekly checks of the vehicles. These checks looked at when the vehicle was due for a service and whether there were any faults with the vehicle.

The inspector followed up on a sample of issues recorded on these checklists.The inspector found that where faults were observed with vehicles, advise was sought from the transport department in the organisation to provide guidance on what to do. For example; in March 2025, an issue had been observed with one vehicle whereby there was leak. The inspector observed that staff had emailed the transport department on two occasions requesting an update on the servicing or maintenance of this vehicles which was off the road while awaiting advice from the transport department. The vehicle was then taken to be serviced.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

At the last inspection of this centre, the registered provider had undertaken to include a system for the continued monitoring arrangement of personal plans to ensure they were regularly updated and were reflective of the current needs of the residents. While the inspector found that for the most part these plans were being updated, the interventions in some of these plans was not implemented in practice. In addition, some of the plans like communication plans, had not been updated since the last inspection and some recommendations from allied health professionals was not clearly outlined in the personal plans. The inspector was also not assured from reviewing one resident's plans whether the living accommodation for this resident was suitable to meet all of their assessed needs.This required review.

Personal plans for residents included an assessment of need and a number of plans outlining the care and support provided to the residents. One resident had a detailed positive behaviour support plan in place to guide practice or direct the reader to other recommendations from allied health professionals. However, the inspector found that strategies included in this plan were not consistently implemented. As an example, it was noted in the plan to increase the residents communication supports by teaching new communication signs.

When the inspector asked to see how this was being implemented, there was no clear communication plan in place to guide practice. This meant that the communication supports could not be effectively evaluated to see if they were working for the resident. It also did not provide assurances or guide practice about how this should be implemented each day for the resident.

The positive behaviour support plan also outlined deep pressure sensory input activities with the resident. When the inspector asked to see how this was done, the

staff said that they had a machine to do this but it was now broken. The plan also outlined that a visual schedule should be in place for the resident and the staff members reported that this had not worked as the resident had taken it off the wall. However, in the behaviour support plan the behavioural support specialist had recorded that the visual schedule should be brought into the resident each day, shown to the resident and then removed. The visual schedule should also include two pictures to inform the resident what was happening first and next. The inspector found from talking to staff that this was not being implemented either as the staff said that resident could understand what was being said to them and therefore they did not use the visual schedules.

As stated in the first section of this report, the inspector was not assured that the layout and design of the centre was suitable to meet all of the assessed needs of the resident. For example; the residents plan stated that boredom was a trigger for this residents behaviour and a review of an incident after the resident had climbed the garden fence, stated that the resident was seeking movement based activities. Additionally, a review of multidisciplinary team meetings in March 2025 noted that a possible contributing factor to climbing over walls was boredom.

A report from an occupational therapist in November 2024 had also recommended that the resident required equipment like a trampoline, a rowing machine and a swing to enable the resident to exert energy. However, none of this equipment was in place on the day of the inspection. It had also been noted at a multi-disciplinary meeting in April 2025, that a personal trainer was not available for this resident and it had been recommended that a list of rainy day activities should be completed. However, on review of the resident's daily schedule, it informed a personal trainer was still scheduled some mornings (even though none was available). When the inspector asked staff about this and what they were doing to address this, they told the inspector that they tried to engage the resident in activities like squats, running from one wall to the window in their apartment and or play ball. The inspector was not assured given the size and layout of the apartment that it was adequate.

Overall, the inspector found that recommendations from allied health professionals were not been consistently implemented in this centre. This was impacting on the quality of care for one resident whose assessed needs required consistency, routine, and sensory activities to help them engage in activities that they enjoyed.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The inspector found that since the last inspection, staff had been provided with additional training and mentoring in the behavioural support plans devised for one resident. This behaviour support plan was comprehensive and detailed how the resident should be supported. The behavioural support plan was also reviewed regularly by the behavioural support specialist. However, as actioned and discussed

under Regulation five: individual assessment and personal plans, the strategies and recommendations included in this plan and other plans were not consistently implemented.

The inspector found that since the last inspection, staff had been provided with on site mentoring about one residents behaviour support plan. The director of operations, informed the inspector that, this had recently informed the need for more regular meetings with staff to ensure they understood the importance of consistently implementing the strategies included this residents plan. This would also enable the staff to raise concerns or discuss strategies that they felt were not working for the resident. The director of operations stated that this review would commence on weekly basis and would be attended by the behavioural support specialist.

There was also a specialist trainer employed in the organisation available to provide advice and education around the use of physical restraint.

Judgment: Compliant

Regulation 8: Protection

The inspector found that the registered provider had a no tolerance approach to abuse and took actions to address allegation of abuse. They also notified relevant authorities where required when these incidents occurred. The inspector found that in one incident (which had happened prior to the resident living in the centre) had not been reported in a timely manner, however, at the time of the inspection this issue had been addressed and the relevant authorities had been notified.

All staff had completed training in safeguarding of vulnerable adults and education on safeguarding was also provided to residents. The inspector spoke to one resident who reported that they felt safe in the centre and were able to talk about concerns they had with staff. Staff were also observed interacting with residents in a kind manner and the residents looked comfortable in the company and presence of staff.

The registered provider had also investigated all allegations of abuse and had taken measures where necessary to mitigate the risks to residents. As noted under Regulation 21: records, some incidents had been notified to the Chief Inspector in relation to staff not following care and support guidelines as outlined in the residents' plans. The registered provider had implemented measures to address this, however, at the time of the inspection the inspector was not assured about the oversight arrangements including the supervision of the resident. This issue was actioned under Regulation 26: risk management procedures.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ravens Hill OSV-0008204

Inspection ID: MON-0046583

Date of inspection: 05/06/2025

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The Acting Person in Charge shall ensure that the following actions are taken regarding systems in place to come into compliance with Regulation 21: 1. The Acting Person in Charge (APIC) shall review archiving system in place and ensure all Team Members have knowledge of same and how to access and retrieve readily available information in a timely manner. Due Date: 08 August 2025 2. The APIC, in conjunction with the Centre administrator, will complete a full review of documentation and ensure all are up-to-date versions and relevant information is filed within the assigned folders in the Centre. Due Date: 31 August 2025 3. Following a review completed by Nua's new Directors of Process Improvement, a process has been implemented to streamline internal documentation to improve Operational Efficiency and Process Improvement. A Working group comprising of Senior Management has been set up to review the recommendations and support with implementing these across the service with the aim of reducing the volume of records and paperwork within the Centre. Due Date: 30 September 2025	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider is committed to ensure that management systems in place in the designated Centre are appropriate to ensure that the service provided is safe and appropriate to the Individuals' needs. This will be consistently and effectively monitored in the following ways: 1. When actions identified are completed pertaining to the judgement of Regulation 21 (Records), Regulation 26 (Risk Management Procedures) and Regulation 5 (Individualized Assessment and Personal Plan) as outlined within this compliance plan, this will support that the service provided is safe, appropriate to Individuals' needs, consistent and effectively monitored by the management arrangements in place. Due Date: 30 September 2025 2. The actions specific to Regulation 21 (Records), Regulation 26 (Risk Management Procedures) and Regulation 5 (Individualized Assessment and Personal Plan) will be reviewed by a member of Nua's Quality Assurance Team to ensure that they are effectively monitored. Due Date: 30 September 2025 3. Following a review completed by Nua's new Directors of Process Improvement, a process has been implemented to streamline internal documentation to improve Operational Efficiency and Process Improvement. A Working group comprising of Senior Management has been set up to review the recommendations and support with implementing these throughout the Centre with the aim of reducing the volume of records and paperwork. Due Date: 30 September 2025	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: 1. The Acting Person in Charge (APIC) and the Director of Operations (DOO) shall conduct a review of the Centre's Individual Risk Management Plans (IRMP's) to ensure all risks pertaining to the Individuals are clearly captured with appropriate control measures recorded. Due Date: 31 July 2025 2. Key risks for the Individuals will be compiled in a summary document. Risks will be	

rated and controls will be reviewed to ensure that all appropriate controls are in place. The summary risk document shall be reviewed on a weekly basis by the Acting PIC to ensure that it is fully up to date and reflective of the needs of each Individual.
Due Date: 08 August 2025

3. The Behavior Specialist shall oversee a review of Positive Behavior Support (PBS) Plans in conjunction with the APIC to ensure that plans contain relevant information and guidance for Team Members in line with the assessed needs of the Individuals.

Due Date: 15 August 2025

4. All Team Members will be provided an opportunity to read and review the updated IRMP's and PBS Plans. These will be further discussed at the Monthly Team meeting and following this a Test of Knowledge (TOK) will be completed by all Team Members. If there are any gaps noted with Team Members' knowledge for the above plans an action plan will be implemented with the relevant Team Members.

Due Date: 31 August 2025

5. The APIC, in conjunction with the Behavioral Specialist, will ensure monitoring forms are implemented to record when Team Members enter and exit the Individual's apartment.
Due Date: 31 July 2025

6. The APIC will ensure the storage of equipment is reviewed daily as per the daily safety walk conducted by the Centre management.
Due Date: 31 July 2025

7. The APIC and the Centre Management will attend Risk Management Training.

Due Date: 31 August 2025

8. A full environmental review will be undertaken by the MDT of the Individual's environment. The MDT will comprise of the Acting PIC, the Director of Operations (DOO), The Senior Director of Operations (SDOO), Psychiatrist, Behavioral Specialist, Maintenance Manager, Occupational Therapist and Keyworker. Following this review any identified actions will be communicated to all relevant stakeholders at Nua's Admission, Discharge and Transition meeting (AT&D).

Due Date: 19 September 2025

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. The Acting Person in Charge (PIC) shall conduct a review of each Personal Plan to ensure alignment and triangulation with other supporting documents such as Multi Element Behavior Support Plans and Individual Risk Management Plans.

Due Date: 31 August 2025

2. The Acting PIC and Centre management will review the daily/weekly planners to ensure there is adequate in-house activities to support with the Individual's engagement in line with their assessed needs.

Due Date: 02 August 2025

3. The Acting PIC will ensure communication strategies to support Individuals in line with their assessed needs are implemented consistently.

Due Date: 31 August 2025

4. The Acting PIC will complete a full review of plans in the Centre and ensure they are updated to reflect recommendations from allied professionals.

Due Date: 06 August 2025

5. The Acting PIC will enroll Team Members on 'Total Communication Approach' refresher training.

Due Date: 31 August 2025

6. Outdoor Equipment which has been recommended by the MDT such as a Swing, Trampoline and Rower will be implemented in the environment. In addition, a review of the external environment will be complete to see if a awning can be implemented in the external environment during periods of rainy conditions to allow the Individual to access areas of the garden if they wish to do so to minimize impact of the poor weather conditions.

Due Date: 31 August 2025

7. A Full environmental review will be undertaken by the MDT of the Individual's environment. The MDT will comprise of the Acting PIC, the Director of Operations (DOO), The Senior Director of Operations (SDOO), Psychiatrist, Behavioral Specialist, Maintenance Manager, Occupational Therapist and Keyworker. Following this review any identified actions will be communicated to all relevant stakeholders at Nua's Admission, Discharge and Transition meeting (AT&D).

Due Date: 19 September 2025

8. All of the above actions will be reviewed by a member of Nua's Quality Assurance (QA)

team.
Due Date: 30 September 2025

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	30/09/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/09/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Not Compliant	Orange	30/09/2025

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/09/2025
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/09/2025
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/09/2025
Regulation 05(8)	The person in charge shall ensure that the personal plan is	Substantially Compliant	Yellow	30/09/2025

	amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).			