Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Ravens Hill
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Westmeath
Type of inspection:	Announced
Date of inspection:	10 September 2024
Centre ID:	OSV-0008204
Fieldwork ID:	MON-0036367

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 10 September 2024	10:30hrs to 19:15hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

Overall, the inspector found from talking to a resident and observing some practices that the staff in the centre were kind, patient and treated residents in a respectful manner on the day of the inspection. While the inspector observed improvements in the quality of life for residents, the inspector was not assured that the governance and management arrangements were appropriate in respect of staff induction and training, the maintenance of records stored in the centre; staff supervision and some auditing practices. As a result the inspector was not assured that residents were receiving a safe service all of the time.

The purpose of this inspection was to monitor compliance and help inform a decision to renew the registration of the centre.This inspection was announced and so the residents had been informed that the inspection was taking place.

Over the course of the inspection, the inspector met the three residents living in the centre and spoke to one of them about what it was liked to live there. The inspector also met with a shift lead manager, the director of operations, a nurse employed in the organisation, a behaviour support specialist, the person in charge and two other staff who spoke about one of the residents' needs and some of the support practices in the centre.

The inspector also reviewed a sample of records pertaining to the quality and safety of care provided in the centre. Some of those records included a sample of residents' personal plans, risk management records, staff rosters and staff personnel files. The inspector also observed some interactions between residents and staff members.

On arrival to the centre, the three residents were in the middle of getting ready for the day. The inspector met with the person in charge to go through some questions about the quality and safety of care. Initially the inspector reviewed questionnaires which had been completed by two residents (with the support of staff) which highlighted a number of improvements. For example; the staff had recorded on behalf of the residents, that residents were not included in decisions around their care, were not able to make phone calls in private and were not informed about things that were happening in the centre. When the inspector followed up on this with the person in charge, the inspector was informed that this information was not correct. This was concerning and led to many other areas of improvement required in the management of records in this centre which will be discussed further in the next sections of this report.

One of the residents met with the inspector to talk about what it was like living in the centre. They said that were happy living there, but they had a long term plan to move to a more independent living arrangement. They explained how they were being supported with this by telling the inspector some of the goals they needed to reach before moving on to the next phase of their plan. The resident talked about

some of the allied health professionals supporting them with this plan. They were also going to an education hub which included courses on 'health and well being' and mathematics. The resident said they were enjoying this. They also informed the inspector that they were supported by staff to maintain links with their family members and said that this was something they wanted to do.

As stated at the last inspection, noise levels in the centre were an ongoing issue as they were impacting on other residents in the centre. The inspector observed on this inspection, that the centre was quiet and more relaxed than on the previous inspection.The resident said that since the last inspection, the provider had put in soundproofing which now meant that the noise levels were not affecting them. At the last inspection there had also been issues in terms of the impact of other residents behaviours of concern on others. The resident said that this was no longer an issue. The resident said that the staff were nice to them and that where they had a concern in the centre, they felt comfortable reporting the concern to the person in charge or other managers. They also explained what happened when they had raised a complaint and; how long it would take for the person in charge or assigned staff member to get back to them about the complaint. This assured the inspector that the resident was comfortable raising concerns.

The resident also showed the inspector around their apartment and informed the inspector they had got a new bed.

The centre was clean and well maintained. The maintenance in one apartment was an ongoing issue due to the complex needs of one resident who did not like strangers in their home. The person in charge ensured that when any maintenance was required in this apartment it was well planned for so as to reduce the resident's anxieties.

One of the apartments was specifically adapted to suit the needs of a resident. For example; the apartment contained limited pieces of furniture in line with the needs of the resident. Since the last inspection some murals had been painted on the wall to make the apartment more home like. The behaviour specialist informed the inspector that, the resident living in this apartment had managed their anxieties around this change in their environment well. In addition, while the inspector observed that this resident’s bed was constructed of a base with a mattress that did not fit the base of the bed, the behaviour specialist explained the reason for this. They outlined the likes and preferences in relation to this resident's sleeping arrangements and stated that the resident liked this sleeping arrangement at present and that any changes to their living space had to be done slowly to support the resident.

The other residents' apartments were well furnished and decorated in line with their preferences. The kitchen was large and well equipped. One resident showed the inspector around the kitchen and said they liked to make their own breakfast and liked to prepare some oven baked meals. On the evening of the inspection all of the residents and staff were having a pizza take-away and one resident seemed very happy with this.

Over the course of the inspection all three residents went out at some stage. For example; one went for a drive and another attended the education hub. At the time of the last inspection one of the residents had just started two days a week in a day service. However, since then the day service was closed and the person in charge was exploring other options for the resident.

The inspector met another resident for a short time before leaving the centre. The resident was relaxing watching their electronic tablet while waiting for their take-away. They showed the inspector their nails which they had recently had manicured and informed the inspector that one of the staff was very good at doing this.

One of the residents who did not like too many people in their living environment, was met outside when they were getting ready to go for a drive. The resident was supported by two staff members. The behaviour specialist went through some of the changes to the resident's care since the last inspection. The behaviour specialist outlined that there were some positive improvements to the resident's quality of life since the last inspection and the resident was engaging more with some activities. The resident was well dressed and was in the bus waiting to go for a drive. Interactions between the resident and staff were observed to be warm and friendly. The behaviour specialist also outlined that since the last inspection the team had reviewed the possibility of increasing the outside space for the resident as it was the enclosed garden was small. The behaviour specialist said that it had been agreed to do this on a slow phased basis, in line with the assessed needs of the resident.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of care and support provided to the residents.

Capacity and capability

As stated previously, this inspection was announced and was carried out to help inform a decision to renew the registration of the centre. The centre was last inspected in February 2024 and the actions arising from that inspection were followed up on.

In addition to this, following the last inspection the Health information and Quality Authority (HIQA) had received unsolicited information in relation to the governance and management of the centre, the availability of drivers in the centre and other practices in relation to staff employed in the centre. In response to these concerns, two provider assurance reports were issued from the office of the Chief Inspector to the provider. These reports were seeking further written assurances around how the provider was meeting the requirements of specific regulations or how they would address areas they may need to improve, if any were identified. The provider had submitted responses to the two assurance reports and had not identified any areas for improvement. As part of this inspection, those written assurances were also

followed up on.

Overall, the inspector found that improvements were required in the governance and management arrangements in this centre. In particular, the inspector was not assured from the perspective of the registered provider that their policies and practices in relation to the induction of staff, staff training and supervision; and the way in which residents information was maintained was assuring a safe service to the residents at all times. Improvements were also required in auditing practices.

There was a defined management structure in place consisting of a person in charge, shift lead managers and a director of operations. The inspector found that, the person in charge, staff team and the director of operations demonstrated a caring approach to the residents receiving care in this centre. However, the inspector found that a number of practices in the centre required improvement in relation to governance and management. For example; the assurance report submitted to HIQA in relation to staff training indicated that, all staff had centre specific training to meet the assessed needs of the residents in the centre. The inspector found that some of this training had not been provided to new staff who had been recruited in the centre since the last inspection.

At the last inspection, records stored in the centre required improvements. The inspector found that the registered provider needed to address this and therefore this is discussed under regulation 23, governance and management. The director of operations outlined some measures that the provider was taking to address this going forward.

At the time of the inspection there were sufficient staff rostered on duty every day to support the residents. However, records in relation to staff files and the induction and training of all staff needed improvements. This is also discussed under regulation 23 governance and management.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted an application to the chief inspector to renew the registration of the designated centre which included all of the documents that are required to be submitted with this application.

One improvement was required to the details recorded on the floor plans which were addressed by the registered provider in a timely manner.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was employed on a full time basis in the organisation.They were, an experienced social care professional with a qualification in management. They were also supported by two shift lead managers who had some managerial responsibilities. For example; shift leaders did some of the staff supervision.

The person in charge was found to be responsive to the inspection process and to meeting the requirements of the regulations. They had systems in place for the oversight and management of the designated centre in line with the providers policies and procedures.They were also aware of their legal remit under the regulations and provided good leadership to their staff team and ensured that staff were supported team meetings.

Judgment: Compliant

Regulation 15: Staffing

A review of a sample of rosters for one week in May, July and August 2024 showed that there were sufficient staff on duty to meet the needs of the residents. This review showed that a consistent team was employed in the centre unless there was planned/unplanned leave or where the provider was waiting to fill vacancies.

The numbers of staff employed each day were in line with the assessed needs of the residents at the time of the inspection. For example; there were six staff on duty each day and five staff on duty each night. Where there was unplanned leave/planned leave staff employed in the centre either completed extra shifts or relief staff were employed. The shift lead manager and the director operations confirmed that staff were only allowed work a specific amount of hours to comply with other legislative requirements. For example; that staff had appropriate rest breaks before driving a vehicle.

However, as discussed under regulation 23 the registered provider needed to review the induction and training provided to new staff to ensure they had the appropriate skills to meet the needs of the residents in this centre. Therefore at the time of this inspection the inspector was not assured that staff had all of the skills and knowledge required to support the residents with all of their needs. This was actioned under governance and management in this report.

The human resource department managed and maintained the records required to be stored on staff personnel files as required under the regulations. The person in charge does not have access to these files. The inspector reviewed three staff personnel files for staff who had been employed in the centre since the beginning of 2024. The inspector found that all staff had up to date Garda vetting in place. However, the employment record for two of the staff were not correct. For example; the dates on one staff members file indicated that they were employed in two different countries at the same time. This was alerted to the director of operations on the day of the inspection. This is actioned under regulation 23 as the person in

charge did not have access to these records.

Judgment: Compliant

Regulation 22: Insurance

The provider had submitted up-to-date insurance details as part of the application to renew the registration of the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

There was a defined management structure in the centre led by a competent person in charge, who reported to an experienced and competent director of operations. Both of these managers demonstrated a very good knowledge of the residents needs. The registered provider also employed a number of key personnel in the organisation to oversee and improve practices. As an example; there was a staff member employed in the wider organisation to manage and review safeguarding concerns.

However, the inspector found that a number of improvements were required in this inspection were related to the registered providers systems which were not effectively ensuring a safe service to residents at all times. For example; as outlined the inspector was not assured that the registered policies and practices in relation to the induction of staff, staff training and supervision; and the way in which residents information was maintained was assuring a safe service to the residents at all times. Improvements were also required in auditing practices to ensure that learning from those audits was being consistently applied.

At the time of the last inspection the registered provider was required to make improvements in the management of records in the centre. Again on this inspection, the inspector found that a number of improvements were required in records maintained, for example; residents personal plans and governance and management records which included staff personnel files.

In relation to residents personal plans, audits conducted by the provider continued to highlight areas of improvement. The improvements were pertaining to staff not completing the appropriate daily records or monitoring charts on a consistent basis pertaining to the residents required support needs was outlined in their personal plans. For example, it had been highlighted in the minutes of meetings in June 2024 and August 2024, that staff were not completing the appropriate daily records pertaining to supports in residents' personal plans each day. However, there had

been no review by the provider to address why this issue kept arising in the centre. In addition to this, the inspector noted a number of inconsistencies in the records stored in relation to residents and the governance and management of the centre that could pose a risk to residents. For example; hand over logs maintained in the centre contained inconsistent information around the residents' needs.

This was concerning as inconsistent information in residents plans could lead to the incorrect support being provided to the residents. For example; the registered providers induction process included that, all staff read and understand the personal plans prior to working in the centre. If this information was incorrect or inconsistent then this could lead to errors occurring.

The inspector also found that where changes did occur in the residents support needs that this was not always recorded in the personal plans including risk management plans. As an example; the inspector observed that some staff were not wearing appropriate personal protective equipment to support one resident. When the inspector followed up on this to see where staff had been informed of this need, they were informed that this was recorded in the handover logs for staff. The inspector could not find any evidence of this in the records viewed. The risk management plan for the resident also did not reflect the changes to this practice.

In relation to staff files, the human resource department managed and maintained the records required to be stored on staff personnel files (as required under the regulations). The inspector reviewed three staff personnel files for staff who had been employed in the centre since the beginning of 2024. The inspector found that all staff had up to date Garda vetting in place. However, the employment record for two of the staff was not correct. For example; the dates on one staff members file indicated that they were employed in two different countries at the same time. This was alerted to the director of operations on the day of the inspection

The registered provider also had governance and management arrangements in the centre to identify areas of practice that required improvement. For example, over the course of three months according to the records provided to the inspector there were over 100 medicine errors recorded in the centre. A large majority of those related to staff not signing that they had administered medicines in a timely manner. However, some were assessed as a level 3 (meaning the error had reached the resident). As a result a nurse who is employed in the wider organisation conducted an assessment of the medicine management practices in the centre. The nurse had attended the last staff meeting to discuss medicine management practices with staff. However, the inspector was not satisfied that this additional support had been provided in a timely manner given that for each of three preceding months over 30 medicine records had been noted each month.

HIQA had also been notified prior to the inspection that some adverse events had not been reported to the regulator as required. This had been highlighted at a recent six monthly audit of the centre and included restrictive practices and safeguarding concerns. This did not provide assurances around the review and oversight of adverse events in the centre.

The provider had systems in place for staff to receive supervision twice a year. However, this required review. The inspector reviewed a sample of these records. Some supervision records were stored in a sealed signed envelope and others were not. One of the records had highlighted a number of concerns by a staff member in relation to potential risks working with a particular resident, the ability to raise concerns to senior managers and a fire safety risk. The inspector followed up with the person in charge and the director of operations regarding the concerns raised. The person in charge and the director of operations were not aware of the information stored in this record and explained that the policy of the organisation was that supervision records were not shared with managers. Instead the person responsible for completing the supervision in this case, the shift lead manager was required to inform the person in charge. This had not happened. The inspector was not assured that this practice was assuring that where staff raised concerns in the centre that they would be addressed.

At the time of the last inspection the provider had implemented improvements to the governance and management arrangements which included additional staff training to ensure that staff had the skills and knowledge to support the residents' needs. The second assurance report submitted to HIQA on 05 June 2024, indicated that all staff had been provided with centre specific training to meet the specific needs of the residents. This was not completed in full with all new staff as indicated by the person in charge on the day of the inspection. As well as this some staff had not completed training for a rescue medicine that two residents may require because of epilepsy.

As part of the provider assurances submitted, they had stated that the staff had the necessary skills to support the residents. For example; the report stated that all staff complete a four day induction training prior to working in the centre.

When new staff commenced in the centre they were allocated four hours protected time to meet with the person in charge or designated person. This protected time facilitated an opportunity for new team members to be briefed, read residents files and provided them with an opportunity to ask questions. This was to ensure they were familiar with residents needs prior to commencing work in the designated centre. This included, personal plans, behaviour support plans, individual risk management plans and others if time allowed. Staff were also required to review three specific policies in relation to control and restraint, property damage and absconding.

At the end of the four hours the person in charge or designated person engages in a question and answers session to confirm transfer of knowledge. An induction form was then completed by the staff member following this process.

However, the inspector found that the each resident’s plans which include risk management plans, and multi-element behaviour support plans was recorded in four separate plans and each one containing a large amount of information. As part of the induction, the staff member was also required to review three specific policies in relation to control and restraint, property damage and absconding. The inspector was not assured that the time allocated to complete this was adequate given the

amount of information included on the induction form. In addition to this it stated on the form that staff should complete ligature risk training where a resident had an identified need, some staff had not completed this.

The inspector also found that staff were allocated the same induction process and times regardless of whether the staff had experience and qualifications or not prior to working in the designated centre. Given the needs of the residents (some of which were complex) the inspector was not assured that this was appropriate particularly if staff had no experience or qualifications working with people with disabilities prior to working in the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed by the inspector and found to meet the requirements of the regulations.

This document detailed the aim and objectives of the service and the facilities and services to be provided to the residents. For example, it set out how a new resident would be admitted to the centre, the complaints procedure and how residents privacy and dignity was maintained in the centre.

The provider and person in charge was aware of the requirement to review and update the statement of purpose on an annual basis (or sooner), as required by the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The registered provider had not ensured that, the chief inspector was notified of all adverse incidents which had occurred in the centre since the last inspection in line with the time frames outlined in the regulations. This included four safeguarding concerns which had been notified to other relevant authorities and the number of restrictive practices employed in the centre.

Judgment: Not compliant

Quality and safety

Overall while residents appeared happy in the centre on the day of the inspection and one resident reported improvements to their quality of life since the last inspection, some improvements were required in general welfare and development and risk management.

The inspector followed up on the actions from the last inspection and found that the provider had, either addressed the areas identified for improvements or was still reviewing some of the actions based on the needs of one resident.

A review of a sample of records pertaining to risk management informed the inspector that improvements were required in this area. For example; what was included in the risk management plan was not always the practice in the centre.

Residents were supported to maintain links with their families in line with their preferences. Since the last inspection one resident had enrolled in a new course.

Despite the shortage of available drivers in the centre, the person in charge planned the roster so that a driver was on duty to facilitate residents meeting their family. However, the lack of availability of drivers remained an issue at the time of this inspection even though the provider was trying to take steps to address this. This meant that residents being able to access the community was an issue some days.

The premises was for the most part clean and well maintained. Each resident had their own self contained apartment and had access to kitchen facilities and a communal sitting room. One resident did not have access to the kitchen, notwithstanding that, this is not in line with the requirements under the regulations, it was in line with the residents assessed needs at the time of the inspection.

Regulation 13: General welfare and development

Over the course of the inspection all three residents went out at some stage. For example; one went for a drive and another attended the education hub. At the time of the last inspection one of the residents had just started two days a week in a day service. However, since then the day service was closed and the person in charge was exploring other options for the resident. Notwithstanding the registered provider needed to address this going forward to ensure that, all residents had access to facilities for occupation and recreation.

At the time of the inspection, there was a shortfall of drivers in the centre, this impacted on the residents being able to go out on planned activities. For example; a resident told the inspector the day before the inspection, they had to wait till the afternoon to go out as another resident needed the bus. The resident said that,

while taxis were offered as an alternative when this happened it did not happen everyday. The person in charge and director of operations were trying to manage this with the current resources based on priority needs. For example; two of the residents went home to visit family and so a driver was always on duty those days.

However, the registered provider needed to address this going forward.This was particularly important as there was no town within a safe walking distance from the centre and therefore transport was essential to ensure that residents had opportunities to participate in activities in accordance with their interests.

Judgment: Substantially compliant

Regulation 17: Premises

At the last inspection one residents bathroom required maintenance work to be carried out. This had been completed.

The centre was well maintained and clean. The maintenance in one apartment was an ongoing issue due to the complex needs of one resident who did not like strangers in their home. The person in charge ensured that and maintenance required was well planned so as to reduce the resident's anxieties.

One of the apartments was specifically adapted to suit the needs of a resident. For example; the apartment contained limited pieces of furniture in line with the needs of the resident at the time of the inspection. Since the last inspection some murals had been painted on the wall to make the apartment more home like. The behaviour specialist informed the inspector that the resident has managed this change in their environment well. The inspector observed that this resident's bed was constructed of a base with a mattress that did not fit the base of the bed, however the behaviour specialist explained the reason for this. The behaviour specialist explained the likes and preferences in relation to this residents sleeping arrangements and advised the inspector that the resident liked this sleeping arrangement at present and that any changes to the residents living space had to be done slowly.

The other residents' apartments were well furnished and decorated in line with the residents' preferences. The kitchen was large and well equipped. A resident showed the inspector this and informed them that they liked to to make their own breakfast and liked to prepare some oven baked meals.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had prepared in writing a guide in respect of the designated

centre. This guide was available to the residents and included a summary of the services to be provided.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector found from reviewing a sample of incidents and risk management plans that improvements were required in the response to incidents and the details contained in residents risk management plans. This was concerning as reading residents risk management plans formed part of the induction for all new staff. The registered provider also employed relief staff in the centre and therefore if the information in these records were not accurate then this could pose a risk to the residents and staff.

For example; as outlined earlier the inspector observed that staff were not wearing some personal protective equipment (PPE)when they were supporting a resident. The person in charge informed the inspector that all staff had received information in relation to this requirement. However, the risk management plan for the resident did not include the requirement for staff to wear this particular piece of PPE. The inspector also found that some other risk management plans contained inconsistent information as discussed under regulation 23 of this report.

Judgment: Substantially compliant

Regulation 8: Protection

The inspector followed up on the actions from the last inspection and found that the registered provider had conducted a comprehensive needs assessment for each of the residents. One of the residents said that they now had a plan in place to move to a more independent setting which they were happy about.

A number of safeguarding concerns had also been reported in the centre since the last inspection. As noted under regulation 31; some of these had not been notified to HIQA in a timely manner. Notwithstanding this the person in charge and the registered provider had notified other relevant stakeholders when these incidents had occurred. They had also introduced safeguarding measures to mitigate risks which included the safeguarding officer attending the centre to speak to residents concerned. One resident who spoke to the inspector said that they felt safe in the centre and provided an example to the inspector about a concern that they had reported to staff and the person in charge where they were not satisfied with some aspects of the service.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector followed up on the actions from the last inspection in relation to this regulation.

At the last inspection it had been observed that the noise levels in the centre were impacting on the rights of other residents in the centre. Since then the provider had put soundproofing measure in place that had resulted in marked improvements. One of the residents who spoke to the inspector informed them that they were happy with this now and were no longer affected by the noise of other residents in the centre at the time of this inspection.

At the last inspection it had also been observed that the living arrangements for one resident needed to be reviewed as the outside space was very limited. The inspector spoke to the behaviour specialist about this and the person in charge. They assured the inspector that the registered provider was still reviewing this and no actions had been implemented to date as any changes in the residents environment needed to carefully thought out and done on a phased basis. The inspector was therefore assured that while this improvement was still under review at the time of this inspection, the registered provider was addressing it going forward.

As noted earlier in the report some improvements had been made to the interior of one residents apartment which made it more homely looking.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ravens Hill OSV-0008204

Inspection ID: MON-0036367

Date of inspection: 10/09/2024

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:
The Registered Provider and the Person in Charge shall ensure that the following actions are taken regarding the management systems in place in the designated Centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored, in the following ways,

Personal Plans

1. The Person in Charge (PIC) shall ensure a weekly review is completed of daily handover logs by Centre management for accuracy and relevance.

2. The PIC shall conduct a professionals meeting with the Behavioral Specialist to review Individuals' therapeutic supports, approaches and where required update plans as necessary to reflect the assessed needs and recommendations. The Behavioural Specialists will assist in developing Behavioural strategies, reviewing and monitoring Personal Plans, and providing training on best practices, where required.

3. The PIC shall assign Key Workers to each Individual, who will develop and support the Individuals Personal Plan. The assigned keyworker will attend additional key working training.

4. The PIC will conduct a thorough review of each Individual's Personal Plan to ensure it aligns with controls and recommendations from their Individual Risk Management Plans and MEBSP.

5. The Provider will ensure that the continuous monitoring system to maintain the accuracy and documentation of Individuals' Personal Plans are being implemented by the PIC, to ensure they are regularly updated and reflective of current needs and recommendations. This shall ensure the continuous review and improvement of Personal

Plans with the support from the Administration Department (Weekly/ Monthly), Behavioral Specialists (Quarterly) and Quality Assurance Team (6-Monthly and/or as per their support schedule).

Medication Management

1. The PIC will ensure the Medication Kardex and MARS sheets are checked twice daily by Centre management on site and confirm to the Director of Operations a review has been conducted and all errors have been noted and documented where required.

2. The Provider shall ensure a Clinical Nurse conducts an on-site support review of medication management practices in the Centre. The purpose of the on-site review shall be to,

a) Conduct a review of medication practices by Team Members in line with the Centre's policy and procedure on safe administration of medication practices,
b) Provide a report on their findings and reasons for medication errors occurring,
c) Identify opportunities for improvement in medication practices.

3. Following the review, the Clinical Nurse shall present their findings to the Provider and the Director of Operations in conjunction with Nua's Quality Assurance Team shall adopt a 'Plan, Do, Check, Act' (PDCA) approach and develop a Quality Improvement Plan, through management and supervisory practices, and training and education on safe administration of medication practices.

4. For Team Members with frequent medication errors, the Director of Operations shall implement in line with policy, the self-reflection session using the Gibbs Reflection Cycle with the assigned Clinical Nurse. This session will review best practices, adherence to policies, and procedures. If needed, a development plan will be created to provide the necessary support and resources for upskilling.

Health Needs

1. The PIC shall ensure Team Members are scheduled to attend training for the administration of rescue medication to ensure that there is an adequate number of Team Members trained on shift to support the Individual until all Team Members have completed this training.

Safeguarding & Protection

1. In line with Policy and Procedure on Safeguarding Vulnerable Persons from Abuse and Responding to Safeguarding Concerns [PL-C-001] - Any incident / act of abuse must be recorded immediately, on Day 1. Safeguarding concerns may be reported on through the incident reporting pathway, significant conversation document, family contact, key working session, complaint.

2. All Team Members have been scheduled to complete Safeguarding Refresher Training and training on the appropriate reporting procedures/ documents.

3. Communication on reporting any safeguarding concerns shall be added to the handover log by the PIC to ensure attention and focus on incidents or significant conversations that may give rise to suspect, alleged or confirm cases of abuse.

4. The PIC shall conduct a review of any significant daily conversations recorded by Team Members to ensure that any suspect, alleged or confirmed cases of abuse is reported, escalated and responded to, in line with the Centre's policy and reporting procedures.

Notifications of Incidents

1. The PIC will ensure that all significant conversation forms completed are reviewed by management and where required, safeguarding or follow-up complaints will be undertaken.

2. Quarterly notifications will be reviewed by the Behavioural specialist in addition to the PIC prior to submission each quarter, ensuring they are reflective of all restrictive practices in place in the Centre.

Training and Development

1. The Director of Operations shall ensure the relevant Centre Managers are enrolled in the next scheduled Supervision training.

2. The Director of Operations shall conduct a review of the Policy and Procedure on Supervision to ensure that appropriate monitoring systems are implemented to assess the quality of supervision records and any actions taken, to ensure actions identified during supervision are addressed in line with agreed timeframes.

Note: The PIC is ultimately responsible for the security of supervision files and in line with the Centre's policy on Supervision is the only person with access to these files.

Note: The PIC and Director of Operations will oversee the quality of supervision records and shall ensure that any actions identified during supervision are taken in line with agreed timeframes.

3. The Provider shall ensure that adherence and implementation of the Centre's Policy and Procedure on Supervision is monitored through Nua's Quality Assurance Team and relevant auditing checks.

4. To strengthen the accountability for work practices carried out in the Centre, the roles and responsibilities of each team member will be reviewed to ensure that:
a) There is absolute clarity in relation to the expectations and responsibilities of their roles.
b) The Director of Operations (DOO) will go through the Key task list with the Person in Charge (PIC) and the Management team within the Centre to ensure all management are aware of their roles and responsibilities.
c) All new team members complete an Orientation Training Programme on

commencement of employment. The Orientation Training Programme has been developed to meet the needs of the relevant centre/department the team member will be assigned to.

5. Overseen by the Director of Operations, the PIC shall ensure Team Members who require relevant training in line with Individuals assessed needs are scheduled for the next training session as per plan. This includes but not limited to, Keyworker training, ligature training, rescue medication training etc.,

6. Overseen by the Director of Operations and by the PIC, they shall ensure new Team Members that are introduced into the Centre have adequate protected time to read insofar as is possible, all documentation on the day of induction, and are afforded time to read relevant plans prior to commencing work with Individuals.

Note: Should it arise that new Team Members that have not reviewed the necessary documentation within the allocated protected and/or based on their level of experience, the PIC shall ensure an appropriate development plan, using the on-the-floor-on-the-job mentoring form, will be created to provide the necessary support and resources for upskilling as part of their continuous professional development programme.

7. The Director of Operations will ensure a full audit is completed on all Team Member files by the HR department and a report provided to confirm compliance and any nonconformities.

Note: All the above points shall be discussed with all Team Members by the PIC and Director of Operations at the next monthly team meeting.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. The PIC will ensure that all significant conversation forms completed are reviewed by management and where required, safeguarding or follow-up complaints will be undertaken.

2. Quarterly notifications will be reviewed by the Behavioural specialist in addition to the PIC prior to submission each quarter, ensuring they are reflective of all restrictive practices in place in the Centre.

3. All the above points shall be discussed with all Team Members by the PIC at the next monthly team meeting on or before 30 November 2024.

Note: All the above points shall be discussed with all Team Members by the PIC and Director of Operations at the next monthly team meeting.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
1. The PIC will conduct a weekly review of the requirement for drivers and where required, additional drivers will be allocated to assist with community access as per Individual's plans. The Director of Operations and Recruitment manager will review weekly the number of drivers in Ravens Hill and allocate additional resources as required.

2. The PIC will complete a review of Individual's weekly activity planners in conjunction with the roster for the following week each Friday and implement a plan to ensure everyone can access the community in line with their activity planner.

Note: All the above points shall be discussed with all Team Members by the PIC and Director of Operations at the next monthly team meeting.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The PIC shall complete a full review of all Individual Risk Management Plans (IRMP's) to ensure all controls are appropriately captured and documented. The PIC will also ensure they have appropriate systems in place for the ongoing monitoring and reviewing of IRMP's. Following this, the Risk Summary document will be updated to ensure all high risks and associated controls are in line with IRMP's and discussed with the staff team at the handover meeting daily.

2. Any changes to PPE requirements for Individuals will be updated immediately on change of the control measures identified within an MEBSP by the PIC.

3. Any amendments to the Individual Risk Management Plans will be communicated to team members via the handover log by the Person in Charge.

Note: All the above points shall be discussed with all Team Members by the PIC and Director of Operations at the next monthly team meeting.

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	30/11/2024
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/11/2024
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'	Not Compliant	Orange	30/11/2024

	needs, consistent and effectively monitored.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	30/11/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/11/2024
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	30/11/2024
Regulation 31(3)(a)	The person in charge shall ensure that a written report is	Substantially Compliant	Yellow	30/11/2024

	provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			