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:	Bethany House
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	30 April 2024
Centre ID:	OSV-0008220
Fieldwork ID:	MON-0043499

About the designated centre

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

This is a service that can provide care and support to four adults with disabilities. It is situated in rural setting in Co. Westmeath and comprises of a large detached house. Within that house there are three large ensuite bedrooms, a large fully furnished kitchen/dining room/sitting room area, a separate sitting room and a one bedroomed self-contained apartment. Transport is provided so as the residents can avail of drives, social outings and attend appointments. There are large well-maintained garden areas to the front and side of the property that include the provision of ample private car parking space. The house is staffed on a 24/7 basis by a person in charge, two shift leader managers and a team of assistant support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 30 April 2024	08:30hrs to 16:40hrs	Anna Doyle	Lead
Tuesday 30 April 2024	08:30hrs to 16:40hrs	Raymond Lynch	Support

What residents told us and what inspectors observed

This unannounced risk inspection was conducted due to the number of notifications submitted to the office of the Chief Inspector in relation to adverse incidents regarding safeguarding within the last year. This inspection was focused on a number of specific regulations to include : governance and management, staffing, staff training, protection, risk management and health care.

Overall, the inspectors found that, the care and support being provided to the residents in this centre was person centred and that where adverse incidents occurred, the person in charge took actions to address the issues identified. Notwithstanding, some improvements were required in medicine management practices, records and staff training.

During the inspection, the inspectors met three of the residents, (one resident did not wish to meet with inspectors), met with two staff and spoke to other staff over the course of the inspection when observing practices. Inspectors also met with the shift lead manager, the person in charge and the director of operations. They also reviewed personal plans pertaining to residents health care needs; records pertaining to the governance and management of the centre, staff files and rotas, training records, risk management and safeguarding.

On arrival to the centre, one of the residents was already up, and the others were in bed. One staff was administering some of the morning medicines and the other staff was supporting the resident who was already up. The day staff team began arriving to the centre from this time onwards. The day started in the centre with a daily handover between day staff and night staff. This daily handover which was recorded on a log and included details of critical issues that were happening in the centre over the last number of days. This ensured that staff who had been on leave were kept informed of critical events that they needed to be aware of to inform consistency of care. This handover log also included the staff members names and details of who was working that day and who would be assigned responsibility to manage the shift.

Some staff on duty had only recently started working in the centre. During the opening meeting with the person in charge they provided an outline of the induction process which included staff working alongside experienced staff and a system for reviewing records pertaining to the care and support of the residents. The inspectors observed on the day of the inspection that these practices were being adhered to as the shift lead manager had assigned staff to read records or work with more experienced staff. Notwithstanding, inspectors found based on the nature of safeguarding incidents being submitted, that the induction process for some staff needed to be reviewed to ensure they had the skills to meet the assessed needs of the residents. This is discussed under staffing in the next section of this report.

The centre was well maintained, clean and homely. Each resident had their own

bedroom which had an en-suite bathroom and one resident had a self contained apartment. There was a large well equipped kitchen/dining room with a small seating area off this. Throughout the course of the inspection, residents were observed sitting talking to staff around the kitchen table and some of them were making plans for the day.

The resident living in the apartment appeared in good form, smiled and shook the inspectors hand. They were cleaning their bedroom (with staff support) and seemed to enjoy this activity. Their apartment was decorated to suit their individual style and preference. The resident had plans made to go shopping later in the day as they wanted to buy a new crockery set and some new glasses. Up to that point the resident had been required to use plastic crockery and glasses due to identified risks. This was a good example of how restrictive practices were being reviewed in the centre to ensure that the least restrictive measure was being used. The resident was very happy about going on this shopping trip.

The resident also said that they wanted to go on holidays in July of this year and named a number of specific counties in Ireland that they wanted to visit.They also had plans to go home next month to celebrate their birthday with their family. Maintaining connections with family was also an integral part of the services provided and the person in charge provided examples of some family members visiting the centre on a regular basis or staff driving residents home to for weekend visits. The inspectors observed that staff were very familiar with the communication preferences of the resident and the resident appeared at all times relaxed and comfortable in the company and presence of staff. Additionally, staff were also kind, caring, and person centred in their interactions with the resident.

The inspectors met with another resident briefly before they left the centre to attend an appointment. They said that they were happy in the house and were looking forward to the summer months ahead. They too appeared happy and content in their home. On return from their appointment they were observed sitting in the sun room area with the cat asleep beside them when the inspectors were leaving the centre.

One of the residents wished to talk to the inspector in their bedroom as they did not like talking about things in the communal areas of the home. This was very important to the resident and all staff were aware of this. The resident chatted for a while about their life experiences and about some of the supports that were in place in the centre. It was evident from talking to the resident that they were involved and included in key decisions about their health care needs and talked about some of the appointments they attended. When asked by the inspector if they liked living in the centre, they said yes and that the person in charge was very supportive.

The staff were observed offering choices to the residents during the day about things they might like to do. They were observed discussing options and offering alternatives to residents when they asked about options that they did not like.

One resident who did not wish to meet with inspectors loved animals and had two dogs and a cat. This resident was observed outside with their animals tending to

them in an area designed in the garden specifically for the dogs.

Two compliments from a family representatives on the quality of care provided in the service was also viewed by the inspectors. They reported that they were delighted that their relative was looking well, focused on engaging in all the things that they liked to do and expressed their gratitude to both management and staff.

A review of one residents meeting which took place on April 28, 2024 also informed that residents were happy in their home. For example, residents were asked at that meeting were they happy in the house and they all report that they were with one stating that it was beautiful.

Residents were engaged in meaningful activities in line with their personal preferences. One resident had a job which they liked. Some residents liked to choose activities they wanted to do on a daily/ weekly basis.

There had been some issues regarding compatibility of residents living together in the centre which had resulted in some safeguarding incidents been reported to HIQA. The inspectors observed from records that all incidents were reported as required. The registered provider had also instigated measures to try and build and support relationships with residents to see if the compatibility issues may be resolved. For example; residents who had similar interests were asked if they would like to go to activities or events together as a way of building relationships. The person in charge was collating information to review if this was having any impact for the residents.

The registered provider was also looking at developing a positive risk management plan that would enable one resident independence to walk to the local shops. This is something the resident enjoyed doing and had been independent in doing prior to coming to this centre. This was another good example of how the registered provider and person in charge were promoting the rights of the person and reviewing and responding to practices that no longer posed a risk to the resident.

The next two section of the report present the findings of this inspection in relation to the governance and management arrangements and how these arrangements impacted the quality of care and support being provided to residents.

Capacity and capability

Overall, the inspectors found that the centre was managed by a competent person in charge who ensured that person centred care was provided to the residents living here. The registered provider was responding to safeguarding concerns in the centre when they were reported. Notwithstanding, inspectors were not assured on review of some of the information included in the adverse incidents reported to HIQA that all staff were provided with appropriate induction training based on their experience/qualifications prior to starting work in the centre. Improvements were

also required in medicine management practices and records stored in the centre.

As outlined earlier in this report, this inspection was conducted due to the level of notifications pertaining to safeguarding incidents being submitted to HIQA, a number of which related to staff practices in the centre. In January 2024, the provider was requested to submit assurances via a provider assurance report around a number of regulations pertaining to the governance and management of the centre and safeguarding concerns. (A provider assurance report is issued to providers to seek assurances that, the registered provider is managing risks in the centre and requires the provider to review the systems they have in place to ensure they are meeting the requirements of the regulations. The registered provider, following their review sometimes outline improvements they are going to implement going forward). At that time the provider submitted a comprehensive assurance report outlining how they were meeting the requirements of the regulations, which included seven actions they were going to take to ensure ongoing compliance with the regulations. The assurances in this report and the actions outlined were followed up as part of this inspection. The inspectors found that all of the actions had been implemented.

The inspectors found that there was clearly defined management structures in the centre which included systems to respond to and manage adverse incidents that were occurring in the centre in relation to safeguarding residents and risk management.

The person in charge, shift lead manager and the staff met on inspection were knowledgeable around the resident's needs and individual preferences. The registered provider was implementing learning from ongoing safeguarding concerns being reported in the centre to include refresher training for staff in safeguarding and residents' specific needs.

A review of a sample of rosters indicated that there were sufficient staff on duty to meet the needs of the residents as described by the person in charge and statement of purpose. However, some improvements were required in the induction process for new staff starting in the centre as the inspectors were not assured that the skill mix of staff was appropriate to meet the assessed needs of the residents at all times.

Staff spoken with had a good knowledge of residents' individual care plans. Additionally, from a sample of training records viewed, the inspectors found that staff were provided a number of training modules so as to ensure they had the necessary skills to respond to the needs of the residents.

Regulation 14: Persons in charge

The person in charge met the requirements of S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and

Adults) with Disabilities) Regulations 2013 (the Regulations).

They were a qualified social care professional with an additional management qualification and were found to be aware of their legal remit to the regulations and were responsive to the inspection process. They demonstrated a person centred approach to care and knew the residents very well. The records reviewed indicated when a resident raised a concern, the person in charge met with them, provided support to the resident and outlined how they were going to manage the concerns for the resident.

They had systems in place for the supervision of their staff team and were aware of the assessed needs of the residents.

They also ensured that staff meeting were facilitated. A review of the minutes of a staff meeting held on March 03, 2024 informed that items such as health and safety, and residents overall health and well being formed part of the agenda.

The person in charge was also responsible for another designated centre operated by the registered provider. In order to maintain oversight of this centre, two shift lead managers were assigned each day to oversee the care and support provided.

At the time of this inspection, the inspectors found that this was not impacting on the care and support being provided in the centre.

Judgment: Compliant

Regulation 15: Staffing

The inspectors were not assured that the skill mix of staff was appropriate to the assessed needs of the residents at all times. Some of the notifications submitted to HIQA regarding safeguarding concerns related to, staff members not ensuring that resident's core human rights issues were being upheld and the actions of some staff were not contributing to developing therapeutic relationships with residents. As a result the inspectors reviewed the induction process for staff part of which included a review of staff files. Inspectors found that while all of the staff recently employed in the centre had either completed accredited qualifications or had experience working with people with disabilities prior to taking up employment in the centre. In addition, some staff previously employed had no qualifications or experience prior to taking up employment.

Over the last number of months there had been a high turnover of staff in the centre, on the day of the inspection four new staff had started over the preceding three weeks. The person in charge and the director of operations gave an outline of how new staff were inducted to work in the organisation and the centre. At the time of the inspection there was one staff vacancy however, the person in charge had consistent relief staff employed to ensure consistency of care to the residents in the

centre.

The inspectors reviewed the induction process for all staff who started employment in the centre and found that regardless of the experience or qualifications of staff, they all received the same level of induction. Given the information reviewed in some of the notifications received, inspectors were not assured that the induction training provided included sufficient training to ensure that residents core human rights of fairness, respect, equality, dignity and autonomy were upheld by staff. This included staff being aware of the importance of developing therapeutic relationship with residents to ensure residents felt safe and secure in their environment. This was particularly important for staff who had no experience of working with people with disabilities some of whom also had complex needs. The inspectors were assured from talking to a senior manager the day after the inspection that this was something the registered provider was reviewing currently.

The inspectors reviewed three staff files on the day of this inspection and found that the centre was maintaining relevant information and documents as specified in Schedule 2 of the Regulations.

A planned and actual rota was maintained in the centre. Some minor improvements were required to ensure that the records were easily accessible. For example; in order to find out who worked a specific shift a number of records had to be reviewed on different computer systems to get the accurate records. This was discussed with the person in charge who intended to address this and therefore the inspectors were satisfied with this.

The director of operations was a qualified nurse and so could provide support to staff for residents specific health care needs. A 24 hours on call service was also available for staff should a manager not be present in the centre which ensured staff had management support at all times should the need arise.

Judgment: Substantially compliant

Regulation 16: Training and staff development

From a sample of training records viewed, the inspectors found that staff were provided with the required mandatory training to ensure they had the necessary skills to respond to the needs of the residents. Notwithstanding as discussed under staffing some improvements were required.

For example, from three staff files viewed, it was observed that they had undertaken a number of training modules which included:

- safeguarding of vulnerable adults
- children's first
- fire safety
- basic first aid

- manual handling
- protection and welfare
- food hygiene
- hand hygiene
- provision of intimate care
- training in autism
- blood pressure
- personal protective equipment
- the safe administration of medicines
- managing behaviours of concern and safety interventions.

Staff had also been provided with on site training some of which included training on:

- specific mental health needs relevant to the residents they were supporting
- report writing
- the escalation process
- refresher safeguarding training (on three occasions over the last year)
- restrictive practices.

In addition to this as discussed earlier a training needs analysis had been conducted which identified further training for staff some of which included human rights, refresher safeguarding and the safe administration of medicines. This was due to take place in May 2024.

Two staff members who were on duty during the inspection demonstrated they had the required knowledge to meet the needs of the residents. For example; one staff member outlined how to support a resident who had a specific health care condition which required monitoring. The staff member was able to outline when the resident could require further medical attention.

Judgment: Compliant

Regulation 21: Records

There was a large volume of records stored in the centre in relation to the care and support of the residents and governance and management records. One the day of the inspection some of the records viewed did not include the dates for when meetings/plans had started. For example; the centre specific safeguarding plan had no date included for when it was formulated.

The inspectors were informed that the registered provider was commencing a service improvement initiative to look at streamlining some of the paper work and records stored in the centre going forward.

Judgment: Substantially compliant

Regulation 23: Governance and management

On the day of this inspection there were clear lines of authority and accountability in this service.

The centre had a clearly defined management structure in place which was led by an experienced and qualified person in charge. They were supported in their role by two shift lead managers. Additionally, a director of operations provided regular support to the management team of the centre.

The designated centre was being audited as required by the regulations and an annual review of the service had been complete for 2023 along with a six monthly unannounced visit to the centre in November 2023.

These audits identified any issues in the service along with a plan of action to address those issues in a timely manner.

For example, the auditing processes identified the following:

- the person in charge was to ensure that weekly health and safety checks were being completed and actions arising from same addressed
- all staff were to complete training in the management of behaviour of concern
- consent forms for the use of restrictive practices were to be signed annually.

These issues had been identified, actioned and addressed by the time of this inspection

The registered provider had also implemented a number of strategies to monitor and review safeguarding concerns being reported in the centre. For example; a root cause analysis had been conducted in relation to the high number of safeguarding concerns that had occurred in the centre this identified that more training was required for staff. Other actions taken by the provider are discussed under regulation 8 of this report.

Judgment: Compliant

Quality and safety

Overall this inspection found that the residents met with appeared happy and content in their home, however, some improvements were required in medicine

management practices.

On the day of this inspection, residents were being supported with the healthcare needs and had access to a wide range of allied health professionals to support them with their emotional and physical wellbeing.

Systems were in place to safeguard the residents to include policies, procedures and reporting structures. The registered provider was addressing safeguarding concerns in the centre and as stated earlier in this report had implemented all of the actions they had submitted as part of their provider assurance report to HIQA in January 2024.

Systems were also in place to manage and mitigate risk and keep residents safe in the centre. The inspectors also observed that one resident was being supported to take increase their independence following an incident in the centre.

Medicine management systems in place required some improvements on the day of the inspection. For example a medicine protocol needed to be reviewed to ensure that it guided practice.

Regulation 26: Risk management procedures

Systems were in place to manage and mitigate risk and keep residents safe in the centre.

There was a policy on risk management and each resident had a number of individual risk management plans on file so as to support their overall safety and well being.

The inspectors looked at one resident file and noted that in order to keep the resident safe, they had 1:1 staffing support throughout the day. Additionally, the resident had very regular access to GP services and mental health professionals for ongoing support regarding risks associated with their health. Staff also had training in the management of behaviour of concern and in risk assessment.

The registered provider was also looking at developing a positive risk management plan that would enable one resident independence to walk to the local shops. This is something the resident enjoyed doing and had been independent in doing prior to coming to this centre. This was another good example of how the registered provider and person in charge were promoting the rights of the person and reviewing and responding to practices that no longer posed a risk to the resident.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The registered provider had a policy in place for the safe administration, storage and disposal of medicines. A staff member went through some of the practices with the inspectors such as the disposal of medicines and how medicines stored in the centre were reconciled to ensure that the medicines received stored and administered were correct. The inspectors found that this system was appropriate at the time of the inspection.

Some of the medicines were delivered from a pharmacy in blister packs which were labelled with the name and dosage of the medicines stored in each blister pack. Some of the names on the blister pack did not match the names on the medicine prescription sheet. This meant that staff could not clearly verify if the medicine they were administering was correct. The inspectors were informed that the pharmacy supplied a ' tic tac pack' (used to identify the correct generic and trade names and descriptions of the medicines) but this was not in place on the day of the inspection. Notwithstanding, the staff member outlined that they would refer to a medicine book which outlined the generic and trade names for each medicine prior to medicines being prescribed if needed. This provided some assurances to the inspectors.

Another staff member went through some of the medicines that a resident was prescribed and was aware of why the medicine was prescribed to the resident.

Medicines records relating to the use of as required medicines were in place to guide staff practice on when to administer this medicine. One residents kardex outlined two medicines that could be administered to a resident when required, however this required review as the way in which it was written was ambiguous and needed to be reviewed. The person in charge were addressing this on the day of the inspection.

Audits were conducted on medicine management practices to ensure that they were in line with best practice.

There were systems in place to report and manage incidents/accidents/near misses around medicine management. A the time of the inspection there had been some adverse incidents relating to medicine management practices. These were generally related to administration errors by staff meaning they were not good practice but they had not impacted the resident. The person in charge took actions to address this, for example some staff were required to complete refresher training on medicine management practices.

Judgment: Substantially compliant

Regulation 6: Health care

From reviewing one residents file, the inspectors observed that they had as required and very regular access to general practitioner (GP) services and a number of other allied health care-related professionals. These included access to:

- dentist
- optician
- audiologist
- dietitian.

Additionally, the resident had regular access to:

- psychiatry support
- psychotherapy support and,
- behavioural support

Health care plans were also in place to guide staff practice. From speaking with the shift lead manager and staff the inspectors were assured that they were aware of the assessed needs of the resident in question. Where a health care need required ongoing monitoring this was in place. For example; some required their blood pressure and weights to be monitored on a regular basis and this was completed by staff where required.

One resident spoke to the inspector about some of their health care needs and it was clear they were involved in all decisions relating to their medical care. The resident also outlined a number of health professionals who were supporting them with their health care needs at the time of the inspection.

Residents were also able to refuse medical treatments and where this occurred, the relevant professionals who had recommended the treatment were informed of this decision.

Overall inspectors found that residents were supported with their health care needs, were included in decisions around specific treatments recommended and were also allowed to refuse these treatments in line with their wishes.

Judgment: Compliant

Regulation 8: Protection

As identified earlier in this report this inspection was carried out due to number of safeguarding concerns being submitted from this centre over the last year. Some of these incidents related to peer to peer interactions and some of them related to staff practices.

The inspectors found at the time of the inspection that the registered provider had implemented a number of strategies to address the safeguarding concerns in the centre. For example; they had developed a contingency plan to address peer to peer

related interactions which included compatibility assessments, and an initiative to try and build relationships with peers to see if they could live together. This contingency plan was still in progress at the time of the inspection and a meeting was scheduled on the day of the inspection to discuss some of the objectives in this plan going forward. This provided assurances that the registered provider was addressing the peer to peer interactions at the time of the inspection.

The registered provider also had a centre specific safeguarding plan developed for the centre which outlined controls that were in place to safeguard residents. This was very detailed, however some minor improvements were required to this, to include the date the plan was started.It would also have been beneficial to include whether safeguarding concerns previously reported had been closed off or were still active. The person in charge agreed to include this in the plan going forward.

In relation, to staffing incidents the registered provider had conducted a root cause analysis of the safeguarding concerns occurring in the centre which included a training needs analysis for staff. Over the last year refresher training in safeguarding had been provided to staff in the centre to ensure that staff responded to and reported safeguarding concerns in the centre. As already outlined under regulation 16; training some improvements were required in staff induction processes.

The inspectors also noted the following:

- where safeguarding concerns had occurred they were responded to
- policies and procedures were available in the centre with regard to safeguarding
- residents were informed about the concept of rights, complaints and safeguarding at residents meetings/forums. At a meeting held on the 28 March 2024 residents were also informed that they could speak to the person in charge or any other staff member at any time if they had any concerns
- the shift lead manager informed the inspectors that they would have no issues in bringing any concern about the welfare and safety of the residents to the attention of the person in charge

Overall inspectors found that the registered provider reported and responded to safeguarding concerns in the centre. As outlined under regulation 15, the registered provider needed to review the staff induction process to assure that the skill mix was appropriate to the assessed needs of the residents.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Bethany House OSV-0008220

Inspection ID: MON-0043499

Date of inspection: 30/04/2024

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 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Regulation 15: Staffing
Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

1. The Person in Charge (PIC) and The Director of Operations (DOO) will complete a full review of the Centre's Statement of Purpose (SOP) to ensure the Centre skill mix is in line with the SOP.
Due Date: 10 June 2024

2. The DOO and the Recruitment Manager shall complete a full review of the Centre's staffing levels. Following this review there are no current vacancies within the Centre's team.
Completed: 23 May 2024

3. The PIC will complete a full review of the Centre's planned and actual rosters for May and June. Following this the PIC will ensure to maintain planned and actual rosters going forward within the Centre.
Due Date: 01 July 2024

4. The Director of Operations (DOO) and the Training Manager are implementing a Center Specific Training Plan to ensure all team members have additional supports to complete their role. This training plan will include, diagnostic supports for all Individuals in the Centre and additional training in safeguarding, risk management, restrictive practices, positive behavioral support, medication, and healthcare needs.

Due Date: 30 June 2024

5. The above points will be discussed with the team at the next monthly team meeting.

Due Date: 13 June 2024

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. The Person in Charge (PIC) and the Designated Safeguarding Officer will complete a Safeguarding review meeting. Following this meeting the Center Specific Safeguarding Plan will be updated.
Due Date: 12 June 2024

2. The Director of Operations (DOO) and the Safeguarding Manager shall conduct a review of Nua's Center Specific Safeguarding Plan document.

Due Date: 20 June 2024

3. The above points will be discussed with the team at the next monthly team meeting.

Due Date: 13 June 2024

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. The Person in Charge (PIC) and Director of Operations (DOO) will complete a full review of all Individuals Kardex's and medication blister pack to ensure medication names correspond.
Due Date: 30 June 2024

2. The PIC completes a full review of medication on a weekly basis. Note: In the event of Tic Tac's for any Individual not being available, the PIC will contact the Dispensing Pharmacist and notify the Clinical Department and the DOO.

Completed: 16 May 2024.

3. The above points will be discussed with the team at the next monthly team meeting.

Due Date: 13 June 2024

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	01/06/2024
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	20/06/2024
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable	Substantially Compliant	Yellow	30/06/2024

	practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			