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

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| Name of designated centre: | The Willows |
| Name of provider: | Nua Healthcare Services Limited |
| Address of centre: | Kildare |
| Type of inspection: | Unannounced |
| Date of inspection: | 22 November 2023 |
| Centre ID: | OSV-0003385 |
| Fieldwork ID: | MON-0038373 |

## About the designated centre

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

The Willows provides care and support for individuals with an intellectual disability, autism and individuals with a mental health diagnosis. 24-hour care is provided for six adults both male and female from 21 years of age. The centre is located in Co. Kildare and consists of two buildings. Residents have access to a number of vehicles to support them to access their local community. In the centre each resident has their own bedroom some of which are ensuite. There are a number of communal areas and access to kitchen and dining facilities. There are a number of enclosed rear gardens for recreational use. The aim of the centre is to provide a high quality standard of care in a safe, homely and comfortable environment for individuals with a range of disabilities. Residents are supported by a person in charge/team leader, social care workers and assistant social care workers. Residents are regularly reviewed and supported by a multidisciplinary team.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 6 |

## 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 |
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| Wednesday 22 November 2023 | 10:15hrs to 17:10hrs | Sarah Cronin | Lead |
| Wednesday 22 November 2023 | 10:15hrs to 17:10hrs | Marie Byrne | Support |

## What residents told us and what inspectors observed

This was an unannounced risk-based inspection which took place to monitor levels of compliance with the regulations following a poor inspection in May 2023. From what residents told us and what the inspectors of social services observed, it was evident that residents were well supported in their home and were engaging in meaningful activities. Inspectors found that significant improvements had occurred across a number of regulations. However, improvements were required in the notification of incidents and safeguarding. These are outlined in the body of the report.

The centre is a large two-storey house set in a rural location outside a town in County Kildare. Six adults with intellectual disabilities and complex behaviour support needs and mental health difficulties live in the centre. There is a main house and two self-contained apartments to the rear of the house. The main house comprises a sitting room, a dining room, a small sensory or relaxation rook, a kitchen, staff office and two bedrooms, one of which has an en-suite. Upstairs there are two further bedrooms which are en-suite, a study, toilet and staff sleepover room. Each of the apartments has their own front door and have a kitchen, bathroom, bedroom and living room. They both lead to a staff office which has an internal door to each apartment. The premises was found to be in a good state of repair and had been painted since the last inspection. It was found to be warm and clean and residents had ample space to store their personal belongings.

Inspectors had the opportunity to meet with five of the six residents on the day of the inspection. Most residents communicated verbally, while one resident had more complex communication support needs. Residents spoke about some of the activities they were doing which included going to day services, working on independent living skills, listening to and engaging with local radio stations, going fishing, visiting family and going out for walks and to the shops. One of the residents now went soccer training in the community once a week. Another was facilitated to have specialised equipment for their citizen band (CB) radio including a large mast on the house and on their vehicle. Residents had the opportunity to be referred to and supported by an outreach time within the organisation. This team were in the process of assessing one resident to increase their engagement with activities of their choice. Another resident was being supported to develop their skills in being independent in a number of areas such as cooking, money management, personal hygiene, social skills and in using public transport. One of the residents had recently done a 'safe pass' course, while another had completed a valeting course to enable them to set up a business. Throughout the day, residents were supported to leave the house to go to day services and to visit family. Residents had access to their own vehicle to enable flexibility in line with residents' support plans. In order to foster and support positive relationships between residents in the house, residents were facilitated to play board games together or a games console in the evening time where they wished to do so.

Interactions observed between staff and residents was found to be supportive and kind. It was evident that residents whom the inspectors met with were comfortable in the company of staff. Some of the residents spoke about who they would speak to in the event they had a complaint or concern. One resident told inspectors that they felt that staff listened to them. To gain further insight into the residents' lived experiences in the centre, inspectors reviewed a sample of individual surveys which had been carried out with residents. Residents said that "Its a really good centre" and "staff are helpful".

While on the whole, residents appeared to be comfortable and content, two residents in the house voiced some dissatisfaction with their living arrangements. There had been a number of peer-to-peer safeguarding incidents in the centre since the last inspection. One resident reported that they did not feel safe around a peer at times. They spoke about how they were ''restrained'' on occasion and that they did not like when this happened. They told the inspector that they would speak with the person in charge about this. The person in charge confirmed that they had followed up on this later in the day and gave further assurances by telephone the day after the inspection took place. Another resident voiced their unhappiness at continuing to live in the centre. They had voiced this on the last inspection and voiced their wish to move. They spoke about not having consented to live in the centre. A resident stated that'' I have a right to have peace'', and ''I want to be happier in the house, I shouldn't have to put up with this. There's a lot of fighting going on in the house recently and a lot of restrictions.'' They reported that they were impacted upon by restrictions in the house which were required for other residents. They reported that they had made a complaint to the provider and that the provider had supported them to access an external advocate and a representative from the Health Service Executive to explore options. However, this was not to the satisfaction of the resident, as progress had not been made up to the day of the inspection.

One inspector visited a resident living in one of the apartments. The resident had complex communication skills and since the last inspection, staff had begun to use a total communication approach to best support them. This had involved input from a Speech and Language therapist. The resident now had a visual schedule, a choice board and staff were using a number of Lámh signs. This was shared with their day service. The resident was relaxing in a chair in their living room listening to headphones. They greeted the person in charge and the inspector. They were well presented and said that they were happy. They had access to a number of activities within their apartment such as colours and jigsaws.

Staff had completed training in applying a human-rights based approach to health and social care. The person in charge reported that residents are now more aware of their own rights and were noted to use language such as "That is my right'' with staff. As part of monthly key working sessions, inspectors saw evidence that rights were being discussed with residents. Each month, a different right or FREDA principle (Fairness, Respect, Equality, Dignity and Autonomy) was used to inform discussions. For example, a recent session had involved a discussion about the right to be treated equally and with respect. A discussion about the right to advocacy and the right to make a complaint followed. The resident reported that they understood

their rights and that they knew who to speak to should they have a complain. Language in a number of documents was noted to be written in person-centred language and residents' rights had been considered where restrictions were in place. On some residents' comprehensive needs assessment, the service had considered what characteristics in support staff would best suit the resident. The provider had referred some residents to external advocates for additional support and consent was sought for these referrals.

Residents were supported to maintain and develop relationships with those important to them in a number of ways - through writing letters, phone calls, visits to the centre and staff provided transport to residents where they were visiting family members.

Residents were consulted with about the running of the centre through weekly resident forums. These forums included meal planning and discussion on relevant topics such as rights and safeguarding. Residents had the opportunity to meet with the provider's designated officer where they wished to do so. Monthly key working sessions were another forum which residents could use to speak about their experiences and plan activities.

In summary, from what residents told us and what inspectors observed, it was evident that residents were supported to lead busy and active lives in the centre. Since the last inspection, there had been a clear focus on supporting residents' to understand their rights and to refer to external agencies where that was required. However, some residents voiced dissatisfaction at their living arrangements. The next two sections of the report present the inspection findings in relation to governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of residents' care and support in the centre.

## Capacity and capability

This was an unannounced risk-based inspection which was undertaken to assess levels of compliance following an inspection in May 2023. The inspection in May had poor findings in the areas of safeguarding, positive behaviour support, risk management, residents' rights and general welfare and development. A warning letter was issued to the provider and they submitted a compliance plan which included a detailed governance improvement plan detailing how they would come back into compliance with the regulations. Since the last inspection, there had been two additional pieces of unsolicited information submitted to the office of the Chief Inspector. Inspectors found that there were significant improvements in the levels of compliance in number of regulations on this inspection. Continued improvements were required in safeguarding and in notification of incidents.

Inspectors found that the provider had strengthened and improved their governance and management arrangements since the last inspection. There was a clear

management structure in place and enhanced oversight and monitoring by the provider to ensure that actions which were committed to in the governance improvement plan were progressed in a timely manner. This enhanced oversight also ensured that internal processes and systems which were in place to monitor and oversee key service areas were used to effectively identify any areas of concern. Members of the senior management team were in the centre for three days a week for the duration of the governance improvement plan. There were a number of professionals who were also present in the centre regularly during the governance improvement plan which included behaviour support, the risk manager, the designated officer, a clinical nurse and the training and development department. A key event schedule report was maintained to ensure that all actions identified in the governance improvement plan were completed within the provider's time lines.

A six-monthly unannounced provider visit had taken place in October 2023. This identified a number of areas which required improvement. These had been progressed on the day of the inspection. The person in charge reviewed reports and incidents on a daily basis. There was evidence of the person in charge following up with relevant staff where it was required. The person in charge maintained oversight of a weekly governance matrix and this was reviewed with senior management on a weekly basis to ensure that progress on actions continued and any trends of concern were discussed. A governance call had taken place on the morning of the inspection.

The person in charge and the deputy operations officer spoke about progress which had been made in the centre since the last inspection and changes made in the centre which had a positive impact on both residents and staff. Staff meetings had increased in frequency for a period of time following the last inspection and took place on a weekly basis with input from members of the multidisciplinary team. These had now reverted to being held on a monthly basis. There was evidence of a clear agenda in place covering incidents and accidents, safeguarding, rights and meetings were resident-focused in nature. Staff handover logs were found to be detailed and well documented and included accidents and incidents, a review of safety interventions, risks and residents' presentation.

The provider had an appropriate number of staff on duty in the centre each day in line with the centre's statement of purpose and residents' assessed support needs. A number of staff had left the centre since the last inspection and these vacancies had been successfully filled. Rosters were well maintained and indicated that residents were enjoying continuity of care.

Inspectors viewed the staff training matrix which indicated that staff had completed training in fire safety, safety intervention, manual handling, first aid, autism and infection prevention and control. A number of bespoke site-specific training sessions had been completed since the last inspection as part of the provider's governance improvement plan. To ensure that these training sessions translated into practice, on-the-floor mentoring was completed with staff. Staff supervision was occurring in line with the provider's policy.

The provider had enhanced their systems for recording, screening and logging complaints. A complaints log was kept and inspectors found that it was suitably detailed on the status of each complaint and any follow up actions. Residents and their representatives were made aware of the complaints process. It was evident from viewing documentation from key working sessions that complaints were discussed with residents. Many residents on the day said that they would speak with the person in charge or the staff in the event they had a complaint. Written correspondence was provided to complainants with the outcome of their complaint. Easy to read information and contact details of the complaints officer and the national advocacy service were on display.

## Regulation 15: Staffing

Inspectors found that there was a full staff complement in place on the day of the inspection, meaning that the centre was appropriately resourced to ensure residents' care and support needs were met in line with their comprehensive needs assessments and the centre's statement of purpose. Planned and actual rosters were well maintained. Residents were supported to ensure continuity of care through the use of regular relief staff. A sample of staff files were viewed and found to contain information and documents specified in Schedule 2 of the regulations.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had received mandatory training and a number of bespoke training sessions since the last inspection. Staff whom the inspectors spoke with were complimentary of the additional training that they had received and reported to have increased confidence in supporting residents. There was a staff supervision schedule in place and staff received on-the-floor mentoring in addition to formal supervision sessions.

Judgment: Compliant

## Regulation 23: Governance and management

The provider demonstrated significant improvements in their oversight and monitoring of the quality and safety of residents' care and support in the centre. Management systems were now being implemented and proving effective to self-identify areas for improvement and implementing actions to bring about these improvements. A six-monthly unannounced provider visit had recently taken place

and all actions had been completed by the day of the inspection.

Judgment: Compliant

## Regulation 31: Notification of incidents

There were ten notifications which were notified to the office of the chief inspector outside time lines specified in the regulations. Six of these had been identified by the provider on a recent six-monthly unannounced provider visit. These were submitted retrospectively. Inspectors noted four further notifications which had been submitted late since the last inspection.

Judgment: Not compliant

## Regulation 34: Complaints procedure

The provider had improved the implementation of their complaints procedure in the centre. The complaints log indicated the status or outcome of complaints and where appropriate, complaints had been transferred to safeguarding for further investigation. Written correspondence was provided to complainants and it was evident that residents were being supported to understand and discuss their rights and their rights to make a complaint.

Judgment: Compliant

## Quality and safety

Residents' welfare was maintained by a good standard of evidence-based care and support. As discussed in other sections of the report, there was an increase in the levels of compliance found in a number of areas pertaining to the quality and safety of residents' care and support. Good practices were found in general welfare and development, communication, positive behaviour support and risk management. However, residents' rights continued to be negatively impacted on by incidents occurring in the centre.

Multidisciplinary teams reviews had taken place to review each resident since the last inspection to ensure that residents' assessed needs and corresponding support plans remained in line with their current presentation. Following poor findings in relation to positive behaviour support on the last inspection, the behavioural specialist manager had visited the house twice a week for a number of weeks over

the summer months. They carried out competency assessments with staff and continued to visit the centre regularly, including attendance at staff meetings. The clinical nurse attended the centre twice a week in that same period of time to review pro re nata (PRN) protocols and to ensure staff were clear on when PRN should be administered, and the details on each of these medicines. A person in the organisation who was employed as a safety intervention instructor carried out a review of a sample of behavioural incidents in the centre. This review indicated significant gaps in report writing, in staffs' implementation of a residents' behaviour support plan and on PRN administration. This report made recommendations for the organisation, all of which had been implemented on the day of the inspection.

Restrictions in place for each resident were clearly documented as part of their personal plans and included in multi-element behaviour support plans and individual risk management plans. Where it was deemed necessary for staff to wear personal protective equipment for health and safety purposes in the event of an increase in behaviours of concern, this was now clearly documented on each residents' personal plans. There were defined outcomes which needed to be met by residents' to reduce each restriction in line with their multi-element behaviour support plan. Some restrictions had been discontinued since the last inspection such as fixed furniture, a raised fence and key operated fire units.

The provider had made significant improvements in relation to the recognition, reporting and oversight of safeguarding incidents in the centre. Staff training had also been carried out which included 'on-the-floor' testing of knowledge. The designated safeguarding officer visited the house weekly and had carried out a safeguarding review. This noted that there had been a significant increase in peer to peer incidents over the past three years. For example, there were no peer to peer incidents in 2021, three in 2022 and 22 in 2023 to date. A root cause analysis was carried out in relation to residents and an action plan was developed which included providing clinical supports, ensuring that staff were knowledgeable on their roles and responsibilities in preventing peer to peer incidents, and carrying out impact assessments in relation to compatibility. The safeguarding officer and management team had developed a centre-specific safeguarding plan. This included an overview of safeguarding issues and incidents in the centre and outlined both general control measures and more resident-specific actions and concerns. Staff were tested on their knowledge of safeguarding regularly and this was documented. Where there were gaps identified, this was addressed through supervision.

The provider had made improvements in educating staff and residents about their rights. As outlined earlier, FREDA principles were used to inform and guide one-to-one discussions with residents. Referrals had been made to external advocacy services for two residents. The impact of restrictive practices on residents' rights had been considered as part of their individual risk management plans. However, restrictive practices, peer-to-peer incidents and behaviours were reported to have a negative impact upon others living in the house. As discussed in the opening section of the report, one resident continued to be unhappy in their living environment and spoke about not giving consent to live there. It is acknowledged that the provider had engaged with external advocacy and the Health Service Executive in this regard. However the situation remained that the residents' right to exercise freedom of

choice was not being upheld in relation to where they wished to live.

As outlined in the opening section of the report, residents presented with a range of communication support needs. On the day of the inspection, inspectors found that residents had communication passports in place where they were required. There were visual planners in place and easy-to-read information was available on a number of different topics. One resident was being supported using a total communication approach.

Residents in the centre were provided with access to facilities for occupation and recreation and to take part in activities in accordance with their interests and needs. Some residents were now attending day services, engaging in activities in the community and developing independent living skills. Furthermore, it was evident from speaking with staff and residents that they were well supported to develop and maintain relationships and links with those who were important to them.

The provider had clear systems in place for the identification, assessment and ongoing review of risk including emergency situations. All risk assessments, the risk register and residents' individual risk management plans had been reviewed with input from relevant members of the multidisciplinary team since the last inspection. Handover logs now included any significant events, learning from accidents and incidents, reviewing safety intervention and reviewing live risks. As previously mentioned, the documentation of incidents had improved since the last inspection. The person in charge was responsible for overseeing incidents and accidents in the centre, identifying trends and ensuring that learning from incidents was shared with staff at handovers. Incidents were trended in relation to use of restraints and on severity on a weekly basis and submitted to management.

The house was found to be in a good state of repair, clean and suitably decorated. Painting had been done internally and externally. There was ample space for residents to spend time alone, or together. Residents had their own bedrooms which were decorated in line with their assessed needs and expressed interests. Residents had ample space to store their belongings. There were suitable laundry and waste facilities in place.

## Regulation 10: Communication

Good practice in supporting residents with complex communication support needs was evident on the day of the inspection. Residents had communication passports, visual supports and planners in place to ensure that staff adapted their communication to best support residents. One resident had received input from a Speech and Language Therapist and staff described using a total communication approach with them which valued all forms of communication. The resident had begun to use Lámh signs and staff described how this was also being implemented in their day service.

Judgment: Compliant

## Regulation 13: General welfare and development

Residents were supported to engage in activities of their choosing within the centre and going out of the centre was facilitated. As documented in the opening section of the report, residents were supported to pursue their interests. For example, one resident had a specific interest in CB radios and this was supported through the provision of specialised equipment in the house. Another resident enjoyed fishing and staff went fishing with them regularly. Relationships with people important to residents were supported and visits were facilitated to family homes where appropriate. Some of these were long distances from the centre and staff facilitated home visits

Judgment: Compliant

## Regulation 17: Premises

The premises was found to be in a good state of repair, and maintained on a regular basis. The centre is a large house and there was ample space for residents to spend time alone or together. Bedrooms were a suitable size and decorated in line with residents' interests and assessed needs. There were suitable arrangements in place for the safe disposal of waste in addition to suitable facilities for residents to launder their own clothes.

Judgment: Compliant

## Regulation 26: Risk management procedures

The provider had ensured consistent implementation of the risk management systems which it had in place in the centre. For example, the provider had completed a full review of the centre's risk register, individual risk management profiles and risk assessments. There was a safety statement in place. A review of documentation relating to incidents was carried out and staff training on report writing was provided. Inspectors noted an improvement in the specificity of details in incidents viewed. Adverse events and incidents were trended and appropriate actions taken. Learning was shared with staff through handovers each day and at staff meetings.

Judgment: Compliant

## Regulation 7: Positive behavioural support

The person in charge had ensured that staff had the knowledge and skills required for their role to support, manage and respond to behaviours of concern. This included the provision of bespoke training on residents' multi-element behaviour support plans and on PRN protocols. On-the-floor mentoring supported staff to transfer this knowledge into everyday practice. Where gaps were identified in knowledge, this was addressed. One of the inspectors spoke with two staff members and they reported that they now had increased confidence in their ability to support residents in line with their multi-element behaviour support plans.

Restrictive practices specific to each resident were recorded in their individual risk management plans. Restrictive practices were regularly reviewed to ensure that they remained proportionate to the presenting risks and that the least restrictive procedure was use for the shortest duration necessary.

Judgment: Compliant

## Regulation 8: Protection

As outlined, the provider had enhanced their oversight, monitoring and reporting of safeguarding incidents in the centre. There had been 47 notifications made to the Office of the Chief Inspector which related to safeguarding since the last inspection. 46 percent of these incidents were peer-to-peer incidents. However, the provider had done a root cause analysis, a safeguarding plan and were trending incidents to ensure ongoing oversight. Impact assessments were carried out to review compatibility of residents.

Judgment: Compliant

## Regulation 9: Residents' rights

Residents' right to freedom of movement and access to items in their environment continued to be impacted upon due to restrictions in place for their peers. For example, one resident told inspectors that they didn't like to have the television in a perspex case and that they felt the centre was very restrictive. Another resident spoke about the impact which physical holds had on them when they were used. There had been a high number of peer-to-peer incidents taking place in the centre since the last inspection. This had a negative impact on the rights of residents living

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| in the house. Two of the residents spoke about this on the day of the inspection, with one referring to not feeling safe around another resident while another said that they had a ''right to be in peace''. Narrative from notifications submitted to the office of the chief inspector gave further evidence of the impact on residents' 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 | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for The Willows OSV-0003385

## Inspection ID: MON-0038373

## Date of inspection: 22/11/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 31: Notification of incidents | Not Compliant |
| Outline how you are going to come into compliance with Regulation 31: Notification of incidents:<br>To demonstrate that the Designated Centre is in line with Regulation 31 1 (f). 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, suspected or confirmed, of abuse of any resident.<br><br>1. The Person in Charge (PIC) will ensure to notify the Office of the Chief Inspector when any of the types of events set out in Regulation 31(1) occur in the centre. Notifications will be submitted to the Office of the Chief Inspector in writing within three working days of the event occurring (Completed).<br>2. The Person in Charge (PIC) in conjunction with the Director of Operations will complete a review of all Notifications prior to submission of the Notifications to the Authority (Completed).<br>3. The Person in Charge (PIC) will attend Designated Safeguarding Officer Training with the HSE (Due Date: 30th January 2024) | |
| Regulation 9: Residents' rights | Not Compliant |
| Outline how you are going to come into compliance with Regulation 9: Residents' rights:<br>To demonstrate that the Designated Centre is in line with Regulation 9 2 (b). The Person in Charge and Registered Provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.<br><br>1. The Person in Charge (PIC), in conjunction with the Director of Operations (DOO) and | |

Nua's Admission, Transition and Discharge (ADT) Manager will complete a review of a needs assessment for individuals in the centre to determine the impact of residents needs and suitability of their placements (Due Date: 9th January 2024).
2. The Person in Charge (PIC), in conjunction with the Director of Operations (DOO) will conduct a review of individuals impact assessments to determine the level of impact residents are having on one another these impact assessments will be brought to Nua's Admission, Transition and Discharge Committee meeting for review (Due Date: 16th January 2023).
3. The Person in Charge will consult with the Local Advocacy Service and submit referrals for resident's who currently do not have an active case with an Advocate (Due Date: 8th January 2024).
4. Person in Charge (PIC), Director of Operations (DOO), Behavioral Specialist and Behavioral Specialist Manager will conduct monthly Restrictive Practice Reviews to ensure each restriction is only implemented following a revision of all alternative strategies been utilised and that they are been used as a last resort and for the shortest period of time. (Due Date: 20th January 2023)
5. Person in Charge (PIC), Director of Operations (DOO), Behavioral Specialist and Behavioral Specialist Manager during the monthly restrictive practice reviews will consider the impact of all restrictions in relation to all individuals in the Centre and this will be documented within the minutes of the meeting (Due Date: 20th January 2023)
6. Key working sessions will be completed with all individuals in the Centre fortnightly with a member of the centre management expanding further on residents rights in relation to restrictive practices and to determine their views and wishes in relation to same (Due Date: 16th January 2024).
7. The staff team will complete online training on the Human Rights Based Approach to further support and develop their knowledge in relation to residents rights (Due Date: 30th January 2024)

## 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 31(1)(f) | 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, suspected or confirmed, of abuse of any resident. | Not Compliant | Orange | 30/01/2024 |
| Regulation 09(2)(b) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life. | Not Compliant | Orange | 30/01/2024 |