

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Broadleaf Manor
Centre ID:	OSV-0003397
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):	Christopher Regan-Rushe
Type of inspection	Unannounced
Number of residents on the date of inspection:	8
Number of vacancies on the date of inspection:	1

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 compliance with National Standards. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 02 May 2017 09:00 To: 02 May 2017 18:30

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 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management

Summary of findings from this inspection

Background to the inspection:

This was the fourth inspection of the centre. In February 2017, an unannounced inspection was conducted. The inspection identified significant failures in the quality and safety of care provided to residents. These included safeguarding, risk management and the management of behaviours that challenge. Inspectors also found that there remained inadequate governance and oversight to ensure a safe and good quality service, which had previously been identified.

Given the serious concerns regarding the quality of service being provided, HIQA took the extraordinary action of issuing a warning letter to Nua Healthcare Services. In response, the provider submitted an action plan to the Office of the Chief Inspector which outlined the actions they would take to ensure residents' safety and well being. All actions were due to be completed by 6 October 2017, with some due to be completed by the day of inspection.

This inspection was undertaken to ascertain if the immediate action taken by the provider was effective in ensuring residents' safety while the changes to the overarching systems were occurring. This inspection focused on specific outcomes that relate to residents' safety.

How we gathered our evidence:

As part of this inspection, inspectors met three residents. Inspectors also met with staff 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 both male and female residents.

Overall findings:

While the provider had taken some action following the last inspection, not all actions had been completed in the agreed time frame. Fundamentally, inspectors found that the provider had failed in ensuring that residents were safe. This is discussed further in the report.

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):

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

Findings:

In February 2017, inspectors found that poor implementation of the admissions process impacted negatively on the safety and well being of residents. Following this, there had been a reduction in the number of residents from 9 to 8 due to the voluntary discharge of one resident. Management informed inspectors that there would be no new admissions to the centre until the relevant action plan from the previous inspection was implemented fully. However, the provider had failed to implement all of the required actions that they had committed to within the agreed time frame. As a result, inspectors identified an ongoing risk to the safety and well being of residents.

The provider had committed to reviewing the admission policy by 28 April 2017. The policy was in a draft format. Inspectors reviewed and discussed the policy with the regional manager. Inspectors found that the provider had failed to ensure that the draft policy gave due consideration to the Statement of Purpose of the centre and the compatibility, safety and impact that future admissions could have on the needs of current residents. For example, the proposed procedure was that once a centre was identified a pre-admission risk assessment would be completed. However the threshold for not admitting a resident, following this risk assessment was not clear.

In addition, the provider stated that specific neuro-psychiatric reviews would be completed for residents identified as needing these by 28 April 2017. Inspectors found that these had been completed however the reports from these reviews were not available in the centre.

Inspectors confirmed that each resident had agreed in writing with the provider the terms in which they would reside in the centre, which was an action arising from February 2017.

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:

In February 2017, the provider had failed to ensure that effective systems were in place for the assessment and management risk. The provider had submitted an action plan to HIQA which aimed to address this by 20 May 2017. Inspectors acknowledged that the final time frame had yet to be reached. However, found that the actions taken in the interim did not ensure the safety of residents, visitors and staff.

There had been 79 incidents involving residents in the centre of varying severity since the last inspection. The incidents included verbal and physical aggression, property damage, residents going missing and self harm. There had been 29 accidents involving staff, which included staff being punched, kicked and head butted. During the inspection, inspectors completed a walk around of the centre and observed that there were inadequate controls in place to prevent incidents from occurring. For example, some of the incidents involved residents using objects for weapons. Inspectors observed materials left over from maintenance to be freely available. A cleaning shed which had previously been a source of weapons was unlocked.

The provider failed to ensure that control measures were consistently implemented in practice and reduced risk. The primary control measure was staff standing between residents to prevent physical assaults. Incidents had occurred which placed residents at significant risk. The potential for such incidents was known to the provider prior to the incidents occurring. Reviews of the individual incidents did not identify why existing control measures had not been effective in preventing the incident from occurring.

Resources had been allocated to the centre to ensure that it was cleaned at regular intervals. However, the level of uncleanliness would indicate that this cleaning was insufficient. This had been identified on two previous inspections of the centre. Areas of the kitchen were visibly dirty and inspectors observed grease build up on the extractor fan and filters which did not appear to have been cleaned for many weeks. In addition cupboard doors were missing in the kitchen and the main electrical wire to the cooker was observed to be trailing out underneath the cooker.

Although the provider had implemented fire management systems, the provider did not demonstrate that they were fit for purpose. Following the inspection, HIQA requested

that the provider complete a review of the fire safety arrangements in the centre. The provider submitted a report completed by an external contractor. However the report did not include sufficient commentary to the defects found on inspection and conflicted with the fire procedure in the centre.

Although, there was a fire alarm, fire extinguishers and emergency lighting, inspectors found that access to one fire alarm panel was restricted as it was in a locked cupboard. Staff stated that all staff had keys on their person as a control measure. However inspectors observed staff handing each other keys at varying points throughout the day. Therefore not all staff had access to keys at all times. Inspectors also observed numerous fire doors to be ineffective due to self closers not operating and seals being broken. The self-closing mechanisms on many of the doors had been recessed into the door leaving visible gaps. In one instance, a lock had been removed from a fire door in a communal area and the remaining hole had not been sealed. Inspectors found that these alterations to the doors meant that they failed to provide adequate protection against smoke and fire if required. Inspectors also noted that there was a significant amount of combustible items stored under the stairs and in attic spaces; including, floor mats, two vacuum cleaners, notice boards and crates from food deliveries.

Access to a fire extinguisher was restricted as a table had been placed in front of it. Inspectors reviewed the evacuation route from the rear of the building and noted that the side gate was locked with a key. This was the route to the access point at the front of the building. There was no emergency release facility.

While staff had received fire safety awareness training, a fire drill had not been conducted to demonstrate that all residents could be evacuated to a place of safety with the lowest number of staff on duty (seven). The following day, the regional manager submitted a record to HIQA demonstrating that a fire drill had taken place that morning. The record stated that it took seven staff seven minutes to evacuate the residents and there had been challenges evacuating some residents.

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:

Safe Services

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

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

Findings:

Inspectors found that the provider had continued to fail to safeguard residents. As a result residents remained unprotected from violence in any form. The provider had committed to undertaking a variety of actions including the discharge of residents and the provision of additional staff. The impact of these actions did not result in a safer service.

Verbal aggressions and attempted physical aggression was a daily occurrence in the centre. A resident submitted a complaint to the provider stating that they felt the centre was no longer their home and that they cannot eat anymore. Residents had been spat at by other residents. On one occasion, a resident was directed by staff to go outside for a cigarette to protect them from assault from a peer. This was in the middle of the night. Inspectors identified that the primary purpose for the additional staff was to stand between residents and physically intervene to prevent assaults from occurring.

As a result, there remained a high level of physical restraint in the centre. There had been 78 physical restraints in ten weeks. Inspectors found that incident records did not demonstrate that they were the least restrictive option available at the time. In one incident a resident was restrained for a total of 40 minutes. The description of the restraint demonstrated that there was a significant risk to the resident's health and wellbeing and contravened best practice.

Residents were living in an environment where restrictions were in place for prolonged periods, including the use of doors locked by key pads and controlled access to facilities for making hot drinks. There was a failure to monitor the implementation of increased levels of restrictions, in line with recommendations. For example, in one case an emergency plan had been developed to complete regular reviews of a resident twice a day for a period of 48 hours. This was due to an increased level of 3-1 staffing. Inspectors found that these reviews had not been completed at the required frequency or intervals.

Recommendations from the behaviour specialist were not consistently implemented. For example, it was recommended that staff should keep verbal engagement to a minimum when residents' exhibited aggressive or assaultive behaviour. Incident records repeatedly stated that multiple staff attempted to verbally engage with residents. One incident involved the seclusion of a voluntary resident, as they were prevented from leaving their personal area. The review by the behaviour team identified that it 'did not appear that such action was necessary'. The provider had failed to ensure the reoccurrence of such an incident. The resident's personal plan was not reviewed until 12 days after the event. In the time between, there had been a number of serious incidents. The provider also did not demonstrate that the resident had consented to this high level of restriction.

Inspectors found that all efforts had not been made to identify and alleviate the cause of residents' behaviours. There was an absence of therapeutic interventions for some residents including occupational therapy for sensory integration. Staff were not clear on

who was accountable for ensuring appropriate referrals were made. Due to a high level of risk, a personal plan was due to be reviewed weekly. This had not occurred, with one review occurring in a one month period. Therefore the provider did not ensure that the appropriate supports were available. The primary measures in place were high level restrictions.

Fundamentally inspectors found that staff employed in the centre did not have the knowledge necessary to support residents based on their assessed needs. As a result basic areas to promote positive behaviour such as adequate fluid and nutrition were not being recorded to demonstrate that individuals' needs were being met. There was a focus on training of breakaway techniques and physical restraint. This resulted in physical restraint being the primary intervention. The person in charge also stated that it was challenging to provide a consistent approach due to the high level of staff turnover in the centre as a result of sick leave and annual leave, which resulted in inexperienced staff supporting residents.

Judgment:

Non Compliant - Major

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:

Inspectors found in February 2017, that management oversight in the centre was failing to ensure effective management of adverse events which impacted negatively on residents. The provider had responded by stating that their current systems would be developed to ensure that all aspects of the quality and safety of care in the service would be assessed. The timeframe for the completion of all actions were 31 July 2017. However the provider had failed to ensure that actions which should have been completed by the day of inspection were done.

The primary finding of this inspection was that inadequate action had been taken to ensure that a safe service was provided to residents while the changes to the overarching systems were occurring. Inspectors found a culture which accepted that

high risk and high levels of restrictions were normal. There was a lack of accountability for the practices within the centre and governance and management systems did not identify the day to day care and support provided to residents. The absence of pragmatic risk management, the centre being unclean and the poor record keeping also demonstrated poor management practices.

Four audits had been completed in the centre since the last inspection, however inspectors found that the validity of these audits were negligible due to the high level of compliance identified. There was also an absence of action plans arising from the audits. For example, it was found that residents' rights were upheld however there was no reference to the high number of restrictive practices used in the centre inclusive of environmental and physical restraint. The health and safety audit also identified a 92% compliance rating however there was no reference to the continued frequency and severity of incidents within the centre. Six unannounced visits had been completed, one by the person in charge and four by the regional manager; however no report had been generated to identify the purpose and findings of the visits.

Inspectors reviewed minutes of the operation and clinical meetings which were the forum for ensuring the quality and safety of care provided and found that the actions generated from the meeting did not impact on the quality and safety of care and support provided to residents. In one meeting it was reported that a resident had 13 incidents in a two week period of a low severity. Inspectors reviewed these incidents and found that many involved the use of physical restraint and distress to the resident involved. There were no immediate actions arising from the meeting to address the day to day life of the resident concerned.

There was also an absence of proactive planning in place to support residents to be discharged in a safe and planned manner. Inspectors were informed that the centre was awaiting confirmation from the Executive of alternative residences. However, in the interim, inspectors could not be assured that the measures identified in the action plan of the provider could occur within a reasonable timeframe.

The overall findings of the inspection demonstrated that the provider had continued to fail to ensure that residents were adequately protected.

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-0003397
Date of Inspection:	02 May 2017
Date of response:	31 May 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:

The draft policy did not give due consideration to the Statement of Purpose of the centre and the compatibility, safety and impact that future admissions could have on the needs of current residents.

1. Action Required:

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

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and 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 Broadleaf Manor, 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, Broadleaf Manor'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. No new admissions will be take place in the Centre for at least 3 months.

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

5. The updated policy shall be communicated to staff in Broadleaf Manor by July 2017, and all staff shall be required to acknowledge same.

6. 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 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 provider had failed to ensure that effective systems were in place for the assessment and management risk

2. 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 the identification of key risks for each resident, the level of risk identified, the management of the risks and the interval for review of the risks.
2. Staff team meeting on 8th June 2017 and the 15th June 2017 to include a review of the Personal Plans for each resident and ensure staff are familiar with the needs of each resident.
3. Key risks for the resident and for the staff will be compiled in a summary document. Person centred risks such as vulnerability of a resident and risks associated with impaired communication shall be included. 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.
4. The summary risk document shall be communicated to all staff on a weekly basis and shall be displayed prominently in the staff area.
5. To assure the ongoing communication of risks, the Shift Handover System is undergoing improvement at present. Shift Handover meetings shall be held at the commencement of each shift or as soon thereafter, and during the shift as required. At these meetings, any change to the needs or risks for the residents shall be highlighted. Additional resources have been introduced to support the residents within Broadleaf Manor. These have been in place from the last HIQA inspection of 2nd May 2017 (as per Action 3 below). Resources will be regularly reviewed to ensure they meet the needs of the residents at Broadleaf Manor.
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 assessed and 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:

The centre was not clean.

3. Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections

published by the Authority.

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

1. A full deep clean of the Centre is planned to take place.
2. A deep cleaning schedule is being developed for the house and shall be rolled out in June 2017 and continue on an ongoing basis.
3. All staff were re-educated on the Cleaning Policy and have signed to acknowledge understanding of same.
4. Lessons learned from the HIQA audit were fed back to all staff following the HIQA Inspection.
5. 15 hours' total per week of external cleaning services have been confirmed and implemented following the HIQA Audit. Arrangements have been made so that backup services are in place if the cleaner is sick or absent.
6. An additional Full Time Equivalent staff is on duty every day and night, with a key focus to support residents and assure safety of residents, however this shall also ensure that other staff assigned to cleaning tasks can carry out these duties.
7. The Person in Charge / Team Leader or Deputy Team Leader's on duty shall carry out daily cleaning spot checks in Broadleaf Manor. All non-conformances shall be highlighted on a daily basis, and actioned immediately. Lessons learned shall be fed back to all staff.
8. The Quality Assurance Team shall support the cleaning oversight via monthly unannounced Audit for the next quarter, and this shall continue until excellent compliance is demonstrated.

Proposed Timescale: 30/06/2017

Theme: Effective Services

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

The provider did not demonstrate that the fire management systems in place were fit for purpose.

4. Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

1. Work regarding removing the barrier to this specific Fire Panel has been completed on the 29th May 2017.
2. The lock on one fire door (which had been removed leaving a hole) has now been replaced.
3. Regarding visible gaps at the top of doors due to the self-closing elements within the door, these gaps have now been addressed.
4. Combustible items have been fully removed from the attic space identified during the inspection and from under the stairs.
5. The Fire Extinguisher which was behind a table is now in a fully accessible location as the table was moved to the other side of the kitchen. A laminated sign remains beside

the Extinguisher to warn staff not to block area.

6. Regarding the emergency evacuation route, all staff are required to carry a key to the garden evacuation route securely on their person until the key pad locks are installed.

7. The emergency evacuation route from the back-garden areas will have key pad locks installed which include an emergency release facility. Work has been approved for completion in June 2017.

8. The risk register for the Centre is being reviewed and updated to reflect the current risks posed and controls in place until the work is completed.

9. Following the addressing of all areas of deficit, a second Full External Fire Review by an Expert Fire Safety Organisation has been organised to evaluate and confirm the suitability and safety of the fire systems within the house, including but not limited to the changes implemented following the HIQA inspection. The Organisation will be provided with the Nua Healthcare policies and procedures and Broadleaf Manor emergency plans prior to the inspection. A report with detailed commentary is required as part of the Contract. Any actions arising shall be dealt with immediately.

Proposed Timescale: 30/06/2017

Theme: Effective Services

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

The provider did not demonstrate that residents could be evacuated to a place of safety in an appropriate time frame.

5. 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 Broadleaf Manor is under review.
2. To ensure the safety of residents in the case of evacuation being necessary, the number of waking night staff on duty at night was reviewed following the HIQA inspection and has been increased from 7 waking night staff to 8 waking night staff at a minimum each night (Completed immediately following HIQA inspection). The extra waking night staff will be regularly reviewed depending on the number of residents in the Centre and the needs of the residents at Broadleaf Manor.
3. A schedule for Fire Drills for the next 12 months has been put in place. This shall incorporate drills with the full complement of staff as well as with the lowest complement of staff.

Proposed Timescale: 30/06/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The provider did not make every effort to identify and alleviate the cause of residents' behavior.

6. 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 Multielement Behaviour Support Plans) 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 therapy referrals are being made for Service User's. Outstanding referrals to Occupational therapy, in relation to sensory integration assessment and planning have been addressed and arranged to take place.
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. Additional resources have been introduced to support the residents and oversee the implementation of MEBSP, and oversee and evaluate the incidents occurring in the centre.
7. Staff team meeting on the 8th 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.
8. Lessons learned from evaluations of incidents and the use of PRN medication as above will also be discussed (and at all subsequent meetings).
9. 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: 28/07/2017

Theme: Safe Services

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

The provider failed to demonstrate that interventions were implemented with the consent of residents.

7. Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

1. Process for obtaining Informed Consent from residents for therapeutic interventions is under review. The organisation will ensure this is fully person centred and in line with HIQA regulations and standards.
2. Where therapeutic interventions are required for any resident of Broadleaf Manor, informed consent shall be obtained from each resident, or his or her representative, in line with the Regulations.
3. A section is to be identified in the resident's Personal Plan where residents can sign to state that they have been involved in the process of developing their Personal Plans and that they are in agreement with them. This shall also include the option where the resident does not wish to sign, to acknowledge that they have been provided with the option of doing so.
4. All Individual Personal Plans are to be reviewed by the resident's Key Worker and the Person in Charge to confirm that the information in the Personal Plans are up to date and reflective of the resident's needs. As part of this process the Personal Plans will be discussed with the resident and the section referred to in (3) above shall be completed with the resident (preferably by their signature or alternatively to note that they wish not to sign).
5. Where interventions are changed, the consenting process shall be repeated.
6. This process shall be overseen by the Person in Charge, Regional Manager and Provider Nominee.
7. The QA Team shall audit informed consent for residents at 1 and 6 months' post implementation and a report shall be provided to the Person in Charge, Middle and Senior Management Team following each audit.

Proposed Timescale: 22/09/2017

Theme: Safe Services

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

The provider failed to demonstrate that restrictive practice was the least restrictive option available.

8. 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 Broadleaf Manor 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. The QA team will complete a medication audit, and 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. To support this oversight and evaluation, A Behaviour Specialist and MAPA instructor were brought into Broadleaf Manor in a full-time capacity following the HIQA inspection and are currently in place. Resources will be regularly reviewed to ensure they meet the needs of the residents at Broadleaf Manor.
5. All staff shall sign to acknowledge they have read and understood each resident's Multielement Behaviour Support Plan; and the lessons learned provided in relation to evaluation of restraint in Broadleaf Manor.
6. 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: 28/06/2017

Theme: Safe Services

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

Residents were not protected from all forms of abuse.

9. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

To assure the protection of residents from all forms of abuse, systems have been reviewed and improved and additional resources have been introduced to support the residents within Broadleaf Manor as follows:

1. As per above, Nua Healthcare is actively working to change the composition of residents residing within Broadleaf Manor. The process is in place to transition one service user from the house. Actions are also being taken with the HSE to support a second resident to transition to alternative location.
2. A risk assessment is being completed for each resident specifically in relation to the unique vulnerabilities of each resident, the level of risk associated with these vulnerabilities, and a Proactive Safeguarding Plan is being developed for each resident.
3. Increase in the number of Social Care Workers on duty in Broadleaf Manor.
4. The Person in Charge and Team Leader are supernumerary, with a focus on support of the staff team and ensuring appropriate staff are available and rostered.
5. Behavioural Support Therapist and a MAPA Trainer are currently on site at present in Broadleaf Manor.
6. All staff shall be provided with re-education on Resident Rights, Safeguarding, Vulnerable Residents, and the Use of Restraint.
7. At the staff team meeting on the 8th June 2017 and the 15th June 2017 the priorities for safeguarding of all residents are to be highlighted and discussed.
8. As above, 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.
9. As above, 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
10. Protection of Residents shall be audited by the QA Team on quarterly basis starting June 2017 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

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 provider failed to take adequate action to ensure residents' safety.

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 is compiling 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 Broadleaf Manor.
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 Broadleaf Manor, increased management supports are available with the increased presence of the Regional Manager. The Regional Manager, PIC and Team Leader act in a supernumerary capacity.
5. To strengthen the accountability for practices, the roles and responsibilities of the individuals in Broadleaf Manor 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, including:
 - i. Allocation of responsibility to Behavioural Support Team member regarding the direct support to the residents and that the Personal Plans reflect same.
 - ii. Team Leader/Deputy's having specific responsibility for completion of rosters, allocation of staff, overseeing staff and residents on a daily basis.
 - b. Regional Manger to provide support to the PIC to oversee all elements and to ensure the PIC has all required information relating to the ongoing process of transition of the resident's.
 - c. Social Care Worker roles and responsibilities.
6. The provider is dedicated to assuring a safe mix of residents in each Designated Centre. The current mix has been reviewed and as above, we are actively working to change the composition of residents residing within Broadleaf Manor with actions being taken with the HSE to support two residents to transition to alternative locations.
7. 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.
8. 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 restraintin order to strengthen the oversight and assurance of safety for all residents and staff in Broadleaf Manor.
9. 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.
10. As above staff shall be required to acknowledge relevant policies and procedures.
11. 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.

12. A full review of compliance with all elements of the regulations is being undertaken by an external agency to identify any additional quality improvements to fully meet resident's needs. This shall be utilised to create a full action plan to develop all areas of the service, not just those identified to date.

Proposed Timescale: 30/06/2017