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:	The Fairways
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Offaly
Type of inspection:	Unannounced
Date of inspection:	05 May 2022
Centre ID:	OSV-0003389
Fieldwork ID:	MON-0036798

About the designated centre

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

The Fairways is a designated centre operated by Nua Helathcare Services Limited. The centre can provide residential care for the needs of up to eight male and female residents, who are over the age of 18 years and who have an intellectual disability. This centre can also cater for the needs with residents who have mental health needs and specific behavioural support needs. The centre is located a short distance from a town in Co. Offaly where each resident has their own en-suite bedroom and access to communal facilities to include kitchen and dining areas, sitting rooms, shared bathrooms, a sensory room, utility and staff offices. There is also an apartment within this centre, which can be occupied by one resident. A large enclosed garden surrounds this centre and is accessible to residents. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Thursday 5 May 2022	09:30hrs to 18:30hrs	Anne Marie Byrne	Lead
Thursday 5 May 2022	09:30hrs to 18:30hrs	Aonghus Hourihane	Support
Thursday 5 May 2022	09:30hrs to 18:30hrs	Ivan Cormican	Support

What residents told us and what inspectors observed

As part of this inspection, the inspectors met with five residents, staff members, team leaders and with the director of operations. At the time of this inspection, the person in charge was absent from the centre. In their absence, the provider had made interim management arrangements and the director of operations informed inspectors that further arrangements were in the process of being made, to appoint a new person in charge to manage the centre, during this absence period.

This was a centre that catered for residents with high support needs, who required specific staff support and care arrangements to ensure that their assessed needs were met. There were seven residents living in this centre at the time of this inspection and due to the complex behaviour support and safeguarding needs that some of them had, they required multiple safeguarding plans and recommended behaviour support interventions to keep them and those they lived with safe. Since this centre's last inspection in December 2021, inspectors found an overall decline in the quality and safety of care that that these residents received.

Upon the inspectors' arrival, they were greeted by members of staff and there was a casual atmosphere in the centre, with staff supporting residents with their morning routines. Each resident had a daily planner which guided staff on what activities were scheduled for residents for the day. Some residents were up and about, while others were having a lie on in bed. In recent months, some residents had returned to day services and were getting ready to head out to their service. Other residents engaged in community based courses, where they enjoyed taking part in various art and craft work. There was one resident who chose to spend much of their recreational time in the centre and inspectors observed staff to engage pleasantly with this resident and encourage them to go for a short drive that afternoon.

Some residents spoke in general with the inspectors about the care and support that they receive. One resident, told inspectors that they were happy living in this centre, spoke about various outings that they had been on and about the activities and interests that staff supported them to pursue. However, there were peer to peer related incidents occurring in this centre, which resulted in a resident feeling unsafe. While inspectors were in conversation with this resident, they spoke of how they were recently involved in a significant incident with another resident whom they lived with, resulting in them requiring medical attention. They told the inspectors that since this incident, they did not feel safe in their home and were afraid that a similar incident would happen to them. This is discussed in further detail later on in this report.

While inspectors observed that improvements were made to staffing resources, there continued to be significant non-compliance to governance and management, safeguarding, and to some aspects of staffing. This inspection also raised further concerns with regards to positive behaviour support and risk management.

This will now be discussed in the next two sections of this report.

Capacity and capability

This was an unannounced risk inspection to assess the provider's overall compliance with the regulations and was facilitated by team leaders and the director of operations. This centre was previously inspected in December 2021, which identified that significant improvements were required to governance and management, safeguarding and staffing. Since then, the provider had notified the Chief Inspector of Social Services of a number of significant incidents which had occurred in this centre. Furthermore, since the last inspection, individuals had also contacted the Chief Inspector regarding concerns they had in relation to the safety and welfare of residents who avail of this service.

Although inspectors found the provider had improved the number of staff available to work in the centre, deficits to staffing arrangements were again found on this inspection. Similar to the last inspection, failings were found to this centre's safeguarding arrangements and this inspection identified additional issues of concern, with respect to positive behavioural support and risk management. Continued failings were identified in the oversight and management of these integral aspects of the service provided to residents, and had a negative impact on the overall quality and safety of care in this centre, resulting in poor outcomes for some residents who lived there.

Considerable improvement was still required to the oversight and monitoring of this centre, particularly where significant incidents had occurred in regards to safeguarding, behavioural support and in relation to residents' safety and welfare. Some of these incidents had resulted in residents sustaining injury, some residents were upset at how incidents were handled and some incidents had also left one particular resident feeling unsafe in their own home. Even though the provider was fulfilling internal processes by gathering much information surrounding these incidents, on an almost weekly basis, to inform governance reports that were subsequently reviewed at senior management meetings, this was not resulting in this information being effectively used to better resident care in this centre. The seven residents that lived in this centre, presented with complex support needs and the provider was failing to recognise the risks and impact to them from the information that was being gathered .The provider was also failing to implement its own oversight systems, which were readily available to them, in response to the incidents occurring, so as to provide these residents with a safer and better quality of service.

Multiple behavioural related incidents were occurring in this centre, some of which had a significant negative impact on residents, and there was an overall failure on the part of the provider, to effectively oversee, review and manage these incidents

to improve the quality and safety of care in this centre. For instance, while staff had good knowledge of residents' needs, the provider was aware of incidents which had occurred, where staff had not appropriately implemented recommended behavioural support interventions, resulting in negative outcomes for some residents, with some even sustaining injury. Despite this information being readily available to the provider, and frequent monitoring occurring as part of regular senior management reviews, there was a lack of urgency on the part of the provider, to thoroughly review these incidents, to determine how they had happened, identify specific failings and inform learning in the centre to reduce the likelihood of similar incidents re-occurring. Inspectors observed an example of this, whereby, a month prior to this inspection, an incident occurred which resulted in a resident being subjected to physical restraint, following the failure of staff to implement behaviour support interventions, in line with the resident's behaviour support plan, which left the resident in an upset state. Even though this incident had occurred one month prior to this inspection, the provider had not yet conducted a review to establish how such an incident of this nature had occurred, to ensure no other resident would be negatively impacted, resulting from staff failing to implement recommended behavioural support interventions.

Where residents were negatively impacted from their involvement in safeguarding incidents, the provider had also failed to ensure that appropriate arrangements were put in place, driven by the information available to them, to ensure these residents felt safe in their home. For one resident, who was recently involved in a peer to peer incident, resulting in them requiring medical attention, they told inspectors that they didn't feel safe to freely access all areas of the centre, as they were afraid that they would come into further contact with this particular resident. Although the provider had information available to them around this incident and were reviewing safeguarding arrangements as part of regular governance reviews, this had not led in the use of this information to provide better safeguarding arrangements for this resident, resulting in this resident continuing to feel unsafe in their own home.

There were further failings identified where the provider had not adequately notified the Chief Inspector of an incident, in accordance with the requirements of the regulations. At the time of this inspection, there was an investigation in progress into an allegation of staff misconduct, which was not clearly notified, in writing, to the Chief Inspector.

Since the last inspection, the provider had improved this centre' staffing resources, by ensuring more staff were available to work in this centre. The last inspection of this centre identified deficits in the assessment of residents' needs to ensure staffing levels were appropriate, and this inspection identified similar findings. Following the last inspection, the person in charge in conjunction with the director of operations, revised residents' assessment of need with regards to their staff support, whereby, some residents were re-assessed as requiring a reduced level of staff support. The records of these re-assessments didn't evidence multi-disciplinary support in this decision and the director of operations confirmed with inspectors that multi-disciplinary input was not sought as part of this re-assessment process.

The continued failings with regards to this centre's staffing, oversight and

monitoring arrangements significantly impacted the provider's ability to provide these seven residents with the type of service that they required. Despite the almost weekly gathering of information that was being completed for trending and escalation purposes, along with frequent senior management meetings occurring to review this information, multiple incidents which were having a negative impact on residents continued to occur, which was not conducive to a good quality of life for these residents.

Regulation 15: Staffing

These residents had complex needs in the areas of behavioural support and safeguarding and any decision to make changes to their staff support, without formal multi-disciplinary review, had the potential to significantly compromise their safety and the safety of those they lived with. Although the provider had reviewed residents' assessment of need since the last inspection, where decisions were made to reduce the level of staff support that some residents received, this was not supported by multi-disciplinary input. For example, for some residents, who were previously receiving a higher level of staff support, their re-assessment of need identified that they no longer required this level of staff support. However, the provider had failed to ensure the involvement of relevant multi-disciplinary professionals, who were involved in their previous assessment of need, were involved in this re-assessment process that resulted in the decision to reduce these residents' level of staff support.

Inspectors did observe where improvement was required to the overall maintenance of this centre's rosters, so as to clearly demonstrate the skill-mix and number of staff on duty each day. For example, while rosters were available, inspectors observed various occasions where the roster had not been updated, impacting the provider's ability to demonstrate the exact number of staff on duty for these said dates.

Judgment: Not compliant

Regulation 23: Governance and management

As part of internal governance systems, inspectors observed that the provider was gathering information in relation to incidents occurring in this centre to inform weekly governance reports, which were regularly discussed and reviewed at senior management reviews. However, this monitoring and oversight system was not resulting in this information being used to make the centre safer for residents. For example, even though weekly governance reports demonstrated an increase in incidents occurring for a resident, who had an identified risk to their safety by leaving the centre without staff support, the weekly oversight of these incidents by

senior management, had not resulted in an appropriate response to the increased level of risk posed to this resident's safety, that this information was indicating.

Furthermore, there was a lack of urgency on the part of the provider to effectively review, where significant incidents of a behavioural related nature had occurred, that placed residents at risk. For instance, where physical restraint was not applied in accordance with residents' recommended behavioural support interventions, at the time of this inspection, this incident had not been reviewed by the provider to establish any specific staff failings that led to this occurring.

Although safeguarding arrangements were in place, the provider had failed to ensure the effectiveness of these in ensuring residents felt safe. For one resident, who was previously involved in a safeguarding incident with a fellow resident, they told inspectors that they continued to feel unsafe. Although regular internal governance systems included a review of safeguarding incidents, the oversight of the centre's safeguarding arrangements didn't ensure all residents felt safe in their home.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider had failed to notify the Chief Inspector of Social Services of all incidents, as required by the regulations. For example, the provider had failed to clearly notify the Chief Inspector, in writing, of an allegation of staff misconduct which was currently in progress at the time of this inspection.

Judgment: Substantially compliant

Quality and safety

Since the last inspection, inspectors found continued deficits in safeguarding arrangements which didn't ensure residents were maintained safe from harm. Inspectors also found a decline in behaviour support arrangements, where residents who required specific behavioural interventions, were not always receiving this in accordance with their recommended behaviour support plan. Similar failings to the last inspection were also found with regards to the inappropriate application of physical restraint, which didn't ensure that the required improvements were made to demonstrate that the least form of restraint was at all times used. Furthermore, multiple incidents were occurring in relation to absences from this centre for a particular resident, and the provider was failing to recognise the increased risk

posed to the resident and effectively respond, assess and monitor for re-occurrence.

An inspector reviewed a sample of residents' personal plans and found that residents that lived in this centre had high support needs in terms of behavioural support. Each resident had a form of behavioural support guidance in place, with a number of residents requiring individualised multi-element behavioural interventions to support them, which were developed in conjunction with a behavioural support specialist. These specific plans described how some residents could engage in self injurious behaviour, property damage and verbal and physical aggression towards both fellow residents and staff. These plans outlined how staff should support residents to maintain a baseline of behaviour and also how to respond, should a resident's behaviour escalate and present as a risk to either themselves, a fellow resident or to a staff member. For example, staff were to implement clearly outlined responses including diversion, specific verbal responses and also the use of physical restrictive practices, should the resident's behaviour escalate to a point where they could harm themselves or others.

On the previous inspection of this centre, the provider failed to demonstrate that the use of physical restrictive practices were the least restrictive option implemented at all times. On this inspection, inspectors found that the oversight of behavioural support and the use of physical restrictive practices in this centre had deteriorated. Inspectors reviewed incident reports, residents' safeguarding plans and spoke with residents and staff and a number of situations were identified where the specified guidance for staff had not been implemented and had resulted in increased distress for a resident. For example, inspectors reviewed records of behavioural incidents which had occurred prior to this inspection, and found that two significant incidents of this nature had occurred. In one of these incidents, a resident gave an account of how they had an interaction with staff which resulted in them requiring medical treatment. Records also outlined how this resident was restrained by staff following the incident and that a staff member had been advised to remove themselves from the situation, as they appeared to be acting in a manner which exacerbated this resident's behaviour. The inspector met with this resident and they described how upset they were that this had occurred and that they were awaiting further medical review for the injury that they had sustained.

The inspector reviewed another incident involving the same resident, in which physical interventions were implemented and found that further significant improvements were required. The recorded incident described how the resident's behaviour was escalating and that they had acquired some cigarettes. The resident then began lighting cigarettes and letting ashes fall on an item of furniture. There were three staff members present who advised the resident as to the danger of smoking in the centre and to stop this behaviour. The resident's behaviour then escalated to verbal aggression and a staff member discharged a fire extinguisher on a lit cigarette. At this point the resident became physically aggressive, which resulted in them being physically restrained. The inspector found that although there was some risk from the lit cigarette, the presence of three staff members mitigated against this risk and that the use of the fire extinguisher on one cigarette was excessive and not in the best interests of this resident. Furthermore, despite behaviour support plans being in place to guide staff on how to respond to this

resident's behaviour, there was an overall failure to implement recommended behavioural support interventions that this resident was assessed as responding well to. Although, staff took time with the resident subsequent to the incident to see how they were, notes from this interaction stated that this resident began to cry when talking to staff, which was a clear indication of the negative impact that this event had on them.

Inspectors found that robust safeguarding of residents was required to keep residents safe from harm in this centre. Although, the provider had safeguarding procedures in place and staff had a good understanding of these procedures, safeguarding concerns continued to occur. Eight safeguarding plans were required to keep residents safe and although these plans were regularly reviewed and updated, they did not clearly outline the staffing arrangements to keep these residents safe. Although, two residents who met with the inspector said that they felt safe from peer-to-peer incidents, one resident stated that they did not feel safe. They spoke about a number of negative verbal and physical interactions that they have had with a peer and although there was a relevant active safeguarding plan in place, this resident remained fearful of all interactions with their fellow resident which indicated that the safeguarding procedures for this resident did not fully support their safety and welfare. Safeguarding was discussed with a senior manager on the day of inspection and they indicated that multidisciplinary team meetings had occurred with regard to one resident. The manager stated that the provider was considering discharging this resident from the centre; however, there was no discharge date for this resident and the provider failed to demonstrate that this action would resolve all safeguarding issues in this centre.

The risk management policy within the centre was reviewed and due to two specific notifications received by the chief inspector in relation to the unexpected absence of a resident the risk management assessment for this resident was reviewed. The risk assessment for the unexpected absences for this resident had been updated on the 28th of April 2022. The risk assessment referenced two incidents and the risk rating was downgraded from orange to yellow. Upon a review of the incidents log for March and April 2022 there was a total of eight occasions when the resident was absent from the centre. The resident had assaulted a staff member and also had a near miss with a car on one occasion while absent from the centre.

The provider didn't identify all occasions when the resident was absent without agreement in the risk assessment and as such couldn't guarantee that the control measures and actions were proportionate to the risk identified.

Regulation 26: Risk management procedures

The provider had a risk management policy in place as stipulated by regulation. The provider's own risk assessment in relation to the unexpected absence of one resident was not in line with the regulations and the provider's standard operating procedure was not always complied with. The risk assessment only considered two

occasions when the resident left the centre without agreement, occasions when they were not within sight of staff. There were six further incidents noted on the residents file when they were absent from the centre and on one of these occasions the resident had a near miss with a car on a busy road. The provider's own standard operating procedure for the resident absent states that the Gardaí are to be called after 15 minutes- on one occasion the Gardaí were not called for one hour.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents who used this service required a high level of behavioural interventions to keep them and others safe from harm and to assist residents to have a good quality of life. The implementation of behavioural support in this centre required significant improvement to ensure that the least restrictive option, in terms of physical interventions, were implemented at all times. Inspectors reviewed behavioural support plans which set out how staff should respond to certain behaviours of concern. The inspector reviewed incident logs and saw that staff were failing to consistently implement these plans, and in one example, inspectors read about how a resident received an injury because staff did not implement this guidance as stated.

Judgment: Not compliant

Regulation 8: Protection

The oversight and response to safeguarding incidents underpinned the quality of care which residents received and there were eight safeguarding plans required to keep residents safe in this centre. Although these plans were regularly reviewed by the provider, they did not clearly outline the staffing requirements to keep people safe from harm. Furthermore, a resident reported that they lived in fear of another resident and the provider's failure to resolve multiple safeguarding concerns for this resident deeply impacted upon their safety and quality of life.

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 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for The Fairways OSV-0003389

Inspection ID: MON-0036798

Date of inspection: 05/05/2022

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 line with Regulation 15(1) & 15(4), the Registered Provider will ensure that the number of staff, their qualifications and the skill mix in the Centre is appropriate to the number and assessed needs of the Service Users, the Centre's statement of purpose and the size and layout of the Designated Centre. Furthermore, the Registered Provide will ensure that there is a 'planned' and 'actual' staff roster in the Centre showing the staff on duty during the day and night, and that it is properly maintained by completing the actions, as outlined below.

It is our intention to update our Comprehensive Needs Assessment (CNA) template to include:

a) A question for the Person in Charge (PIC) in relation to the need (or not as the case may be), for multidisciplinary team (MDT) inputs at the time of assessment and review of assessment.
b) Should MDT inputs be required, the CNA will include an associated confirmation sign-off from their discipline's perspective on the assessment and / or review of assessment. (Due Date: 17 June 2022)

The aforementioned action regarding the update of the CNA will be communicated to all Centre/Service Managers and MDT members to ensure their knowledge of / and future implementation of the updated CNA format. (Due Date: 25 June 2022)

There will also be a team debrief to include continual attention to any new staff entering the service on the CNA, to include:

a) The updates to the template format
b) The potential need for / verification from MDT members of agreement / review of

assessment and:
c) The associated supports for safety and developmental needs of individual Service Users. (Due Date: 31 August 2022).

The 0.5 PIC in the centre has been increased to 1 WTE. In addition, there is a Team Leader (TL) that is supernumerary to the Centre. This staff has been assigned specific responsibility for managing the staff roster and reports directly into the PIC. Furthermore, the Centre's administration has been instructed to do a further periodic temperature check to ensure centre-level compliance, and where inconsistencies become evident, to escalate immediately to the Centre PIC and Director of Operations (DOO) for address. This approach to be reviewed one month post implementation. (Due Date: 31 July 2022).

The following additional actions have also been agreed:

1. The PIC, in consultation with the Service User's MDT members, will complete a full review of the Service User's CNA. Following this review, the PIC will ensure that staffing levels within the Centre are in line with the Service User's assessed needs (Due Date: 24 June 2022).

2. The PIC, in conjunction with the DOO, will conduct a full review of the Centre's recruitment plan to ensure that staffing requirements are in line with the assessed needs of the Service Users and the Centre's Statement of Purpose. (Due Date: 08 July 2022).

Note: (6) Six full-time equivalents have been identified as part of the PIC's recruitment & selection process and are being inducted on the following dates:

- (1) One FTE induction due date: 13 June 2022
- (4) Three FTE induction due date: 20 June 2022
- (1) One FTE induction due date: 27 June 2022

Note: We have also had (2) additional FTE inducted for the Centre on the 30 May 2022 and the 1 June 2022. (Completed).

3. A planned meeting is scheduled with the Recruitment Manager and the DOO on a bi-weekly basis to address full-time lines within the Centre and to oversee the new hire pipeline. (Due Date: 31 July 2022).

4. The Statement of Purpose will be reviewed and updated by the PIC to ensure that staffing levels are aligned with the number of Service Users residing in the Designated Centre at that time. It will also reference the maximum Service User occupancy level and associated staffing levels, at full occupancy. (Due Date: 24 June 2022).

Note: ID326 was discharged from The Fairways on 01 June 2022, in line with the Centre's Policy on Admissions, Transitions and Discharges (PL-ADT-001), Regulation 25(4) and in consultation with the Service User and relevant stakeholders.

5. The updated Statement of Purpose, referred to above, will be submitted to the Authority reflecting the changes made to the number of staff employed as well as the

PIC in the Centre increasing to 1 WTE. (Due Date: 24 June 2022).

6. Following the review of Service Users assessed needs and the Centre's recruitment plan, the PIC, in conjunction with the DOO, will ensure staffing levels are sufficient to meet the needs and safety of the Service Users. This will be reflected in the Centre's Risk Register, Staffing Contingency Plans and associated Standard Operating Procedures. (Due Date: 01 July 2022).

Note: Where minimum staffing levels are required to reduce footfall in the Centre to meet the services Infection Prevention and Control needs, in conjunction with Nua Healthcare's Covid-19 Risk Assessments, staffing levels will be reviewed by the PIC, in conjunction with the DOO and MDT to ensure staffing levels are sufficient to meet the needs and safety of the Service Users.

7. The DOO has increased allocated time in The Fairways to support the PIC and to oversee the implementation of required improvements. (Completed).

8. The PIC and their Management team will continue to provide on-the-floor management and supervision to staff on a daily basis, providing support and feedback, as required. (Due Date: 31 July 2022).

9. All of the above actions will be discussed with the staff team at monthly team meetings held in June, July, and August by the PIC. (Due Date: 31 August 2022).

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 Centre is line with Regulation 23(1)(c), the Registered Provider will ensure that management systems are in place in the Designated Centre to ensure that the service provided is safe, appropriate to Service Users' needs, consistent and effectively monitored, as outlined below.

We will review our Policies and Procedures in relation to Governance, Leadership and Management, specifically focusing on opportunities to identify circumstances requiring more immediate attention. To that end, we conducted a review of the compatibility of the remaining (6) six Service Users in the Centre, to ensure that the mix of Service Users and their environment was appropriate for their medium to long-term care within the Centre.

The following actions were identified:

1. It was concluded, prior to the May 5th inspection, that the environment was not

suitable for (1) one Service User and they were identified for a safe transition and discharge from The Fairways, as discussed on the day of inspection. Alternative accommodation was identified for ID326, who was discharged from The Fairways on 01 June 2022, in line with the Centre's Policy on Admissions, Transitions and Discharges (PL-ADT-001), Regulation 25(4), and in consultation with the Service User and relevant stakeholders. (Completed).

2. ID292 has also been identified as suitable for transition from The Fairways to a lower support Centre, as per Nua's internal care pathways. ID292 will be transitioned from the Centre in line with the Centre's Policy on Admissions, Transitions and Discharges (PL-ADT-001), Regulation 25(4), and in consultation with the Service User and relevant stakeholders by 31 July 2022 or sooner, if possible. (Due Date: 31 July 2022 or sooner, if possible).

3. ID158 will remain in The Fairways but will be transitioned to a standalone apartment within the Centre following the discharge of ID292. (Due Date: 22 August 2022 or sooner, if possible).

4. A review of the Centre's floor plans will be conducted to identify if improvements can be made to the environment to support the Service Users residing in the Centre.

Note: If changes to the floor plans are identified, we will notify the Authority through a vary of condition(s) application for approval. (Due Date: 31 August 2022 or sooner, if possible).

5. Whilst the above actions are being completed, we also endeavor to mitigate the instances of peer-to-peer abuse by taking the following actions:

a) The PIC will review all incidents and accidents to ensure that all actions have been carried out.
b) The staff team will attend refresher safeguarding training
c) Safeguarding meetings within the Centre will increase to bi-weekly for the next 3 months and the frequency of same will be reviewed thereafter. (Due Date: 31 August 2022 or sooner, if possible).

The Register Provider is dedicated to strengthening the management systems in place to ensure that the service provided is safe, appropriate to the Service Users' needs, consistent, and effectively monitored.

Actions in place to achieve this are as follows:

1. The Team Leader (TL) is supernumerary to the Centre. This staff has been assigned specific responsibility for managing the staff roster and directly reports into the PIC with a specific focus on ensuring that there is sufficient and appropriate staff in place to meet the needs of the Service Users. (Due Date: 17 June 2022).

2. A review of the weekly governance reporting matrix has been completed to further enhance reporting practices. As a quality improvement measure to Nua's weekly governance meeting, the following KPI's will be implemented and overseen by Nua's

Quality Assurance (QA) Department:

- Quarterly Notification -Trends
- Non-Reportable Incident – Trends
- Provider Assurance Reports – Trends
- Breakdown of substantially compliant judgements -Trends

(Due Date: 30 June 2022).

3. A QA Officer has been assigned to the Centre on a weekly basis to review the implementation of the HIQA Action Plan. (Due Date: 31 August 2022).

4. Increased management support is available within the Centre through the additional presence of the DOO. The DOO, the PIC and TL will act in a supernumerary capacity during this time. (Review Date: 31 July 2022).

5. To strengthen the accountability for work practices carried out in the Centre, the roles and responsibilities of each team member will be reviewed to ensure that there is absolute clarity in relation to the expectations and responsibilities of their roles. This will include the following:

(a) Specific responsibility on the PIC for the oversight and action of incident reports, complaints, verbal feedback from Service Users, and oversight of the actions of all staff in the Centre, including:
I. Allocation of responsibility to the Behavioural Specialist regarding direct support to the Service Users and ensuring that their Personal Plans reflect same.
II. Specific responsibility on the TL for completion of the rosters, allocation of staff and overseeing staff and Service Users daily.
(b) The DOO providing support to the PIC to oversee all elements of the Centre, and to ensure that the PIC has all required information relating to the ongoing process of transitioning the identified Service Users.
(c) Support Workers to follow the roles and responsibilities as outlined within their Key Task Lists.
(Due Date: 30 June 2022).

6. All of the above actions will be discussed with the staff team at monthly team meetings held in June, July, and August by the PIC. (Due Date: 31 August 2022).

To underpin all of these actions and consistent with Nua Healthcare Services' best practice, Management functions have been debriefed on the need to apply a 'Plan, Do, Check, Act' approach towards monitoring corrective action effectiveness.

In any instance whereby a plan appears not effective, Centre Management must act upon same by informing their DOO of the non-effective aspect of the plan, along with the further corrective actions taken or proposed to be taken. Should the DOO not be capable of supporting the local management team, they must immediately escalate the matter to the Area COO for all necessary supports.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
To demonstrate that the Centre is line with Regulation 31(1)(g), the Person in Charge will ensure to give the Chief Inspector of Social Services, notice in writing within 3 working days of the following adverse incidents occurring in the Designated Centre, defined as: "any allegation of misconduct by the Registered Provider or by staff by the following actions".

1. Where there is an allegation of abuse of a Service User by a member of staff, we will continue to notify the Authority using the NF06 form. Where there is an allegation of other misconduct by a member of staff, we will continue to notify the Authority using the NF07 form. (Due Date: 17 June 2022).

2. The PIC will continue to ensure that a regulatory notification is submitted to the Authority within 3 working days of the occurrence of any incident set out in Regulation 31(1) (a) to (h) (Due Date: 17 June 2022).

3. All of the above actions will be discussed with the staff team at monthly team meetings held in June, July, and August by the PIC. (Due Date: 31 August 2022).

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
To demonstrate that the Centre is line with Regulation 26, Nua's current Policy on Admissions, Transitions and Discharges (PL-ADT-001), sets out the requirement for an Initial Needs Assessment (INA), a Comprehensive Needs Assessment, an Impact Assessment, a Risk Assessment, and the development of Standard Operating Procedures, prior to admitting any new Service User to our Centres. Our day-to-day operational work practices require that all staff remain vigilant in terms of assessing the changing needs of each Service User, and in particular, managing the ongoing review of risk.

The 0.5 PIC in the Centre has been increased to 1 WTE. In addition, there is a Team Leader (TL) that is supernumerary to the centre. This staff has been assigned specific responsibility for overseeing the quality of incident recording and updating risk registers and the effective debriefing of team members and reports directly into the PIC. Furthermore, the Centre's administration has been instructed to do a further periodic temperature check to ensure centre-level compliance, and where inconsistencies become

evident, to escalate immediately to the Centre PIC and DOO for address. This approach will be reviewed one month post implementation.

Following a review of the findings raised by the Inspector, we believe that we can make improvements to the Centre's risk management systems and ways of working, as follows:

1. Provide further training and development to the PIC and staff team in risk assessment and the management and ongoing review of risk. (Due date: 30 June 2022).

2. The PIC to undertake a review of all incidents in the last six months to ensure that all corrective actions have been identified, recorded, and followed up on. (Due date: 30 June 2022).

3. The PIC to undertake a review of the Risk Register to ensure that all the risks have been identified and that all actions have been taken to mitigate identified risks. (Due date: 30 June 2022).

4. Assign a Behavioural Specialist to assist the PIC with the specific task of reviewing Incidents and the Risk Register. (Due date: 30 June 2022).

5. Review the Centre's procedures associated with managing escalating risk, including the emergency plans in place to mitigate such risk to acceptable levels. (Due date: 30 June 2022).

6. Assign refresher training in Risk Management to Centre's staff team, along with an associated test of knowledge. (Due date: 30 June 2022).

7. Ensure the Behavioural Team produce trend analyses on a weekly basis and that it is included in the Clinical Department's reports to the PIC, the DOO and the COO. The trend analyses reports must be accompanied by commentary regarding the action taken to mitigate risk or recommendations and / or requests for support to mitigate same. (Due date: 31 August 2022).

8. Personal Plans to be reviewed in their entirety, to ensure that the information is accurate and supportive to the staff team. This includes the identification of key risks for each Service User, the level of risk identified, and the management of the risks. (Due date: 31 July 2022).

9. Staff team meetings will include a review of Personal Plans for each Service User to ensure that staff are familiar with each of their assessed needs. (Due date: 31 August 2022).

10. Key risks for the Service User and staff will be compiled in a summary document, this will include person-centred risks such as vulnerability of a Service User and the risks associated. 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 PIC to ensure that it is fully up to date and reflective of the needs of each Service User and staff. (Due date: 30 June 2022).

11. The summary risk document will be communicated to all staff on a weekly basis and displayed prominently in the staff area. (Due date: 31 August 2022).

12. All Service Users will be reviewed by the MDT, and an ongoing basis, to ensure that their clinical and behavioural needs are assessed and met. (Due date: 31 August 2022).

13. All of the above actions will be discussed with the staff team at monthly team meetings held in June, July, and August by the PIC. (Due Date: 31 August 2022).

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
To demonstrate that the Centre is line with Regulation 7, the Person in Charge will ensure that the following actions are taken:

A review of the application of performance management procedures for each staff team member will be conducted, and from this review, and as appropriate, personal performance improvement plans will be developed for individual staff members to assist them in better applying themselves to the application of training and procedures.

For completeness and for the avoidance of any doubt as to the effectiveness of services, the following additional actions will also be taken:

1. A Behavioural Specialist will be assigned to the Centre on a weekly basis to review the support provided to the Service Users by the staff, and to support the staff team in meeting the Service Users behavioural needs. (Review Date: 31 July 2022).

2. The Behavioural Team will produce trend analyses on a weekly basis and that it is included in the Clinical Department's reports to the PIC, the DOO and the COO. The trend analyses reports must be accompanied by commentary regarding the action taken to mitigate risk or recommendations and / or requests for support to mitigate same. (Due date: 31 August 2022).

3. A MAPA Trainer will be assigned to the Centre on a weekly basis to provide additional support to staff on a one-to-one basis and to provide support individual Service User's, as required. (Review Date: 31 July 2022).

4. The PIC will monitor the number and type of incidents in the Centre on an ongoing basis, along with the staffing arrangements, in consultation with the DOO and MDT, to ensure they are sufficient and relevant to the Service User's behavioural needs. (Due Date: 31 July 2022).

5. The Behavioural Specialist, in conjunction with the PIC, will conduct a review and update, as required, of Service User's Multi-Element Behaviour Support Plan (MEBSP) and or their proactive and reactive strategies, Section 5 their Personal Plan. Updated plans will be communicated to the staff team and discussed at monthly staff team meetings. (Due Date: 31 August 2022).

6. The Behavioural Specialist will attend staff team meetings to discuss strategies used when dealing with Challenging Behaviour. The Behavioural Specialist will visit the Centre on a weekly basis to support the staff team with implementing strategies in as outlined in the Service User's Multi-Element Behaviour Support Plan (MEBSP) and or their proactive and reactive strategies in their Personal Plan. (Due Date: 31 August 2022).

7. Management will be present in the Centre 7-days per week as reasonably practicable. Personal Plans will be reviewed as required and in consultation with the Service Users and their MDT, to ensure that all of their needs are being met. (Due Date: 31 July 2022).

8. In addition to the full review of restraints, Personal Plans will be reviewed in their entirety, to include Risk Assessments, SOP's and MEBSP's, to ensure that the information is accurate, that key risks are identified and managed, and that every effort is being made to identify and alleviate Challenging Behaviours. As part of each Service User's assessment on the cause of their behaviour, consideration will be given to the Service User mix and whether that has an impact. (Due Date: 31 July 2022).

9. All staff in the Centre will undergo refresher training in Restrictive Practices and the associated Policies. (Due Date: 31 July 2022).

10. Key risks for the Service User and staff will be compiled in a summary document, this will include person-centred risks such as vulnerability of a Service User and the risks associated. 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 PIC to ensure that it is fully up to date and reflective of the needs of each Service User and staff. (Due date: 30 June 2022).

11. The summary risk document will be communicated to all staff on a weekly basis and displayed prominently in the staff area. (Due date: 31 August 2022).

12. All Service Users will be reviewed by the MDT, and an ongoing basis, to ensure that their clinical and behavioural needs are assessed and met. (Due date: 31 August 2022).

13. Staff team meetings will include a review of Personal Plans for each Service User to ensure that staff are familiar with each of their assessed needs, including triggers to behaviour that challenges, support required and interventions to prevent and manage escalation of behaviour. (Due date: 31 August 2022).

14. Re-education to be provided to all staff to ensure that they understand and acknowledge the use of the restraint Policy and Procedure; including that physical intervention is never the primary intervention. (Due date: 31 July 2022).

15. Conduct a full review of the use of physical or environmental restraint in the Centre in line with the Regulations, including a review of current restraints in place to ensure there is a continued effective assessment for restraints in place, including identification of alternatives tried and the outcome, evidence that this is the least restrictive intervention available, and justification of any restraint. (Due date: 31 July 2022).

16. All staff will sign to acknowledge that they have read and understood each Service User's MEBSP, and the lessons learned in relation to evaluation of restraint in the Centre. (Due date: 30 June 2022).

17. All of the above actions will be discussed with the staff team at monthly team meetings held in June, July, and August by the PIC. (Due Date: 31 August 2022).

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
To demonstrate that the Centre is line with Regulation 8(2), the Person in Charge (PIC) will protect Service Users from all forms of abuse by ensuring that following actions are taken.

1. It was concluded, prior to the 05 May 2022 inspection, that the environment was not suitable for (1) one Service User and they were identified for a safe transition and discharge from The Fairways, as discussed on the day of inspection. Alternative accommodation was identified for ID326, who was discharged from The Fairways on 01 June 2022, in line with the Centre's Policy on Admissions, Transitions and Discharges (PL-ADT-001), Regulation 25(4), and in consultation with the Service User and relevant stakeholders. (Completed).

2. ID292 has also been identified as suitable for transition from The Fairways to a lower support Centre, as per Nua's internal care pathways. ID292 will be transitioned from the Centre in line with the Centre's Policy on Admissions, Transitions and Discharges (PL-ADT-001), Regulation 25(4), and in consultation with the Service User and relevant stakeholders by 31 July 2022 or sooner, if possible. (Due Date: 31 July 2022 or sooner, if possible).

3. ID158 will remain in The Fairways but will be transitioned to a standalone apartment within the Centre following the discharge of ID292. (Due Date: 22 August 2022 or sooner, if possible).

4. A review of the Centre's floor plans will be conducted to identify if improvements can be made to the environment to support the Service Users residing in the Centre.

Note: If changes to the floor plans are identified, we will notify the Authority through a vary of condition(s) application for approval. (Due Date: 31 August 2022 or sooner, if

possible).

5. Whilst the above actions are being completed, we also endeavor to mitigate the instances of peer-to-peer abuse by taking the following actions:

a) The PIC will review all incidents and accidents to ensure that all actions have been carried out.
b) The staff team will attend refresher safeguarding training
c) Safeguarding meetings within the Centre will increase to bi-weekly for the next 3 months and the frequency of same will be reviewed thereafter. (Due Date: 31 August 2022 or sooner, if possible).

6. The PIC, in conjunction with the Designated Officer, will continue to complete reviews of all 'active' safeguarding plans in the Centre to ensure that all control measures in place are adequate and sufficient to maintain quality and safe care to the Service Users and that they reflect the staffing levels and arrangements in place in the Centre. (Due Date: 31 August 2022).

7. There is a Centre Specific Safeguarding Register in the Centre. This continues to be reviewed and updated by the PIC following any safeguarding concerns. (Due Date: 31 August 2022).

8. The Designated Officer will be assigned to the Centre on a weekly basis to review all "active" safeguarding plans. Additionally, the Designated Officer will meet with the Service Users, if required, in relation to any safeguarding concerns. Minutes will be completed for these meetings and shared with the staff team. (Due Date: 31 August 2022).

9. The Designated Officers will attend the monthly staff meetings to provide further assistance and education on safeguarding plans and measures implemented in the Centre. (Due Date: 31 August 2022).

10. All of the above actions will be discussed with the staff team at monthly team meetings held in June, July, and August by the PIC. (Due Date: 31 August 2022).

Please note that we will continue to review the Service User mix and continuity of service delivery on the back of each identified transition from this Centre.

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	31/08/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	31/08/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre	Not Compliant	Orange	31/08/2022

	to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: the unexpected absence of any resident.	Not Compliant	Orange	31/08/2022
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	31/08/2022
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the	Not Compliant	Orange	31/08/2022

	following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/08/2022
Regulation 31(1)(g)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation of misconduct by the registered provider or by staff.	Substantially Compliant	Yellow	31/08/2022
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation	Not Compliant	Orange	31/08/2022

	every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	31/08/2022
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	31/08/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/08/2022