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 Willows
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	18 May 2023
Centre ID:	OSV-0003385
Fieldwork ID:	MON-0040041

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. Support aims to be consistent with the mission, vision and values of the organisation and the centres' specific statement of purpose and function. Residents are supported by a person in charge/team leader, social care workers and assistant social care workers. Should additional staff be required, staffing numbers will be reviewed and amended in line with residents' dependencies. All residents undergo a full pre admission assessment, which includes an impact assessment of the new resident on existing residents. Residents are regularly reviewed and supported by a multidisciplinary team. Where the needs of the resident can no longer be met in the centre, this is identified by the person in charge, staff and multidisciplinary team, and the residents are supported to transition to alternative services.

The following information outlines some additional data on this centre.

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
Thursday 18 May 2023	19:00hrs to 22:00hrs	Sarah Cronin	Lead
Friday 19 May 2023	10:00hrs to 17:00hrs	Sarah Cronin	Lead
Thursday 18 May 2023	19:00hrs to 22:00hrs	Marie Byrne	Support
Friday 19 May 2023	10:00hrs to 17:00hrs	Marie Byrne	Support

What residents told us and what inspectors observed

This inspection was carried out following receipt of unsolicited information. It was an unannounced inspection and was facilitated by the person in charge. From what residents told us and what inspectors observed, residents living in this designated centre were found to be well supported by their staff team and engaging in activities of their choice in their local communities. However, the inspection found poor levels of compliance in a number of areas such as positive behaviour support, risk management, safeguarding and governance and management. These are detailed in the body of the report. Due to the high levels of non-compliance found on this inspection and the level of contraventions of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, the provider was invited to attend a warning meeting.

The designated centre provides a full-time residential service to six adults who have high support needs due to mental health difficulties, intellectual disabilities and behaviours that challenge. The house is a two-storey house on a large site outside a town in Co. Kildare and there are two apartments to the rear of the house. The house is home to four residents. Downstairs comprises a sitting room, a dining room, a small sensory room, a kitchen, a staff office, two bedrooms, one of which has an en suite and a large bathroom. Upstairs comprises two further bedrooms, both of which are en suite. There is a study, a toilet and a staff sleepover room. The apartments are to the rear of the house. Each has their own entrance and both are single occupancy units. The apartments comprise a kitchen, bathroom, bedroom and living room. These are accessible by a staff office, which is situated in between the apartments and has an internal door into each apartment. There is an enclosed private garden to the back of the apartments, and another large one to the side of the main house. The premises was found to be in a good state of repair. It was found to be warm and clean and residents had ample space to store their belongings and to spend time alone or with others , in line with their choices. However, both the door and the gate at the entrance to the house had coded access. There was no bell either at the gate or at the front door which made entry to the house difficult for visitors.

Inspectors had the opportunity to meet with all of the residents over the course of the inspection. Most residents communicated verbally, while one resident required additional supports such as using simple language and photographs. Over the course of the inspection, inspectors observed residents being supported to engage in activities of their choosing. Each resident had access to their own vehicle, which enabled them freedom to access places or activities at times of their choosing.

On arrival to the centre, residents were relaxing for the evening, with two residents playing a board game together, others were watching television and others were speaking with staff. One of the residents had completed a charity event and bake sale the day before the inspection, which they seemed very proud of. Staff spoke about how successful the day had been and how hard the resident had worked on

organising the day. Inspectors visited both apartments. One resident was found relaxing and watching television. They showed inspectors around their apartment and showed them their daily schedule. This had photographs of each activity the resident engaged in. The resident was well presented and appeared happy. The second resident greeted inspectors and chose not to engage with them. Their apartment had a whiteboard which had details of the goals that they were working on, particularly in the area of money management. The following morning, one of the residents was going out fishing for the day with a member of staff. Another was going out to play pool while another was going for coffee. Other residents remained in the house and did activities of their choice. Staff members spoke about each residents' talents and preferences to inspectors. The majority of staff felt that residents had opportunities to engage in activities which they enjoyed.

While most residents told residents they felt happy and safe in the centre, one resident spoke repeatedly about wanting to live elsewhere and closer to their family. The resident spoke about not giving consent to moving to the centre, and that they did not engage much in the local community , as they wished to be in the area they used to live. They reported enjoying a job in their previous centre and queried how long they would need to stay in the designated centre.

Consultation with residents took place at a weekly meeting in addition to weekly 'happiness' surveys which the provider carried out. Inspectors viewed the minutes of these meetings and found that they contained very little detail as to what residents' views were. Furthermore, the consultation with residents for the annual review was also found to be very limited. Key worker meetings did take place, but inspectors were not assured that residents were consulted with and participated in discussions in a meaningful way about their care and about issues related to the centre.

Residents exercised their rights to choice within each day. However, a number of other rights were found to be negatively impacted in the centre through both culture and work practices relating to behaviours. There were high levels of restrictive practices in place in the centre which impacted on residents' rights. These included environmental practices, restrictions on items such as cigarettes and alcohol and residents being seated in certain parts of vehicles for health and safety reasons. There were a significant number of incidents which took place and required a physical hold. Risk assessments for these restrictions did not recognise that these restrictions had a negative impact on residents' rights.

Inspectors found that some residents' rights to privacy and dignity were not upheld in the centre. For example, there had been three allegations of neglect and a complaint on behalf of one resident in relation to their personal care needs being provided in line with their care plans. Inspectors found that another resident had not been encouraged to maintain their own privacy and dignity in relation to personal care on both days of the inspection. There were four complaints made by residents about staff in relation to their rights' to dignity and respect not being upheld.

In summary, from what residents told us, what inspectors observed and from meeting with staff members, it was evident that staff were supporting residents to access community activities. However, inspectors found poor levels of compliance

with a number of regulations which were having a negative impact on residents living in the centre. These findings were across a number of areas such as residents' rights, safeguarding, risk management and positive behaviour support. The next two sections of the report present the inspection findings in relation to the governance and management arrangements in the centre, and how these arrangements impacted on the quality and safety of residents' care.

Capacity and capability

Overall, the inspection found that while the provider was attempting to ensure that residents were supported by a regular staff team and engaging in meaningful activities, a number of actions were required to ensure that residents were in receipt of a safe and quality service. Poor levels of compliance were found in the oversight and monitoring of care and support, supporting staff to exercise their responsibilities for the quality and safety of services that they were delivering, safeguarding, positive behaviour support , risk management and residents' rights.

As outlined in the opening section of the report, this was an unannounced inspection which was completed as part of the regulatory plan for the centre following receipt of both solicited and unsolicited information from the centre. There had been three pieces of unsolicited information, in the form of concerns submitted to the Chief Inspector of Social Services in the months preceding the inspection. A provider assurance report was issued in April 2023 following receipt of one of these pieces of information. Inspectors found that the provider assurance report did not give suitable assurances on the actions the provider was taking to address areas of concern. It did not recognise areas requiring improvement which were identified on this inspection. The provider had identified some actions in relation to Regulation 8 (Protection) and Regulation 23 (Governance and Management). However, these actions had not resulted in the required improvements. For example, staff had completed safeguarding training in April 2023, but inspectors found deficits in staff knowledge in relation to recognising and responding to safeguarding concerns.

Inspectors found that the governance and management arrangements in the centre were not effective in ensuring adequate oversight of the quality and safety of residents' care. The centre had a clearly defined management structure in place. A new person in charge had commenced shortly before this inspection. They worked in the designated centre on a full-time basis and were supported by two deputy team leaders. The provider had a number of internal processes and systems in place to monitor and report on key service areas on a weekly basis such as incidents and accidents, safeguarding, staffing and complaints. Reports were completed on a weekly basis by the person in charge and this was reviewed by senior management. It was evident that the centre was reviewing care and support, however these reviews were not identifying areas which were found on this inspection. For example, there were significant gaps in risk management, safeguarding and positive

behaviour support and gaps were not identified on these weekly reports.

The provider had carried out a six-monthly unannounced provider visits in line with regulatory requirements. The most recent six monthly unannounced visit had identified some areas for improvement in line with the findings from this inspection. However, the annual report , which had been completed within the same month as this visit, did not pick up on any of these areas.The annual review referred to consultation with residents and their representatives in the report, but did not contain sufficient detail as to what residents' views were.

The centre was found to be appropriately resourced to ensure that residents' assessed needs were met. There was a large staff team of 37 staff. Inspectors spoke with ten staff out of a team of 37 on an individual basis over the course of the inspection. They were found to be knowledgeable about residents preferences and their assessed needs. However, there were some gaps in staff knowledge, which will be detailed under the quality and safety section of this report. Planned and actual rosters were well maintained and all shifts were completed by staff within the team. For each shift, there was a suitable number of staff , with the required skill mix and ratio for residents. The provider had recently recruited and filled a number of staff vacancies in the centre which had resulted in improved continuity of care and support for residents.

Staff had completed mandatory training and training in a number of areas outlined in the centre's statement of purpose. These included fire safety, safeguarding, safety interventions, first aid and a range of courses related to infection prevention and control. Five staff were due to complete a course in positive behaviour support in the weeks following inspection. Staff were found to be in receipt of regular formal supervision.

A record was maintained of all incidents and adverse events in the centre. The provider had notified the Office of the Chief Inspector of the occurrence of certain events in line with regulatory requirements. However, two notifications relating to allegations of abuse had not been notified as required by the regulation. These were submitted following the inspection.

Regulation 15: Staffing

The provider ensured that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents, the statement of purpose and the size and the layout of the centre.The centre was found to be fully staffed in line with the statement of purpose. The provider had recently filled four staff vacancies and this had led to improvements in the continuity of care and support for residents. Where shifts were vacant, these were covered by regular relief staff. Inspectors viewed planned and actual rosters and found that these were well maintained.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training and had completed training in mandatory areas such as fire safety, safeguarding, autism, manual handling, first aid and the safe administration of administration. All staff had completed training in safety interventions for behavioural incidents at foundation level. A small number of staff had not completed training in positive behaviour support, although this was planned in the weeks following inspection. Staff were found to be in receipt of regular supervision. Staff reported that they felt well supported in their roles and felt able to raise any concerns where they wished to do so. While inspectors noted that there were some gaps in staff knowledge in safeguarding and positive behaviour support, this is addressed in Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that the governance and management arrangements in the centre were not effective in ensuring adequate oversight of the quality and safety of residents' care. The provider had a number of internal processes and systems in place to monitor and report on key areas on a weekly basis. However, these reports were not identifying areas which required improvement in the centre in order to effectively monitor residents' care. For example, there were significant gaps in risk management, following up on incidents and ensuring that documentation was consistent to guide staff practices.

In order to ensure staff had up-to-date knowledge and skills to inform their work practices, the provider carried out 'on the floor mentoring' . However, inspectors found that there were gaps in staff knowledge relating to safeguarding and positive behaviour support and this was leading to some inconsistent practices, which had potential to have a negative impact upon residents.

The provider had completed six-monthly unannounced provider visits in line with regulatory requirements. The most recent six- monthly unannounced provider visit had identified the need for improvements in relation to positive behaviour support, protection, governance and management and risk management. However, the annual review, which was completed in the same month, did not pick up on any of these areas requiring improvement. The annual review referred to consultation with residents and their representatives in the report, but did not contain sufficient detail as to what residents' views were.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider had failed to notify the Authority of two safeguarding concerns which had been reported in 2022. These were submitted following inspection.

Judgment: Not compliant

Quality and safety

Overall, residents were living in a service which supported them to engage in their preferred activities and one which supported them to achieve their goals. However, improvements were required in risk management, positive behaviour support, protection and rights. Residents had access to a range of health and social care professionals such as a GP, psychiatrists, speech and language therapists, occupational therapists and dietitians. A behaviour behaviour specialist attended the centre on a fortnightly basis and reviewed residents' plans each quarter. Care plans indicated proactive and reactive strategies to use with residents. One resident had a more detailed multi-element behaviour support plan in place, with clear objectives and consideration of reduction of restraints. There was guidance for staff on the use of a traffic light system to assess the residents' presentation and appropriate responses.

Inspectors were not assured that there was clear monitoring and oversight of behaviour support plans, nor were they assured that the use of these restrictions were the least restrictive option, or that they were for the shortest period of time possible. On a review of behavioural incidents which had taken place, in addition to notifications received, there was a high level of physical holds taking place in the centre. For example, in the twelve months prior to the inspection taking place, there had been 38 physical interventions used with five residents. Some of these holds were documented as taking up to ten minutes. One staff member highlighted the need for a consistent approach and referred to restraint being more likely to happen if staff were not following the residents' behaviour support plan. There were inconsistencies in staff knowledge and implementation of behaviour support plans and control measures in residents' individual risk management plans. Staff gave inconsistent answers on when and how to use physical restraints and when to discontinue a hold in addition to the use of PRN medication

There were a number of policies in place to guide practice such as a a behaviour management policy and procedure, a policy on the use of restrictive procedures and specific policy and procedure on Safety Intervention. These policies referenced the provider's commitment to a restraint-free environment by adopting a human rights-

based approach. Residents' rights were upheld in areas such as making choices about their daily routines and their goals. However, there was not clear recognition on the negative impact which restrictions in the centre had on residents' rights. Documentation provided by the organisation gave prompts to staff after each risk assessment for residents whether these had an impact upon their rights. Of the sample of 46 risk assessments viewed, this had been answered as a no for all of them in spite of restrictions impacting on a number of residents' rights. This is further detailed under Regulation 9: Residents' rights below.

While most residents told the inspectors that they felt safe in their home, inspectors were not assured that there was clarity among the staff team on what constituted a safeguarding concern and their responsibilities to report these concerns in addition to the provider not recognising two incidents which had occured in 2022. All preliminary screenings by the provider had returned with no grounds for concern, however they were putting some extra measures in place. This indicated that the provider recognised the need for additional supports but that this had not translated into a formal safeguarding plan where appropriate in line with national policy.

There were clear risk management systems in place in the centre. The risk management policy was found to meet regulatory requirements. The provider had a detailed online system in place to report any incidents or accidents in the centre. The centre had a specific risk register in place in addition to each resident having a detailed individual risk management plan. Risk ratings required review in both of these areas to ensure that ratings were reflective of the risk. While incidents were well documented, inspectors found that many incidents had not been followed up on in line with the provider's policy. The use of personal protective equipment such as mandatory wearing of a baseball cap with one resident and intermittent use of bite jackets for use with another resident was documented. However, risk assessments or incident reports did not clearly justify the use of these pieces of equipment.

Regulation 26: Risk management procedures

Risk assessments pertaining to the centre and individual residents required review to ensure that they were reflective of the current risks in the centre to ensure that appropriate control measures were in place. For example, safeguarding was rated as a moderate risk on the register. However, there had been twelve allegations of abuse in the previous 12 months. Restrictive practice was also rated as moderate risk, and again this was not reflective of the number of incidents which were occurring. Similarly, individual risk ratings did not reflect the current risks for residents. For example, for one resident who had recent incidents of engaging in self injurious behaviour which required physical interventions, this was rated as a low risk on their individual risk management plan.

Inspectors found that incidents and accidents were well documented using the provider's online system. However, they found that many incidents had not been followed up on in line with the provider's policy. For example, the system prompted

staff to identify whether a de-brief was required following an incident, in addition to whether an incident had potential to have caused the resident or themselves harm. These were not consistently followed across a number of incidents, which meant that reviews of documentation and plans did not occur as outlined in the policy. For example, following an incident where a resident was in three different holds for the same incident for a total of 15 minutes and then transferred to a safety pod for a further 25 minutes, the follow-up documentation rated this as the lowest possible severity and did not recognise that there was a potential risk of injury to either the resident or the staff. Therefore, this was not immediately escalated in line with policy. Another incident was viewed where a resident was crying and upset and documentation indicated that no debrief was needed. For a third resident who required communication support, documentation reported that due to the resident being non-verbal, that a debrief was not applicable to them.

The use of personal protective equipment for protecting staff from possible injuries from any incidents involving residents was in place for some residents. It was a mandatory requirement for all staff working with a particular resident to wear baseball caps. However, it was unclear why this was mandatory, as there was not a high risk or multiple incidents of hair pulling to demonstrate the need for this to be in place. Staff referred to the use of bite jackets where they were required. These were also referred to in individual risk management plans. However, minutes from the most recent restrictive practice committee indicated that use of these jackets were not permitted in the centre.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents had access to a behaviour specialist who attended the centre on a fortnightly basis and reviewed plans each quarter. Care plans indicated proactive and reactive strategies to use with residents. One resident had a more detailed multi-element behaviour support plan in place. Inspectors spoke with nine staff members about residents behaviour support plans and how physical restraint was implemented. There were inconsistencies across staff on residents' behaviour support plans plans, on how and when restraint would be used and when it would be discontinued and on the use of PRN medication. For example, one staff member told inspectors that there were no residents prescribed PRN medication for anxiety or mental health conditions, when there were a number of residents who were prescribed these medications.The need for a consistent approach by all of the team was highlighted by staff who reported that restraint was more likely to happen if staff were not following the planner and the behaviour support plan.

On a review of behavioural incidents which had taken place, in addition to notifications received, there was a high level of physical holds in place. For example, in the twelve months prior to the inspection taking place, there were a total of 38 holds for five different residents. These holds ranged from low level to high level in

both standing and seated positions. Staff had completed a Safety Intervention Course and reported that holds were practised each week. The length of holds varied from 20 seconds to 11 minutes. However, a significant proportion of these holds were between five and ten minutes. Some holds continued while a resident was seated in a safety pod bean bag. Inspectors were not assured that the use of these restrictions were the least restrictive option, nor that they were for the shortest period of time possible.

Judgment: Not compliant

Regulation 8: Protection

Inspectors were not assured that there were appropriate safeguarding measures in place in relation to staff practices, in recognising and reporting safeguarding concerns and in ensuring that preliminary screenings were carried out in an appropriate manner to ensure that safeguarding measures were put in place where they were required. Staff had received online training in relation to safeguarding, inspectors were not assured that staff could appropriately identify safeguarding concerns when presented with a safeguarding scenario. For example, inspectors presented staff members with scenarios they may encounter in their work and only one staff member recognised a concern as a safeguarding issue, while the other eight did not recognise a concern presented to them and did not state that they would record the allegation or concern in line with the providers' and national policy.

There had been 12 notifications of safeguarding concerns in the 15 months prior to the inspection taking place. Of these 12 notifications, five were allegations against staff members from different residents. All of these concerns were found to be documented and reported. However, at the stage of preliminary screening, all of these 12 notifications were returned with 'no grounds for concern', or found that residents had withdrawn their statements and apologised. For one of these notifications, the HSE deemed that there were in fact grounds for concern and that a safeguarding plan was required in line with national policy.

A review of complaints in the centre identified two complaints which had been made in the centre which had not been recognised or reported as safeguarding concerns.

Judgment: Not compliant

Regulation 9: Residents' rights

It was evident that residents were supported to exercise their rights to make choices in their every day activities , meals and clothes. However, the number of physical holds in place, in addition to the length of time which residents were restricted

impacted on residents' rights to freedom of movement. It was not evident what consultation had taken place with residents.

From speaking with staff, it was evident that staff engaged with residents regularly as part of their daily routines. There were residents meetings taking place. However, the minutes of these meetings did not give any indication of what residents had inputted or contributed to the meeting. A 'happiness ' survey was carried out on a weekly basis and inputted into a spreadsheet. Inspectors found that there was no detailed evidence of what residents had said in response to this question. Answers were documented as yes or no in answer to a single question. For a resident who had more complex communication needs, it was noted on some documentation that a de-brief post incidents did not occur due to the resident being unable to verbally communicate.

A review of three residents' individual risk management plans noted that both environmental and physical restrictions were control measures for risk assessments in place. As outlined earlier in the report, the provider recognised the need to uphold residents' rights and had documented the need to take a rights-based approach to restrictive practice. Risk assessments had a piece which asked staff whether risks and restrictions had an impact on residents' rights. Of the 46 risk assessments viewed by inspectors which were in place for 3 residents, staff had indicated that these restrictions did not have any impact on residents' rights on every assessment. This meant that there was a failure to recognise the negative impact which significant restrictions had on residents' rights across a number of areas.

Inspectors viewed documentation which indicated that residents' rights to privacy and dignity, particularly in relation to personal care were not upheld at times in the centre. For example, there had been three allegations of neglect and a complaint on behalf of a resident in relation to their personal care needs not being provided in line with their care plans. Inspectors found that another resident had not been encouraged to maintain their own privacy and dignity in relation to personal care on both days of the inspection. There were four complaints made by residents about staff in relation to their rights to dignity and respect not being upheld.

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	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for The Willows OSV-0003385

Inspection ID: MON-0040041

Date of inspection: 19/05/2023

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To demonstrate that the Designated Centre is in line with Regulation 23(1)(c) 23 1 (e) and 21 3 (a) The Registered Provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

1. A Director of Operations (DOO) will be present in the Centre five (5) days a week commencing week beginning 12th of June to support the PIC and to oversee the implementation of required improvements. There will also be unannounced visits over the seven (7) day period in the Centre (Due 13th July 2023).

2. Team Meetings will take place weekly and Behavioral Specialist will attend these meetings. These meetings will specifically focus on review of positive behavior support and risk management to ensure plans for all Individuals are cohesive and guide staff practices (Due 13th July 2023).

3. The annual review report will be reviewed and revised to include the feedback from the six-monthly Unannounced Provider visit in relation to the areas of non-compliance. The Provider Representative (QA officer) will conduct visits with the Individuals and their representatives to ensure that the Individuals views are taken on board in full. This will be incorporated and actioned into the Annual Report of the Centre (Due 30th June 2023).

4. A Behavioral Specialist will attend the Centre on a weekly basis commencing week of the 12th of June to review Behavioral Support Plans where relevant or Section 5 of the Personal Plans for all Individuals. The Behavioral Specialist will conduct on the floor mentoring with staff to guide practice and enhance staff knowledge of Strategies to support Individuals (Due 13th July 2023).

5. Behavioral Specialist in conjunction with the PIC will complete a review of each incident within the Centre in 2023 and incidents on a weekly basis as part of the Governance Plan to identify additional strategies to support Individual (Due 13th July 2023).

6. Peron In Charge (PIC), DOO, Behavioral Specialist and Behavioral Specialist Manager will conduct bi-weekly Restrictive Practice Reviews to ensure each restriction is only implemented following a revision of all alternative strategies been utilised and that they are been used as a last resort and for the shortest period of time. Following this review all Personal Plan, Behaviour Support Plan and Risk Management will be updated to reflect any changes that occur, and minutes of meeting will be on file showing clear rational for restriction (Due 13th July 2023).

7. Behavioral Specialist Manager will visit the Centre bi-weekly and complete competency assessment with the staff team on the implementation of Behavioral Support Plans where relevant and section 5 of Personal Plans. Competency assessments will be completed, and corrective actions will be provided to Behaviour Specialist, PIC, DOO for implementation as required (Due 13th July 2023).

8. Administration Department will be present in the Centre four (4) days a week to review the connectivity between the Individual documents, Positive Behaviour Support, Individual Risk Management and Restrictive Practice meeting minutes to ensure that they are all cohesive and consistent in detail to ensure they guide the staff practice. Feedback will be provided to the PIC and DOO for implementation in conjunction with the Administration staff (Due 13th July 2023).

9. Nua's Designated Safeguarding Officer will visit the Centre on weekly bases commencing week beginning 12th of June 2023 to review all Safeguarding Plans with PIC and meet with individuals, when available (Due 13th July 2023).

10. Centre specific classroom-based training will be completed with the team which will include the following key areas, Positive Behaviour Support, Safeguarding, Risk Management, Report Writing, PRN protocols, Regulator Requirements and Residents Rights. All Training will be competency bases and developmental plans for staff will be developed where required (Due 13th July 2023).

11. Training to be provided to both the Centre and the relevant departments on the Implementation of the current Policy and Procedures of Nua Healthcare and the requirement to implement and adherence to the same. This training will specifically focus on the following Policies.

- Positive Behaviour Support
- Safeguarding
- Risk Management
- Notification of Incidents
- Residents Rights
- Restrictive Practice
- Personal Plans

12. Clinical Nurse will attend the Centre bi- weekly commencing week of the 12th June 2023 to review the PRN protocols and Personal Plans with the PIC to ensure that these plans provide clear guidance to staff on when PRN is to be utilised for individuals in line with guidance from their treating psychiatrist (Due 13th July 2023).

13. A Multi-Disciplinary Team meeting will take place to discuss all six (6) Individuals plans with all key disciplines in attendance. The Purpose of this meeting will be to review supports required for each Individual and ensuring their engagement in their Personal Plans and Goals (Due 13th July 2023).

14. Accountability for work practices will be strengthened throughout the Centre's management team, ensuring staff team know their roles and responsibilities in line with associated Key Task Lists. This will be conducted by HR and PIC (Due 13th July 2023).

15. To strengthen the accountability for work practices carried out in The Willows, the roles and responsibilities of each team member along with associated Key Task Lists 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:

- Specific responsibility on the PIC for the oversight and action of incident reports, complaints, verbal feedback from Individuals, and oversight of the actions of all staff in the Centre (Due 13th July 2023).
- 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 supporting the Individuals (Due 13th July 2023).
- Support Workers to follow the roles and responsibilities as outlined within their Key Task lists (Due 13th July 2023).
- The PIC and management team will continue to provide on the floor supervision to staff on a daily basis, providing support and feedback as required (Due 13th July 2023).

16. A QA Officer will be assigned to the Centre on a weekly basis commencing on 12th June 2023 to review the implementation of the Governance Improvement Plan and areas identified by PIC and DOO. The QA officer will provide a report after each visit which is submitted to the PIC and DOO (Due 13th July 2023).

17. A weekly meeting will take place between PIC, DTL, DOO and COO to review the status of actions within the Governance Improvement plan and additional actions will be implemented as required. Additional actions will be included in relation to additional regulations as required. Update will be provided at the weekly governance meeting with attendance of all SMT and Provider Nominee (Due 13th July 2023).

18. A Key Event Schedule (KES) linked to the Governance Plan will be implemented from Monday the 12th of June to monitor all actions to be complete with responsibilities for tasks assigned to identified stakeholders. Note: All proof documents will be held in a folder of evidence in the Centre (Due 13th July 2023)

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of	

incidents:
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.

1. The PIC to ensure that all notifications are submitted in line with Regulation (Due 12th June 2023/Completed).

2. PIC will ensure full review of Incidents/ Daily Notes and Significant Conversations from is completed in Centre to ensure notifications are not missed (Due 12th June 2023/ Completed).

3. Centre specific classroom-based training will be completed with the team which will include the following key areas, Positive Behaviour Support, Safeguarding, Risk Management, Report Writing, PRN protocols, Regulator Requirements and Residents Rights. All Training will be competency bases and developmental plans for staff will be developed where required (Due 13th July 2023).

4. Nua's Designated Safeguarding Officer will visit the Centre on weekly basis commencing week beginning 12th of June 2023 to review all Safeguarding Plans with PIC and meet with individuals, when available (Due 13th July 2023).

5. A meeting to be held with QA officers, QA manager and COO's to discuss the importance of ensuring all notifications are identified throughout audits and learnings from missed notifications to be discussed linked to this HIQA report (Due 20th June 2023).

6. A meeting to be held with the Complaints Officers, Designated Officers and Safeguarding and Complaints Manager to take the learning from the missed notification (Due 16th June 2023/ Completed).

7. Meeting to be held with the Safeguarding and Complaints Manager to review and enhance the current process for safeguarding notifications and to take in response from the National Safeguarding Team where the outcome of the preliminary screening submitted by Nua has been changed by the National Safeguarding Team. A revision of the process relating to where the National Safeguarding Team change the outcome of a screening will be implemented to ensure all outcomes are escalated to DOO who will in turn notify the Authority through a follow up process with the relevant notification code referenced (Due 16th June 2023).

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 Designated Centre is in line with Regulation and 26 (2) The Registered Provider and Person in Charge 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.

1. PIC and Risk Manager to complete a full review of all Individual Risk Management Plans (IRMP) and the Centre Specific Risk Register to review the risk ratings and controls in place and to ensure that the individual risk rating is reflective to the Centre risks and Individual Specific risk ratings (Due 26th June 2023).

2. Centre specific classroom-based training will be completed with the team which will focus on Individual Risk Management plans and Centre Specific Risk Registers. All Training will be competency based and developmental plans for staff will be developed where required (Due 13th July 2023).

3. PIC, DTL's and DOO to attend a Risk Management Specific training course to enhance their Risk Management knowledge (Due 13th July 2023).

4. A Behavioral Specialist will attend the Centre on a weekly basis commencing week of the 12th of June to review Behavioral Support Plans where relevant or Section 5 of the Personal Plans for all Individuals. The Behavioural Specialist will conduct on the floor mentoring with staff to guide practice and enhance staff knowledge of Strategies and the process of conducting debriefs with the Individuals in line with their assessed needs (Due 13th July 2023).

5. Behavioral Specialist in conjunction with the PIC will complete a review of each incident within the Centre on a weekly basis as part of the Governance Plan to identify additional strategies to support Individual and ensure that all relevant plans and document specific to the Individual are updates where required (Due 13th July 2023).

6. PIC, DOO, Behavioral Specialist and Behavioral Specialist Manager will conduct bi-weekly Restrictive Practice Reviews to ensure each restriction is only implemented following a revision of all alternative strategies been utilised and that they are been used as a last resort and for the shortest period of time. Following this review all Personal Plan, Behaviour Support Plan and Risk Management will be updated to reflect any changes that occur, and minutes of meeting will be on file showing clear rational for restriction (Due 13th July 2023).

7. The PIC and Risk Manager will compile a weekly risk summary document commencing the week of 12th June 2023 for all individuals and staff, this will include person-centered risks such as vulnerability of each Individual 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 Individual and staff (Due 13th July 2023).

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 Designated Centre is in line with Regulation 7(1) and 7 (5)(c)

The Person In Charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour and where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.

1. A Behavioral Specialist will attend the Centre on a weekly basis commencing week of the 12th of June to review Behavioural Support Plans where relevant or Section 5 of the Personal Plans for all Individuals. The Behavioural Specialist will conduct on the floor mentoring with staff to guide practice and enhance staff knowledge of Strategies (Due 13th July 2023).

2. PIC, DOO, Behavioral Specialist and Behavioral Specialist Manager will conduct bi-weekly Restrictive Practice Reviews to ensure each restriction is only implemented following a revision of all alternative strategies been utilised and that they are been used as a last resort and for the shortest period of time. Following this review all Personal Plan, Behaviour Support Plan and Risk Management will be updated to reflect any changes that occur, and minutes of meeting will be on file showing clear rational for restriction (Due 13th July 2023).

3. The Behavioral Specialist will produce trend analysis on the number of incidents and restraints on a weekly basis and this report will be provided 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 13th July 2023).

4. Clinical Nurse will attend the Centre bi- weekly commencing week of the 12th June 2023 to review the PRN protocols and Personal Plans with the PIC to ensure that these plans provide clear guidance to staff on when PRN is to be utilised for individuals in line with guidance from their treating psychiatrist (Due 13th July 2023).

5. Centre Specific Training plan for Centre team will cover the following areas for this regulation (Due 13th July 2023).
- Positive Behaviour Support
- Use of Safety Interventions/ safety pod training in line with Individual's plans
- Use of PRN medication in line with Individual's plans

6. PIC, DOO and Behavioural Specialist will conduct a review of all restrictions and PPE gear for each Individual and ensure that all documents are reflective of the Individual need for restriction and use of PPE. PIC, DOO, and Behavioral Specialist will ensure that Personal Plan, Behaviour Support Plans, Individual Risk Management Plan are incorporated as part of the restrictive practice committee review and that the register and plans are updated to reflect the needs for restrictions and PPE to guide staff practice (Due 13th July 2023).

7. Behavioral Specialist in conjunction with the PIC will complete a review of each incident within the Centre on a weekly basis as part of the Governance Plan to identify additional strategies to support Individual. In addition, the Safety Intervention Trainers will conduct a review of all each occasion where physical restraint was implementation

2023 to identify the learnings for the staff team on ensuring their adherence to Safety Intervention training in relation to the use of restraint as a last resort and used for the shortest period of time (Due 13th July 2023).

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
To demonstrate that the Designated Centre is in line with Regulation 8 (3) and Regulation 8(7) The Person In Charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse and shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

1. Centre specific classroom-based training will be completed with the team which will focus on Safeguarding and Protection. This training will cover identifying and recognising all types of abuse, reporting, and documenting all concerns and escalation of any potential concerns to Nua's Safeguarding Team. This training will be competency based and scenario-based training (Due 13th July 2023).

2. Nua's Designated Safeguarding Officer will visit the Centre on weekly bases commencing week beginning 12th of June 2023 to review all Safeguarding Plans with PIC and meet with individuals, when available. Nua's Safeguarding and Complaints Manager will support the Designated Safeguarding Officer to develop a Centre Specific Safeguarding Plan in relation to supporting staff practices in area of supporting Individuals (Due 13th July 2023).

3. Meeting to be held with the Safeguarding and Complaints Manager to review and enhance the current process for safeguarding notifications and to take in response from the National Safeguarding Team where the outcome of the preliminary screening submitted by Nua has been changed by the National Safeguarding Team. A revision of the process relating to where the National Safeguarding Team change the outcome of a screening will be implemented to ensure all outcomes are escalated to DOO who will in turn notify the Authority through a follow up process with the relevant notification code referenced (Due 16th June 2023).

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To demonstrate that the Designated Centre is in line with Regulation 9 (1), 9 (2)(e) and 9(3)The Registered Provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident and shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.

1. Behavioral Specialist in conjunction with the PIC will complete a review of each incident within the Centre on a weekly basis as part of the Governance Plan to identify

additional strategies to support Individuals. In addition, the Safety Intervention Trainers will conduct a review of all each occasion where physical restraint was implementation in 2023 to identify the learnings for the staff team on ensuring their adherence to Safety Intervention training in relation to the use of restraint as a last resort and used for the shortest period of time (Due 13th July 2023).

2. PIC to chair the Individual forums in line with the communication needs of the Individuals and implement a structured approach to meetings to ensure that the Individuals are consulted on key aspects of the running of the Centre. PIC to complete meeting minutes which provides evidence of the consultation with all Individuals (Due 13th July 2023).

3. PIC to connect with the Local Advocacy Service to get them to attend the Centre in relation to providing Individuals with information in relation to the Supports available to them through the Advocacy Service (Due 13th July 2023).

4. A Behavioral Specialist will attend the Centre on a weekly basis commencing week of the 12th of June to review Behavioral Support Plans where relevant or Section 5 of the Personal Plans for all Individuals. The Behavioral Specialist will conduct on the floor mentoring with staff to guide practice and enhance staff knowledge of Strategies and the process of conducting debriefs with the Individuals in line with their communication needs (Due 13th July 2023).

5. COO's will review the process within the Centre in relation to ascertaining the views of the Individuals to include Key working sessions, Individual forums and the application of the Happiness Service (Due 13th July 2023).

6. PIC and Risk Manager to complete a full review of all Individual Risk Management Plans (IRMP) and the Centre Specific Risk Register to ensure that the impact on Individual Rights is considered in relation to each restriction implemented within the Centre (Due 26th June 2023).

7. Centre Specific Training plan to be completed which will focus on importance of Individual Rights and ensuring that consultation with Individuals is completed (Due 13th July 2023).

8. Behavioral Specialist and Keyworkers to ensure that all Individuals have been consulted in relation to the proactive and reactive strategies within their Personal Plans section 5 and Behavioral Plans and that this is documented (Due 13th July 2023).

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	13/07/2023
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	13/07/2023
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance	Not Compliant	Orange	13/07/2023

	manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			
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	13/07/2023
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	13/07/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is	Not Compliant	Orange	13/07/2023

	challenging and to support residents to manage their behaviour.			
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	13/07/2023
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	13/07/2023
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	13/07/2023
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation,	Not Compliant	Orange	13/07/2023

	disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.			
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	13/07/2023
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	13/07/2023