

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Chapel View
Centre ID:	OSV-0001931
Centre county:	Kildare
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services Unlimited Company
Provider Nominee:	Shane Kenny
Lead inspector:	Jillian Connolly
Support inspector(s):	Conan O'Hara
Type of inspection	Unannounced
Number of residents on the date of inspection:	10
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
18 January 2017 15:30	18 January 2017 20:30
19 January 2017 10:30	19 January 2017 17:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

This was the fourth inspection of the centre. In May 2016 an inspection was conducted which identified significant failings in the care and support provided to residents. Following that inspection a regulatory meeting was held between the provider and HIQA. The provider also submitted a plan to HIQA stating the actions that would be taken to ensure compliance with the regulations. The purpose of this inspection was to identify if the appropriate action had been taken.

How we gathered our evidence:

As part of this inspection, inspectors met with eight residents. Inspectors also met with relatives and staff, observed practices and reviewed documentation such as residents' personal plans, health and safety documentation and audits. Residents, management and staff facilitated the inspection.

Description of the service:

The designated centre is one house located in Co. Kildare. The centre is registered for individuals over the age of 18. Inspectors were informed by the person in charge that the service is for male residents only. The centre is operated by Nua Healthcare.

Overall findings:

Residents and their families spoke positively about the service they received.

However, inspection findings demonstrated that significant improvement was still required to ensure that a safe and quality service was provided. Overall inspectors found that:

- The systems in place for the management of risk did not protect residents or staff
- Staffing levels were not organized in line with the assessed needs of residents
- Admissions did not safeguard current residents from adverse affects
- Positive behaviour support was not consistently provided to residents

Inspectors found that fundamentally, the service was not safe due to an overall failing by the provider to ensure that the governance and management systems in place were implemented effectively. Sufficient action had not been taken following the inspection in May 2016 to ensure that residents were safe and appropriately supported in line with their needs.

Within this report, the inspection findings are presented under the relevant outcome. The action plan at the end of the report sets out the failings identified during the inspection and the actions required by the provider to comply with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The admissions policy for the centre had been reviewed following the last inspection. However, inspectors found that admissions procedure was impacting negatively on the quality of life of the current residents and did not adequately take account of the need to protect residents from abuse by their peers.

Inspectors reviewed a pre admission impact assessment for one resident. The resident had complex needs with associated high risks to other residents and staff. However, the impact of these risks to the safety of others had not been adequately assessed in the context of current residents and the supports that they required. Control measures did not provide enough information to staff and as a result were ineffective.

Supporting evidence is being withheld from this report in order to protect to anonymity of individual residents. This has been clearly communicated to management.

Judgment:

Non Compliant - Major

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Following the last inspection the provider had commenced a 'New Ways of Working'. One aspect of this was the incorporation of all the supports residents required into one document called their personal plan. Improvement was required to ensure that residents were supported to engage in lifelong learning and skill development.

Residents had an assessment completed on admission. However, inspectors identified an instance in which this assessment had only been partially completed. Following on from the assessment, a personal plan was created which aimed to identify the supports required. Individual risk assessments had also been completed for residents and standard operating procedures developed to guide practice on control measures identified. Residents also had monthly sessions with their key workers in which goals for the month were identified. Inspectors found inconsistencies in the goal setting process. In some instances, goals identified promoted skill building, such as developing housekeeping skills. In other instances goals were short term one off activities such as support to go to church. Inspectors also found that goals were not consistently reviewed to assess their effectiveness.

Residents knew who their key workers were and confirmed that they met with them. Relatives stated that they were kept informed of the well being of their loved ones and changes to their care.

Residents had access to allied health professionals.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There were policies and procedures in place to promote the health and safety of residents, staff and visitors. This included a safety statement, a risk management policy

and an assessment of the risks particular to the centre. Risks specific to individual residents had also been assessed. However, inspectors found that the systems in place for the assessment and management of risk were not implemented effectively.

Inspectors found that the level of risk identified in risks assessments were not consistently accurate. For example, a review of incident records demonstrated that staff were frequently injured. Five of these injuries required notification to the Health and Safety Authority in a one month period. A risk assessment had been conducted to ascertain the risk of a staff member becoming injured whilst working in the centre. The risk was assessed as a medium risk.

Furthermore, the incident forms provided to inspectors did not demonstrate that incidences were being appropriately reviewed. This was required by policy. Allied health professionals had also made recommendations on measures to be used to reduce risk. These measures were not consistently implemented. For example, male staff to be present at certain times when it was clear that a risk was present. An incident record stated that only female staff members had been involved.

Inspectors reviewed an incident record involving significant risk to resident(s), staff and the public. The potential of this occurring had been previously identified by an allied health professional prior to the incident occurring however had not been assessed by the provider. There were no control measures identified prior to or following the incident occurring.

There were systems in place for the protection and management of fire. This included equipment such as a fire alarm, fire extinguishers and emergency lighting. Fire doors also had automatic self closers in place which were connected to the fire alarm system. The procedure to be followed in the event of a fire was also on display. Staff had received training in fire management and had taken part in a fire drill. Residents described to inspectors the actions to be taken in the event of a fire and confirmed that they had taken part in fire drills at night. However, a review of fire drills did not demonstrate that the ten residents could be evacuated to a place of safety with four staff, which was the lowest number staff on duty at night. There was also an absence of assessment on the individual supports residents required to evacuate.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Positive behaviour support and restrictive practice were implemented in the centre. However, inspectors found that the policies were not effectively implemented in practice. The provider did not demonstrate that the least restrictive method was used for the shortest duration of time. Furthermore all efforts had not been made to identify and alleviate the cause of residents' behaviour.

There were policies and procedures for positive behavior support and the use of restrictive practices. Staff had also received training in breakaway techniques and physical restraint. The centre was adopting a new system in which positive behaviour support plans were incorporated in the personal plans of residents.

Residents' personal plans identified proactive and reactive strategies to support positive behaviour. PRN (as required) medication was administered in response to behaviours that challenge. These medications were sedative in nature. They were administered without appropriate guidance.

Physical restraint was regularly used within the centre. Inspectors reviewed a sample of accident and incident records which demonstrated that physical restraint had been used. These records did not identify if the proactive strategies had been implemented on that given day.

There was also a resident who had been physically restrained by staff on three occasions. The resident did not have a personal plan in place at the time to authorize this intervention. Records of incidents did not demonstrate that the personal plan had been reviewed following the intervention. On the second day of inspection, the person in charge gave inspectors a copy of an interim behaviour support plan for the resident. It had been provided that day by the appropriate allied health professional and contained more detail.

There were policies and procedures in place for the protection of vulnerable adults. Staff had received training in the identification and response to abuse. Residents that inspectors met with stated that they liked their home. Relatives were very positive about the centre and felt that their relatives were well looked after and safe. The provider had notified HIQA of allegations and suspicions of abuse in compliance with the regulations.

Judgment:

Non Compliant - Major

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Residents stated that they had access to their general practitioner (GP) and allied health professionals, if a need arose. However inspectors found that improvements were required to the day to day practices in the centre to ensure that residents' healthcare needs were appropriately assessed and met.

Residents' health care needs were identified within their personal plans. Inspectors found that chronic conditions were addressed and there were plans of care in place to meet that need. For example, if a resident had a diagnosis of epilepsy or diabetes. However inspectors found that when an acute health care need arose, personal plans were not reviewed or updated and therefore it was not clear what supports residents required to meet that need. For example, personal plans were not reviewed following a resident's discharge from hospital to identify, what supports if any, the resident required. The daily notes for a resident stated that they were monitored but it was not clear what the monitoring involved as there was an absence of clinical observations completed.

A review of records also demonstrated that staff were not clear on the clinical presentation of a resident when providing the information to their GP. The clinical observations for the resident on the previous day recorded that the resident had low blood pressure. However the GP was informed that the resident's blood pressure on the previous day may have been high.

Inspectors observed a mealtime and found it to be a pleasant experience. Residents stated that they were happy with the food provided in the centre and spoke particularly positively regarding the cooking skills of one member of staff. The meals for the week were displayed in the dining room and residents were aware of what was for dinner. Residents also assisted staff with the weekly shopping. There were sufficient staff available to support residents at mealtimes.

Inspectors found that residents had end of life care plans in place if they consented to this. Residents stated that they were supported to attend the funeral of their friends if they wished to.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There was a clear governance and management structure in the centre. However, considering the cumulative and repeated failings identified in this report, inspectors were not assured that the governance and management systems in place ensured a safe and effective service.

There was a system in place in which the person in charge completed weekly reports which were progressed to the regional manager. Inspectors were informed that the information contained in these reports were presented at operational and clinical meetings. However, these systems did not result in a safe and quality service.

Inspectors were provided with a copy of the audits completed since the last inspection. They included an audit of individual personal plans, restrictive procedures, medication, hygiene, health and safety and the admissions process. Information obtained in audits showed that controls measures were not effective. Inspectors found that when an area was re audited, such as medication, there was minimal improvement. An audit conducted in May 2016 identified inconsistencies and concerns regarding a resident's assessment. There had been no change to the assessment following on from this. Inspectors also found that audits did not improve the quality and safety of care provided.

An action arising from the previous inspection was that there had been no report generated from an unannounced visit which was completed by the provider. The provider had responded by stating that this would be addressed by 1 August 2016. This had not been done within the timeframe stated and the reports were not available in the centre on the day of inspection. One week following the inspection, the person in charge submitted the reports to HIQA. However the inspector found that while the reports identified areas of non compliance, there was no action plan identified to ensure that the deficits in service delivery were adequately addressed.

Judgment:

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors observed practice and found that staff engaged with residents in a dignified and respectful manner. However inspectors found that staff resources were not organized in a way to meet the assessed needs of residents.

Inspectors were provided with the hours that each resident was due to be provided with individual supports i.e the support of one or two members of staff. However inspectors observed that the assessments of residents' needs differed from this information. For example a resident was due to be provided with the support of two staff during the day and one to one staff at night. In practice, the inspectors observed the resident to be supported with one to one staffing for four hours during the day. When inspectors queried where the second staff was they were informed that they were supporting another resident to go to the cinema.

Inspectors also spent time with four residents for approximately 90 minutes. At this time the four residents exited and entered the room. The assessed needs of all the residents combined stated that there was a requirement for a total of four staff however there was only one staff present. Inspectors also observed residents who were assessed as requiring supervision of staff when other residents were present to be unsupervised for periods of up to thirty minutes. An unwitnessed assault had also occurred in the centre, despite both residents involved requiring the support of 1:1 staffing levels. The provision of high staffing levels was identified as a safeguarding measure in response to allegations and suspicions of abuse.

A sample of rosters and staff confirmed that there was also a one hour period in the evening in which there were three staff on duty. However, considering the needs of the residents, this number of staffing did not ensure that all residents could receive the support that they required at that time.

Inspectors were provided with a copy of staff training records and confirmed that staff received the appropriate mandatory training. This included manual handling, fire safety and the protection of vulnerable adults. Additional training was also provided in the safe

administration of medication, food hygiene and infection control. Staff were also receiving formal supervision.

A review of staff files demonstrated that they contained all of the information required by Schedule 2 of the regulations.

Judgment:

Non Compliant - Major

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Jillian Connolly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Nua Healthcare Services Unlimited Company
Centre ID:	OSV-0001931
Date of Inspection:	18 January 2017
Date of response:	07 June 2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Admissions to the centre did not ensure that current residents felt safe within their home.

1. Action Required:

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

practices take account of the need to protect residents from abuse by their peers.

Please state the actions you have taken or are planning to take:

Nua Healthcare aim to protect all residents living in a Nua Healthcare Designated Centre's including Chapel View, with the residents' safety as well and the safety and protection of current residents residing in the Centre paramount to the Admission Process.

1. The admissions process within Nua Healthcare is undergoing a full review at present to achieve:

- An updated Admission Process which incorporates full consideration of the scope of services set out in the individual Centre's (in this case, Chapel View's) Statement of Purpose.
- A prominent focus on Impact Risk Assessments for the Designated Centre based on each service user currently residing in the Centre.
- Validation of the pre-assessment outcomes prior to admissions by the PIC.
- Greater involvement from the PIC in the assessment of residents when they are being considered for the Centre, rather than decisions made primarily by the ADT committee.
- Formal agreement from the ADT Committee and the PIC when a resident is to be admitted to the Centre.
- A clear transition processes for residents deemed suitable to reside in the Designated Centre following the full assessment process. The transition process shall include at least one pre admission visit from the resident and representative where possible. The transition process shall also include routine and detailed monitoring of residents when they are admitted to a Centre and the impact that this has on other residents in the service, with the priority to protect residents from abuse by their peers.
- A 'Fast-Track' escalation process for communication of issues that arise when a resident is introduced to the Centre and where issues are identified.

2. Process mapping of the Admissions Policy and Procedure has been scheduled to commence in June 2017.

3. This draft document shall be approved and made available in all Designated Centres by July 2017.

4. The updated policy shall be communicated to staff in Chapel View by July 2017, and all staff shall be required to acknowledge same.

5. The Quality Assurance Department shall monitor compliance with the policy and procedure through quarterly audits for all new admissions for the next 12 months. Results from the Audit shall be communicated to the Persons in Charge, Middle and Senior Management Team each quarter.

Proposed Timescale: 31/07/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Residents' goals were not consistently reviewed to assess the effectiveness of the goals.

2. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:

1. Training to be provided to the Key-workers in relation to the identification, recording and effectiveness of personal goals.
2. PIC to review Personal Plans consistently to assess the effectiveness of the goals whilst taking into account changes in circumstances and new developments along with each individual's wishes.
3. Personal Plans are being reviewed in their entirety to ensure the information is accurate and of support to the staff team. Key workers for each resident shall review the records and confirm the information is accurate.
4. Staff team meetings to take place on the 22 and 29 June 2017 to include a review of the Personal Plans for each resident and ensure staff are familiar with the needs of each resident, Personal Plans will be presented at team meeting in draft format, each of them will then be reviewed at team meeting to include Residents' goals, with key recommendations and supports required.
5. All of the above points will be discussed at the staff team meeting to take place on the 22 and 29 June 2017

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The comprehensive assessment was only partially completed.

3. Action Required:

Under Regulation 05 (1) (a) you are required to: 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 prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:

1. The admissions process within Nua Healthcare is undergoing a full review at present to achieve:
 - An updated Admission Process which incorporates full consideration of the scope of services set out in the individual Centre's (in this case, Chapel View's) Statement of Purpose.
 - A prominent focus on Impact Risk Assessments for the Designated Centre based on each service user currently residing in the Centre.
 - Validation of the pre-assessment outcomes prior to admissions by the PIC.
 - Greater involvement from the PIC in the assessment of residents when they are being considered for the Centre, including the PIC undertaking assessments prior to accepting a new resident, and participating in the ADT Meeting when facilitating a new

placement, rather than decisions made primarily by the ADT committee.

- Formal agreement from the ADT Committee and the PIC when a resident is to be admitted to the Centre following the completion of comprehensive assessment of need prior to admission.
 - A clear transition processes for residents deemed suitable to reside in the Designated Centre following the full assessment process.
 - Process mapping of the Admissions Policy and Procedure has been scheduled to commence in June 2017.
 - Implement a process of formal monitoring of residents following placement to the Centre.
 - Mechanisms for identifying key risk areas following admission of a resident, and processes for addressing any risks in a timely manner.
6. This draft document shall be approved and made available in all Designated Centres by July 2017.
7. The updated policy shall be communicated to staff in Chapel View by July 2017, and all staff shall be required to acknowledge same.
8. The Person in Charge is responsible for ensuring appropriate referrals are being made for Service User's. Outstanding referral to Speech and Language, in relation to swallow assessment and planning have been addressed and arranged to take place as required.
9. Staff team meeting to take place on the 22 and 29 June 2017 to include a review of the Personal Plans for each resident and ensure staff are familiar with the needs of each resident, Personal Plans will be presented at team meeting in draft format, each of them will then be reviewed at team meeting to include revisiting assessments completed prior to admission, with key recommendations and supports required.

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Personal plans did not consistently promote skill building and development.

4. Action Required:

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the residents' personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:

1. Training to be provided to the Key-workers in relation to the identification, recording and promote skill building and development for all residents'.
2. Personal Plans are developed with the resident in a manner that is age appropriate and consistent with their level of understanding. Realistic goals are agreed in consultation with the resident and supports given to the resident to achieve these goals while promoting skill building and development for all residents'.
3. Personal Plans are being reviewed in their entirety to ensure it allows skill building

and development for all residents'.

4. Staff team meeting to take place on the 22 and 29 June 2017 to include a review of the Personal Plans for each resident and ensure staff are familiar with the needs of each resident, Personal Plans will be presented at team meeting in draft format, each of them will then be reviewed at team meeting to include Residents' goals, with key recommendations and supports required for the promotion of skill building and development for all residents'.

5. All of the above points will be discussed at the staff team meeting to take place on the 22 and 29 June 2017

Proposed Timescale: 31/07/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The systems in place for the assessment and management of risk were not implemented effectively.

5. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:

1. Personal Plans are being reviewed in their entirety to ensure the information is accurate and of support to the staff team. This includes identifying key risks for each resident.
2. Key risks for the resident and for the staff will be compiled in a summary document. Risks shall be risk rated and controls shall be reviewed to ensure all potential controls are in place. The summary risk document shall be reviewed on a weekly basis by the PIC to ensure it is fully up to date and reflective of the needs of the residents and staff.
3. The summary risk document shall be communicated to all staff on a weekly basis and shall be displayed prominently in the staff area.
4. Shift Handover meetings are being held at the commencement of each shift, and during the shift as required. At these meetings, any change to the needs of the residents shall be highlighted.
5. Staff team meeting to take place on the 22 and 29 June 2017 to include a review of the Personal Plans for each resident and ensure staff are familiar with the needs of each resident, Personal Plans will be presented at team meeting in draft format, each of them will then be reviewed at team meeting to include revisiting assessments completed, with key recommendations and supports required.
6. All residents have been reviewed by the Clinical Team and are being reviewed on an ongoing basis to ensure their clinical and behavioural needs are being met.

Proposed Timescale: 30/06/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Records of fire drills did not demonstrate that residents could be effectively evacuated from the centre.

6. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:

1. The Process for conducting Fire Drills in Chapel View is under review.
2. A schedule for Fire Drills for the next 12 months is been put in place. This shall incorporate drills with the full complement of staff as well as with the lowest complement of staff.
3. All relevant information to be recorded to include those attending fire drills, time required for full evacuation and issues encountered if any. The response of residents and staff to the procedure to be recorded and reviewed to ensure learning which is to demonstrate that residents could be effectively evacuated from the Centre.

Proposed Timescale: 30/06/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Records of incidents did not demonstrate that the use of physical restraint was the least restrictive practice and used for the shortest duration.

7. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:

A restraint free environment is promoted in Nua Healthcare insofar as is possible. The policy of Nua Healthcare is that if restraint is used, they are applied in accordance with national policy and evidence based practice.

1. Re-education is being provided to all staff to ensure they understand and acknowledge the use of restraint policy and procedure; including that physical intervention is never the primary intervention.
2. A full review of the use of physical or environmental restraint is being undertaken for

Chapel View in line with the Regulations. The review shall include a review of current restraints in place for residents, whether there is effective assessment for restraints in place, including identification of alternatives tried and the outcome, evidence that this is the least restrictive intervention available, and justification of any restraint.

3. The Person in Charge shall oversee the outcomes of

i. any use of PRN Psychotropic Medication or Sedative Medication in the designated centre. This shall be supported by the Clinical Team and Behaviour Specialists. Any PRN medication utilised shall be reviewed by the Clinical Team and Person in Charge on a weekly basis. In addition a trend analysis and evaluation shall be provided to the person in charge on a weekly basis identifying any discrepancy in suitability of the use, concerns, and lessons learned to be provided to staff.

ii. any incident which occurs involving the use of physical or environmental restraint. This shall include evaluation of whether the restraint was the least restrictive intervention available and was it in line with the refinements in the personal plan and was it utilised appropriately.

4. All staff shall sign to acknowledge they have read and understood each resident's Multi-element Behaviour Support Plan; and the lessons learned provided in relation to evaluation of restraint in Chapel View.

5. The QA team shall carry out an audit of restraint quarterly or more often if required thereafter for the next 12 months. A report shall be provided to the Person in Charge, Middle and Senior Management Team following each audit.

Proposed Timescale: 30/06/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Residents were not consistently supported to identify and alleviate their behaviour.

8. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:

1. In addition to the full review of restraint as identified above, Personal Plans are being reviewed in their entirety (including Risk Assessments/SOPs and the Multi-element Behaviour Support Plans were in place) to ensure the information is accurate, to ensure key risks are identified and managed for residents, and that every effort to identify and alleviate the cause of residents' behaviours has been made. The mix of residents, and whether this has an impact on behaviour, shall be considered as part of each Service User's assessment on the cause of resident's behaviour.

2. The Person in Charge is responsible for ensuring appropriate referrals are being made for Service User's. Outstanding referral to Speech and Language, in relation to swallow assessment and planning have been addressed and arranged to take place as required.

3. The aim includes to ensure the most effective interventions are in place for staff to alleviate the cause of behaviour and manage escalation with low arousal techniques insofar as possible if it does occur.
4. As per Outcome 7 above, a summary risk document for the resident will be compiled in a separate summary document and communicated to all staff on a weekly basis. It shall be available prominently in the staff area.
5. Shift Handover meetings shall be held at the commencement of each shift or as soon as possible thereafter, and during the shift as required. At these meetings, any change to the needs of the residents shall be highlighted.
6. Staff team meeting on the 22 and 29 June 2017 to include a review of the Personal Plans for each resident and ensure staff are familiar with the needs of each resident, including triggers to behaviour that challenges, support required and interventions to prevent and manage escalation of behaviour.
7. Lessons learned from evaluations of incidents and the use of PRN medication as above will also be discussed (and at all subsequent meetings).
8. All residents have been reviewed by the Clinical Team and continue to be reviewed on an ongoing basis to ensure their clinical and behavioural needs are being met.

Proposed Timescale: 30/06/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Improvements were required to the day to day practices in the centre to ensure that residents' health care needs were appropriately assessed and met and that staff were aware of residents' needs.

9. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:

1. All residents Healthcare Plans will be reviewed and updated to include all supports required to ensure that residents' health care needs are appropriately assessed and met.
2. Specific Health Management Plans such as, a Medication Management Plan and Health Relapse Plan have been developed in consultation with the resident' and their Clinical Team. The recording of any acute medical conditions on a "Specific Health Management Plan" and the recommendations from the allied services that need to be implemented and recorded.
3. Monitoring charts are in place as required for resident' and will be reviewed weekly by the key-worker and any issues reported to the PIC or Deputy Team Leader.
4. All residents are reviewed regularly by the Clinical Team ensuring residents' health care needs were appropriately assessed and met while monitoring medication.
5. A full-time nurse has been made supernumerary in the Centre to monitor all

residents' health care needs.

6. All of the above points will be discussed at the staff team meeting on the 22 and 29 June 2017.

Proposed Timescale: 30/06/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The management systems in place were ineffective.

10. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

The Provider is dedicated to strengthening the management systems in place to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. Actions in place to achieve this as follows:

1. Nua Healthcare has compiled a Governance Plan for HIQA to outline its plans to improve the Governance, Leadership and Management within the organisation, and the impact this will have on individual Centres including Chapel View.
2. The Governance Plan shall include a focus on the purpose and function of meetings and forums taking place in the Designated Centre's. One focus shall be on the process for actioning all issues discussed at meetings in a SMART (Specific, Measurable, Action-Oriented, Relevant and Timely) way.
3. A review and restructure of the Quality Assurance is underway to assure the validity and reliability of all audits carried out in Nua Healthcare.
4. Within Chapel View, increased management supports are available with the increased presence of the Regional Manager. The Regional Manager and PIC act in a supernumerary capacity.
5. To strengthen the accountability for practices, the roles and responsibilities of the individuals in Chapel View are being reviewed to ensure all people are clear of their roles at this time. This includes:
 - a. Specific responsibility of PIC for oversight of, and action with, incident reports, complaints, verbal feedback from residents, and to oversee the actions of all staff in the house.
 - b. Regional Manger to provide support to the PIC to oversee all elements and to ensure the PIC has all required information.
 - c. Social Care Worker roles and responsibilities.
6. The Admissions, Discharge and Transition process is under review to ensure safety of residents is not compromised, and to include increased involvement of the PIC.
7. Active Evaluation, analysis and trending and feedback of this information with

commentary, actions and lessons learned will take place regarding

i. incidents;

ii. behaviour support; and

iii. the use of restraint

in order to strengthen the oversight and assurance of safety for all residents and staff in Chapel View.

8. All staff shall be educated on the culture of Nua Healthcare which shall promote a restraint-free culture with a focus on resident safety and excellent quality of life. This shall be reiterated to staff on an ongoing basis.

9. As above staff shall be required to acknowledge relevant policies and procedures.

10. To ensure staff have the fundamental knowledge necessary to support resident's further, actions planned are:

-Nua has an extensive induction and training program in place, which will be supported by the introduction of competency bases assessments for key policies and procedures.

-Resident needs and risks will be communicated in an improved manner on a daily basis (staff handover process improvement).

-Staff Meetings shall be more effective with SMART goals for all issues developed and actioned.

-a schedule of education and training is in place for the year ahead providing ongoing refresher education and training for staff.

Proposed Timescale: 31/07/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no action plan in the written reports generated from the unannounced visits to identify how deficits in service delivery would be identified.

11. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:

1. The unannounced visit report has been finalised with a written report complete including areas of improvement identified within the action plan.

Proposed Timescale: 07/06/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Inspectors found that the organization of staffing resources differed from the assessed needs of residents.

12. Action Required:

Under Regulation 15 (1) you are required to: 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.

Please state the actions you have taken or are planning to take:

1. The Staff Nurse is supernumerary since 15 May 2017 with a focus on ensuring all residents' health care needs are being met.
2. There are sufficient and appropriate staff to meet the needs of the roster at all times.
3. The PIC is full time in Chapel View to support staff and oversee all actions.
4. The Regional Manager has increased allocated time in Chapel View to support the PIC and oversee the implementation of required improvements.
5. A Behavioural Support Therapist is present in the Centre one day a week to review the support provided to the residents by the staff and to support staff to meet resident's needs. This will be reviewed on an ongoing basis.
6. The staffing arrangements will be reviewed to ensure they are sufficient and relevant to the resident's assessed needs.

Proposed Timescale: 30/06/2017