Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	The Haven
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	25 November 2022
Centre ID:	OSV-0005236
Fieldwork ID:	MON-0038302

About the designated centre

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

The Haven is located in a rural area of County Kildare and provides 24-hour residential support for up to five adults with an intellectual disability. The centre consists of a large two-storey house with an adjacent self-contained single apartment. In the main house the ground floor consists of a kitchen, utility area, living room, sitting room, bathroom and bedrooms, one of which is the staff sleepover room/office, with another two bedrooms and a bathroom upstairs. The apartment contains a kitchen-dining room, a sitting room, bedroom and large bathroom. There are also spacious gardens and grounds surrounding the house and apartment. The staff team is made up of social care workers, assistant social care workers, deputy managers, and a person in charge. Nursing input is available from a nurse employed with the organisation.

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
Friday 25 November 2022	10:20hrs to 17:10hrs	Gearoid Harrahill	Lead
Friday 25 November 2022	10:20hrs to 17:10hrs	Michael Keating	Support

What residents told us and what inspectors observed

During this unannounced inspection, the inspectors had the opportunity to meet all four residents living in the designated centre, as well as speak with the support staff members and observe the routines and support structures of the residents.

Three residents were supported in a large two-storey countryside house, with another resident supported in a separate single-occupancy apartment on the same premises. The main house was featured with a spacious and bright kitchen and dining room area, and three sitting rooms in which residents could spend time alone or with their support staff. The apartment had its own facilities such as a kitchen, dining area, TV lounge and accessible shower. Each resident had a private bedroom, which were found to be highly personalised and decorated based on residents' hobbies and interests. Multiple service vehicles were available to facilitate each person's access to the community.

Following negative findings on the upkeep of the premises on the previous inspection, there had been improvements to maintain the cleanliness and homeliness of the property. While some items remained outstanding, overall the service was clean and in an improved state of repair, with areas of the house having been painted or decorated this year. While a number of environmental restrictions were in place around the premises, the inspectors observed examples of some of these being phased out where no longer deemed necessary, to provide a more homely living environment.

Inspectors observed patient and friendly engagement between staff and residents. Recent staffing changes had resulted in nine members of staff including new managers and front-line staff joining the service in recent weeks. The provider had a suite of training and induction courses for all staff to introduce them to the residents and support them to be familiar with their assessed support needs. While it was evident that some staff members were still getting to know the residents at the time of inspection, the inspectors observed good examples of respectful, dignified and kind interactions.

There had been concerns substantiated in the designated centre that residents were often poorly activated and routinely asleep in bed until after lunchtime. Inspectors observed staff encouraging residents to engage with their planned routine and preferred activities earlier in the day. When inspectors arrived in the morning, residents were up or in the process of doing so, supported to wash, have breakfast and plan out their day. One resident left in the morning to go horse-riding, and one resident planned to go swimming. In the afternoon, two residents left to go to the cinema, and some of the residents were getting ready to visit their families. Later in the evening one of the residents was playing football in the garden with their support staff. Residents were supported to stay overnight with family as part of their routine. For residents travelling in the centre vehicles, the staff team made arrangements to ensure that staff who could drive were present at the required

times.

The management were in the process of exploring new and returning opportunities for residents to socialise with each other and their wider community. The person in charge and their deputies highlighted an objective to have more activities in the community as a group and encourage a culture in which residents are supported to do things together. Opportunities for engaging with day services were also being assessed.

The next two sections of the report present 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 the service being delivered.

Capacity and capability

The provider was engaged in a governance-driven emergency plan in response to escalating concerns regarding oversight arrangements and the quality of resident support. The inspectors found evidence to indicate how the provider intended to enhance centre governance to achieve quality improvement. However, the local governance and provider oversight had not been effective in identifying deficits in the service and the concerns raised by other parties and authorities.

This unannounced inspection was carried out in response to information, trends and incidents of concern brought to the attention of the Chief Inspector relating to this designated centre. Inspectors also verified emergency governance measures advised by the senior management of the service provider following an inspection carried out by the Health Service Executive. Measures implemented included increased supernumerary management presence, additional front-line staff at night, and a large portion of the front-line staff team being relocated to other services, and in their place team members assigned from other designated centres. There was also a new person in charge assigned to this service, as well as deputy managers to support and cover them. There was a suitable number and skill mix of staff to support the assessed needs of the residents, all of whom require 1:1 or 2:1 staff support. In the main, rosters clearly evidenced presence of management and shift leaders, though a small number of gaps were observed on weekends in the sample reviewed.

In addition to the provider ensuring that all members of the team were up to date on their mandatory training and skills, the provider also arranged a suite of centre-specific education sessions to train the staff on meeting the support needs of the residents and the protocols and procedures of the designated centre. Inspectors spoke with all front-line staff present on the day of inspection, most of whom were new and in the process of getting to know the residents.

While it is acknowledged that work to update information systems and

documentation was in progress, inspectors observed some examples of missing or contradictory information in centre records. This included records on responses to allegations and complaints, and information on resident support needs which were not readily available to the support team. This was important given that a large portion of the support team as well as local management were new and required clear and accurate information and guidance.

Weekly governance meetings were taking place between the local and provider-level management with updates on the progress of the governance improvement plan. The service had appropriate input from the multidisciplinary team, including weekly reviews by the behavioural therapist and clinical director, two-weekly visits from the safeguarding officer, and recent reviews by the occupational therapist and dietitian. The provider had also carried out a quality assurance audit of the service in late November 2022, in which a number of time bound actions were clearly identified.

Ultimately, while it was evident that the service provider was engaged in a comprehensive emergency response plan to improve the service quality, the management arrangements and oversight structures had not identified any of the issues outlined in the concerns raised about the service. Of particular note, the local management had not identified culture issues in the service such as residents being poorly activated and not supported to get out of bed until the afternoon. The six-monthly unannounced visit by the provider, last completed in July 2022, had also not identified these concerns. Some of the findings of the previous inspection in March 2022 were also found again on this inspection.

Regulation 14: Persons in charge

The person in charge was suitably experienced and qualified in leadership and management of a health and social care setting. They were allocated to work full time across two designated centres and had appropriate deputation arrangements in their absence.

Judgment: Compliant

Regulation 16: Training and staff development

The provider was in the process of providing a suite of education sessions to provide the staff members with the training and knowledge required to work in this designated centre and to meet the support needs of the service users.

The provider had identified the training which was mandatory to work in this designated centre, and had a system for tracking attendance dates and which members of staff were due to attend refresher sessions in matters such as safeguarding of vulnerable adults, fire safety, infection control and supporting

people with autism.

Judgment: Compliant

Regulation 21: Records

During the inspection, a number of gaps or inconsistencies were found in some records, including information which was not readily accessible to the front-line staff related to resident support needs.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had responded to escalated risks in the service with emergency governance and management arrangements including a short-term enhancement in senior manager presence and a revision in local management and front-line shift patterns in the centre. Sufficient oversight arrangements were in place for weekdays, with deputation arrangements in place for weekend leadership, however in the sample of rosters reviewed not all days had identified management cover.

Ultimately the management and oversight arrangements had not identified culture issues in the designated centre such as residents being poorly activated and not getting out of bed before the afternoon. The most recent quality and safety report from July 2022 did not identify any of the issues raised in reported concerns.

A number of repeated findings were observed by inspectors from the previous inspection in March 2022 which had not been addressed within the provider's own timeframes.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had a procedure for the receipt and management of complaints raised in the service, and a record log was available for review in the centre. The detail recorded in this log was not sufficient to be clear on the specific nature of the complaint, and while there was a record that the conclusion was communicated to the complainant, the record did note how they were assured whether or not the complainant was satisfied with the outcome or actions taken.

Judgment: Substantially compliant

Quality and safety

In the main, the inspectors observed examples of areas in which compliance with regulations had improved since the previous inspection and areas in which similar findings were repeated. Inspectors observed aspects of residents' engagement with routines and activities had improved as part of the revised oversight arrangements.

The inspectors found evidence to indicate that activity levels had increased for residents in recent weeks, and that residents were awake, up and engaging in their activities of choice starting in the morning rather than in the afternoon. Residents were supported to engage in activities in the wider community including horse-riding, swimming and cinema trips, and the provider was demonstrating effort to identify and provide varied activities in accordance with residents' interests, capacities and developmental needs. Among this, the provider had identified a need to get residents engaged with day services which suit their assessed needs.

Inspectors reviewed a sample of residents' comprehensive assessments of need and how they informed the health, personal and social care support plans of each resident. The assessment of need covered a wide range of support requirements, however in some cases, it was not clear from the assessment what the identified needs of the resident were, and which of the described needs required a corresponding support plan. For example, where an assessment had referred to the need for supporting resident independent living, this had not been developed. Some support plans were not readily available to staff, and some support plans had not been updated to reflect changing circumstances. Inspectors found a lack of evidence to indicate that the effectiveness of support plans was being evaluated, and that these reviews were completed with the participation of the residents or their representative. Staff maintained suitable records as required by the assessment of need, including recording weight, blood pressure, intake of food and fluids, showering, sleep quality and trends of incidents related to their diagnoses. Staff had guidance related to encouraging residents to engage in daily activities such as eating healthily and maintaining personal hygiene.

Some residents had a positive behaviour support plan in place, which defined the various behaviours with which residents may present. These plans described precursor behaviours, proactive and reactive strategies to be used by staff to maintain a low-stress environment and keep themselves and the resident safe. Some plans identified multiple types of verbal, physical or self-injurious behaviours. In these instances, the circumstances which may trigger an incident were described collectively rather than identifying the settings and triggers which may cause each variation of their behaviour, based on analysis of incident history. As a result, some responses were not specific to each behaviour with which the resident may present. Where the assessment of need prescribed the use of physical interventions as a last

resort when other de-escalation strategies have not been successful, the corresponding behaviour support plan did not provide guidance to staff on its use.

The inspectors were provided evidence that restrictive practices active in the designated centre were kept under regular review to analyse the frequency and impact of their use, with examples of how some restrictive features were being phased out where the associated risk had decreased.

There had been improved compliance and oversight of the cleanliness of the designated centre since the last inspection, and examples were observed of where areas had been painted or repaired. Some items for repair or maintenance were identified, including some repeat findings from the previous inspection. In the main, the house was suitably designed to contain and detect fire and facilitate a swift evacuation, however one fire door was observed to be routinely propped open with a weight instead of being held open in a manner which would allow it to close in an emergency.

Where incidents were alleged or witnessed which caused concern for the safety or wellbeing of the residents, the service provider had reported these to the appropriate external parties and ensured that they were provided suitable follow-up information to establish the facts and come to a conclusion on the matter. Inspectors observed examples of actions identified to reduce risk of repeated incidents. The provider had recently re-evaluated the impact assessment of residents living in the shared space to be assured that it was safe and appropriate for them to continue living together.

Regulation 13: General welfare and development

Residents were being encouraged and supported to develop and maintain their personal and family relationships and links with the wider community in accordance with their wishes. Inspectors found evidence to indicate that activity levels had increased for residents in recent weeks, and that residents were engaged in their activities of choice earlier in the day. A need was identified for some residents to attain access to meaningful opportunities for education, employment or day services in accordance with their wishes and assessed support needs.

Judgment: Substantially compliant

Regulation 17: Premises

Inspectors found improvement in the cleanliness of the premises following the previous inspection, and areas of the property had been painted and repaired. Some areas required attention to address maintenance issues, including damaged kitchen units, a broken armchair, some stained safety padding, a leaking toilet, broken

bathroom taps and some cosmetic wall damage.

While the premises overall was nicely decorated and furnished according to the assessed needs of residents, some living room areas had CCTV cameras installed in the ceilings which had neither been active nor required for its occupant for some time.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider maintained a risk register for the designated centre which clearly identified, rated and set out control measures to mitigate risks related to this designated centre. Inspectors reviewed a sample of incident reports and found evidence of actions or reviews implemented in response to same or to reduce likelihood of repeated occurrence.

Judgment: Compliant

Regulation 27: Protection against infection

Inspectors observed improved cleanliness of the environment of the designated centre. Suitable procedures were observed for management of waste, food, cleaning equipment, hand hygiene, and routine monitoring for potential infection risk.

Judgment: Compliant

Regulation 28: Fire precautions

Overall, the centre was equipped to detect, identify and fight the spread of fire and smoke on the premise and provide suitable maps and lighting to aid evacuation. However, inspectors identified an upstairs fire door which was routinely propped open in a manner which compromised the fire containment feature, which had not been addressed following the previous inspection.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found evidence of appropriate practices for the management, storage, administration and disposal of medicines. Where residents were prescribed PRN medicine (administered only when an identified need arises) there were clear protocols for their use to guide staff. Residents had been assessed to determine their capacity and appropriate level of support required in taking their medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

In the sample reviewed, the comprehensive assessments of needs did not clearly summarise and outline the identified support needs of residents. Support plans were in place for the majority of needs which the inspectors could identify from the assessments, however, in some cases these provided limited information relevant to guide the staff team on supporting the assessed needs. There was a lack of evidence that all plans were subject to evaluation to determine if they were effective in meeting their objectives, and limited evidence was found that the residents or their representatives were involved in the review of their content. Some plans on file were no longer actively being implemented, and there were some discrepancies between the support structures outlined in the assessment of need and the staff guidance included in the support plans.

Judgment: Not compliant

Regulation 6: Health care

Inspectors found evidence to indicate that residents were referred to the care of their doctor and multidisciplinary team, and their supports reviewed regularly by clinicians including the occupational therapist, psychologist and dietitian.

Judgment: Compliant

Regulation 7: Positive behavioural support

The positive behaviour support plans reviewed did not provide appropriate guidance on the management of some behaviours. In particular, functional analysis, incident history and frequency, and the causes and triggers for each specific behaviour were not clearly defined, and there was some discrepancy between records of what

behaviours were exhibited.

The descriptions and definitions of physical restraint interventions were not included in the relevant support plan and it was not possible for staff to be fully informed of what intervention has been determined as effective for that person. Some response measures set out to protect staff and others from harm during distress incidents could not be implemented as per the guidance of the support plans. For example, where protective equipment was prescribed for use in certain situations, staff who had not yet used it could not find it and were not advised on where to retrieve it when needed.

There had been an improvement in the ongoing review of restrictive practices in the designated centre. The restrictive practices register and review minutes accounted for all active features and practices, and indicated where plans were in place to reduce or phase out restrictions for which the associated risk had decreased, or to trial less restrictive alternative measures.

Judgment: Not compliant

Regulation 8: Protection

Inspectors found evidence indicating that where allegations or incidents occurred, they were treated seriously by the provider and were investigated promptly. The provider made relevant referrals to An Garda Síochána and the designated officer within appropriate times. Impact assessments had been completed recently looking at the suitability of residents to continue sharing their living space with their peers.

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 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Haven OSV-0005236

Inspection ID: MON-0038302

Date of inspection: 25/11/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: To demonstrate that the Centre is line with Regulation 21, the Person in Charge will ensure that the following actions are taken: 1. The Person in Charge (PIC) shall conduct a review all residents documentation records and ensure all records and documentation are filed appropriately. 2. The PIC will ensure all records and documentations are maintained to a high standard with regular checks conducted by the Centre's administrator. 3. The above points will be discussed with the staff team at the next monthly staff team meeting.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To demonstrate that the Centre is line with Regulation 23, the Person in Charge will ensure that the following actions are taken: A Governance Driven Improvement Plan was implemented to drive and improvement quality improvement initiatives with a continued focus on the Designated Centre's, Governance and Management, Positive Behavior Support, Protection, Individual Assessment and Personalized Plans, General Welfare and Development and Premises.	

Note: There are identified actions for key personnel to support with implementation of the Governance Driven Improvement Plan.

Note: The Director of Operations (DOO) is based in the Centre on a weekly basis to support the Person in Charge (PIC) completing all aspects in the plan and the actions are being tracked by a member of Quality Assurance team.

Note: The DOO is providing a weekly update on the Governance Driven Improvement Plan to the Senior Management Team.

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

1. The Person in Charge (PIC) will conduct a review of all actions generated as part of the Centre's quality improvement initiatives, ensuring all actions are SMART and relevant to the findings of previous audits and closed out within agreed timeframes, where required.

2. Following the next scheduled audits, the PIC will ensure all actions are SMART and relevant to the findings of previous audits and closed out within agreed timeframes, where required.

3. The Centre's administration team, will ensure to monitor progress on all actions and update the PIC on a weekly basis and in turn update the Director of Operations, where required

4. The PIC will ensure, where actions are arising from the Centre's quality improvement initiatives, a weekly update is provided to the Director of Operations on actions that are closed.

5. Where required, the Director of Operations will conduct a periodic review of agreed actions closed linked to the Centre's quality improvement initiatives, reviewing the evidence provided by the PIC.

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

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
To demonstrate that the Centre is line with Regulation 34, the Person in Charge will

ensure that the following actions are taken:

1. Nua's Complaints Officer will visit the Centre and complete a full review in conjunction with the Person in Charge (PIC) of all individual complaints recorded on the Centre's Registers in 2022. Following this the PIC will ensure all feedback from the complainants and outcome of investigations (s), where required, has been documented on the complaints register.

2. The above point will be discussed with the staff team at the next monthly team meeting by 30th January 2023.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
To demonstrate that the Centre is line with Regulation 13, the Person in Charge will ensure that the following actions are taken:

1. The Person in Charge (PIC) in conjunction with The Director of Operations (DOO) will conduct a review all opportunities for Service Users to attend day services and avail of opportunities in accordance with their wishes and support needs, where required and where appropriate to do so. The identifying educational opportunities for them in accordance with their wishes.

Note: Three (3) Service Users have returned to day services. One (1) Service User has declined to attend day services.

2. The DOO will meet with all Service users' families to identify have or supports they would like to see implemented for service users.

3. Following the above scheduled meetings any additional activities scheduled will be added to Service users' planners, where required and appropriate to do so.

4. The above point will be discussed with the staff team at the next monthly team meeting by 30th January 2023.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To demonstrate that the Centre is line with Regulation 17, the Person in Charge will ensure that the following actions are taken:

1. The Person in Charge (PIC) and Director of Operations (DOO) shall complete a review with the maintenance department and set a completion time for required works identified during the inspection.

2. The PIC shall conduct a review of the systems in place regarding the management/overview of maintaining Premises in the Designated Centre to ensure that
(a) A review of the Centre and its layout and environment is checked daily, and any maintenance or repairs are scheduled and addressed.
(b) Any maintenance or repairs required are scheduled and addressed in a timely manner.

Note: Following a review with the PIC in conjunction with the DOO, CCTV cameras have been removed in all areas of the Centre, where required.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
To demonstrate that the Centre is line with Regulation 28, the Person in Charge will ensure that the following actions are taken:

1. The PIC in conjunction with Nua's maintenance team shall conduct a review of the Centre's fire safety arrangements regarding detecting, containing, and extinguishing fires to ensure any fire containment features are not compromised. This action is scheduled to be completed by 13 January 2023.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
To demonstrate that the Centre is line with Regulation 5, the Person in Charge will ensure that the following actions are taken:

1. The Person in Charge (PIC) in conjunction with members of the MDT team will complete a full review of each Service Users Comprehensive Needs Assessments (CNA's)

to ensure that all information in relation to assessed needs is captured.

2. The PIC in conjunction with the Behavioral Specialist will complete a full review of each Service Users Personal Plans.

3. Plans are to be reviewed where appropriate by multi-disciplinary and to note the effectiveness of same when completing the review.

4. The PIC will complete a review of the Center's annual review report and ensure that all Service Users and their representative's feedback is captured in the report.

5. The above points will be discussed with the staff team at the next monthly team meeting by 30th January 2023.

Regulation 7: Positive behavioural support	Not Compliant

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

1. The Person in Charge (PIC) will review the guidance and behavioural definitions within the Multi-Element Behaviour Support Plans with the Senior Behavioural Specialist, to provide guidance on management of behaviours.
2. The (PIC) will review all Personal Protective Equipment (PPE) in the Centre and ensure systems are in place where all staff are aware of the purpose for and location of PPE equipment. This will be updated in the Service Users' Risk Management Plans and will also be included as a standing agenda on the daily handover.
3. The above points will be discussed with the staff team at the next monthly team meeting by 30th January 2023.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(4)(a)	The person in charge shall ensure that residents are supported to access opportunities for education, training and employment.	Substantially Compliant	Yellow	30/01/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	30/01/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/01/2023

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	30/01/2023
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	30/01/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/01/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	13/01/2023
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of	Substantially Compliant	Yellow	30/01/2023

	any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	30/01/2023
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/01/2023
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more	Not Compliant	Orange	30/01/2023

	frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/01/2023
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and	Substantially Compliant	Yellow	30/01/2023

	new developments.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/01/2023