Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Tignish House
Centre ID:	OSV-0004262
Centre county:	Wicklow
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):	Thomas Hogan
Type of inspection	Announced
Number of residents on the date of inspection:	5
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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
24 May 2017 09:30	24 May 2017 17:30
25 May 2017 10:00	25 May 2017 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:
This was the third inspection of the centre. The inspection, prior to this, was conducted in November 2016. This inspection was conducted following an application by the provider to renew the registration of the centre under the Health Act 2007. Inspectors also followed up on the actions arising from the previous inspection.

How we gathered our evidence:
As part of this inspection, the inspector met 4 residents. The inspector also met with 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. Wicklow. Services were provided to male over the age of 18. The centre is operated by Nua Healthcare.

Overall findings:
The findings of this inspection demonstrated that residents were supported by a consistent team of staff who aimed to provide appropriate care and support to the residents. However, inspectors found that the systems in place did not facilitate a safe and effective service. Fundamentally due to environmental constraints, high levels of restrictive practice and an absence of governance oversight, inspectors found that residents' rights were infringed.

The provider had applied to provide services to 5 residents. However, inspectors found that the centre was not a suitable size or layout to meet the assessed needs of 5 residents.

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 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Efforts had been made to uphold the dignity of residents. However, inspectors found that residents' privacy and rights were compromised. This was due to a systematic failure to ensure that residents were consulted and agreed to all aspects of the care and support provided to them.

There were policies and procedures in place for the receipt and management of complaints. Inspectors confirmed that the policy met the requirements of regulation 34. There had been no complaints in the centre since that last inspection. Therefore, inspectors were unable to assess the effectiveness of the procedures. However, staff knew the process to be followed.

Each of the residents had their own bedroom. Notwithstanding that, due to the residents' needs, this arrangement did not always ensure that the dignity of all residents was maintained. Staff endeavoured to protect the privacy of residents however due to environmental constraints this was not always possible. Residents' personal information was stored in a secure location.

Restrictive practice was regularly used in the centre. Inspectors found that there was an absence of due consideration given to the impact that restrictive practices had on the rights of all residents. For example, items such as the toaster was locked away however the impact on this to all residents had not been considered. Another restriction in place was for staff to be present at all times when a resident was in a communal area. There had been no consideration given to this infringement on an individual's right to free movement. There was an advocacy service available for residents. Management

confirmed that there had been no referrals to this service.

There were systems in place for the management of residents' personal finances. Inspectors found that the system promoted accountability and safety.

Residents took part in a variety of activities in line with their interests and capabilities, these included attending local parks, going to the shops and foot spas.

Judgment:
Non Compliant - Major

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors observed staff to be aware of the individual communication needs of residents. Alternative communications such as pictorial aids were actively used. Support has been obtained from appropriate allied health professionals. Staff were in the process of being trained in a variety of different communication systems including adapted sign language. Personal plans were reflective of the individual communication needs of residents.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:

Residents were supported by staff to maintain relationships with their families and friends. This included regular phone calls between the centre and families. There was a policy in place for visitors to the centre and there was a room available where residents could meet visitors in private if they wished.

Judgment:
Compliant

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:
Inspectors found that the system in place for the admissions and discharge of residents did not ensure that admissions to the centre were based on a transparent criteria and safeguarded existing residents.

Inspectors reviewed an admission to the centre and found that it did not assess if the centre could meet the needs of the resident. For example, noise was identified as a contributing factor to causing the resident to experience distress. No specific control measures had been identified of how this could be managed considering the number and needs of the current residents and the environment. A psychology assessment which was completed six months after the resident moved in stated that incidents of challenging behaviour could be as a result of other residents making noise. The admissions procedure also did not assess the impact of new admissions on all residents.

The written agreement did not adequately identify the circumstances in which a resident could be discharged from the centre. This was an action arising from the previous inspection and had not been addressed.

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:
Effective Services

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

Findings:
While each resident had a personal plan in place, improvement was required to ensure that the residents were consistently supported to maximise their potential in line with their personal plans. Improvement was also required to ensure that personal plans were multi – disciplinary and adequately reviewed following a change in need.

Inspectors reviewed a sample of personal plans and found that needs were identified under a variety of headings. For example, communication, sensory needs, money management and healthcare were overarching areas in which residents were assessed as requiring support. These outcomes were used to guide the monthly goals identified for residents. For example, if money management was identified as a need a monthly goal was to purchase items in a local shop. The system required that three monthly goals be identified. However, inspectors found that some of the overarching outcomes may not be addressed for a number of months if not included in the monthly goals. For example, in April 2017 it was identified that a resident would be supported to get used to new locations. However, there was no reference to this in May 2017.

Inspectors also found that the personal plans were not guided by the appropriate allied health professionals. For example, if a sensory need was identified, interventions were not guided or reviewed by the appropriate allied health professional.

Inspectors were informed of the proposed discharge of a resident in the coming months. The personal plan of the resident had not been reviewed to identify the supports the resident would require to ensure that the discharge would take place in a safe and planned manner.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors identified that improvements had been made to the physical premises since the last inspection. This included re – decoration of some areas. However, fundamentally considering the size and layout of the premises and the needs of the residents, inspectors found that the centre was not suitable to meet the needs of 5 residents.

The centre consisted of 6 bedrooms, a kitchen, a living room and a relaxation room. There was also a staff office, a bathroom and a small utility room. One of the bedrooms was en suite. Inspectors observed the corridors to be narrow and did not facilitate more than one person at a time to walk down them. Due to the supports residents required, there could be up to eight staff working in the centre for the majority of the day. Inspectors observed this resulted in a crowded environment, with the kitchen or living room being unable to adequately facilitate this. This finding was supported by the frequency of physical restraint in the centre and the locations in which it was used, such as the narrow corridor.

Inspectors also found that while the centre had recently been redecorated in some areas, attention was required to other areas such as the bathroom. The centre also required additional cleaning to ensure that it was of a suitable standard. Inspectors observed a mal odour in some areas.

There were generous external grounds for use by residents and suitable facilities for the disposal of waste.

Judgment:
Non Compliant - Major

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:

Inspectors found that systems in place for the assessment and management of risk did not effectively reduce the risk to residents, staff and visitors. There were policies and procedures in place which met the requirement of regulation 26. However, as reviews of individual incidents did not identify the effectiveness of control measures or the overall frequency of incidents within the centre, the procedures were not effective.

Inspectors reviewed a sample of accidents and incident forms and found that the severity rating was directly linked to the escalation pathway. However, the severity level only accounted for physical injury or property damage. It did not account for the number of incidents of a similar nature which had occurred or if a physical restraint had occurred. Reviews also did not consider if identified control measures in risk assessments had been utilised and were effective. Risk assessments were not reviewed after each individual incident or at a frequency as required by the policies and procedures.

There was also an absence of oversight of the clinical and operational risk within the centre. An environmental risk assessment had been completed of the centre however this did not consider the assessed needs of residents.

There were policies and procedures in place for the prevention of healthcare associated infections.

There were fire management systems in place. However, improvement was required to ensure that the measures in place were checked at appropriate intervals to ensure that they were operating effectively. The centre had a fire alarm, fire extinguishers, emergency lighting and fire doors. Records demonstrated that the fire alarm and fire extinguishers were serviced at appropriate intervals. There were no records available for the servicing of emergency lighting. Staff also completed regular checks of the prementioned. However, these checks did not identify that fire doors were not closing effectively or did not account for if fire exits were unobstructed.

Fire drills occurred in the centre. The provider had addressed the previous regulatory failing and had completed a fire drill to ensure that the maximum number of residents could be evacuated with the lowest compliment of staffing. However, there was insufficient action taken if challenges arose during the fire drills. For example, a repeat fire drill had been scheduled but had not occurred.

Staff were aware of the emergency evacuation procedure and had received training in the prevention and management of fire.

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:
There were policies and procedures in place for the protection of vulnerable adults. Staff had received training in this procedure and were aware of what constitutes abuse. However, inspectors found that residents were not protected from violence of every form in the centre.

Positive behaviour support was required in the centre. However, the provider did not demonstrate that all efforts had been made to identify and alleviate the cause. Inspectors also found that when restrictive practice was applied, it was not evident that it was the least restrictive method. There were regular incidents of aggressive and assaultive behaviour in the centre. Residents were exposed to threatening behaviour by their fellow residents. Incidents included residents attempting to strike other residents, residents spitting at other residents and residents witnessing other residents being physically restrained.

Inspectors identified an inconsistent response to these incidents. In some cases redirection was used and in other instances physical restraint or medication was the response. However, the primary approach was reactive as opposed to proactive. Multi – element support plans identified the actions to be taken once a resident started exhibiting behaviours that challenge. However, it was not clear if proactive strategies were implemented prior to incidents occurring. There were clear factors identified which contributed to incidents occurring. However, these were not considered in reviews of incidents. As a result, incidents continued to occur.

Restrictions were applied to residents. However, there was an absence of consent for these restrictions from residents and/or their families. The response to clear indicators of a resident's declining wellbeing was delayed. In one incident the multi disciplinary team did not meet until five weeks after a resident was restrained.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The person in charge was aware of their statutory responsibility to inform the Chief Inspector of the adverse events which occurred in the centre as required by regulation 31.

Judgment:
Compliant

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors observed residents to be engaged in social activities external to the centre.

Judgment:
Compliant

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 were supported to attend their General Practitioner (GP) or other external health appointments if a need was identified. However, improvements were required to ensure that residents' healthcare needs were appropriately monitored.

Personal plans identified residents' needs. Interventions were also identified. However inspectors found that some aspects of personal plans were not informed by the appropriate allied health professionals. For example, anxiety management plans were not informed by psychology or psychiatry. Inspectors also found that a resident was identified as requiring no support with their breathing. However, there had been concerns identified in this area.

Furthermore, the guidelines in place for the monitoring of blood pressure were inadequate. They guided practice on how to take blood pressure but did not inform the action to be taken in the event of an abnormality being detected. Staff were also not clear on this. There had been instances in which blood pressure was identified as being outside the normal parameters and no action had been taken.

Residents were also supported to monitor their weight, however this was not consistent. In one instance this was to be done weekly. However, it was occurring inconsistently and in different metrics.

Residents required support to ensure that they had an adequate dietary intake. Residents had been referred to the appropriate allied health professionals. However, there was no oversight of the daily/weekly nutritional intake to ensure that it was in line with the recommendations identified.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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 for the prescribing, storage, administering and disposing of medication. Inspectors observed that medication was stored in a secure location. Staff had received training in the safe administration of medication.

Inspectors reviewed a sample of prescription records and identified that they contained the necessary information. Administration records confirmed that medication was administered at the times prescribed.

There were guidelines in place for the administration of PRN medicines (medicines only taken as the need arises). In some instances, they were clear and approved by the appropriate professional. In other instances, the guidance was generic and not reflective of the medication prescribed to the resident.

Residents were assessed for their ability to self medicate.

Inspectors confirmed that appropriate action had been taken following medication errors.

Judgment:
Non Compliant - Moderate

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The provider submitted a statement of purpose as part of the application to renew the registration of the centre. Inspectors reviewed the document and found that it contained all of the items as required by Schedule 1. However, there had been a change to the person nominated on behalf of the provider prior to the inspection occurring. As a result, the statement of purpose submitted as part of the application to renew the registration of the centre did not contain the accurate information.

Judgment:
Substantially Compliant

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 that the governance and management systems in place did not ensure the registered provider had adequate oversight of the care and support provided to residents. Fundamentally, the overarching finding of this inspection was that reviews conducted did not adequately account for the individual needs of each resident, the support they required and the impact that support had on other residents within the centre.

There was a clear management structure in place in the centre. The person in charge was full time and supernumerary in the centre. The person in charge was supported by two deputy team leaders. The person in charge reported to the regional manager, who in turn reported to the Director of Operations. The Director of Operations was the person nominated on behalf of the provider for the purposes of engaging with HIQA.

Inspectors were informed that a mechanism for reviewing the quality and safety of care to residents was the bi-weekly clinical meetings and operational meetings. However, inspectors reviewed a sample of these meetings and found that they did not sufficiently impact on the quality and safety of care provider for residents. For example, it was identified at one meeting that a resident had been bruised following the use of physical restraint. There was no action arising from this.

Unannounced visits had been conducted in the centre and reports generated. The unannounced visits identified deficits in service delivery. Inspectors found that they had not been adequately addressed. For example, monitoring residents' health care had been identified as an issue. Inspectors found this remained as a deficit.

An annual review had also been completed and actions identified. A review of the document found that it was not reflective of the actual practices in the centre. For example it stated that 'All incidents are discussed at the organisations clinical meeting where corrective actions and supports are implemented to ensure all residents are safeguarded.' Based on the frequency of incidents and level of restrictive practice, inspectors found that this statement was not accurate.

Judgment:
Non Compliant - Major

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The person in charge had not been absent for more than 28 days. The provider was aware of their requirement to notify HIQA if this occurred.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors found that the centre was adequately resourced to meet the needs of residents. There was sufficient food, heating and light in the centre. There was transport available for residents' use. There were additional resources such as maintenance and a clinical team.

Judgment:
Compliant

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

Findings:
Overall inspectors found that there was sufficient staff to meet the needs of residents. Staffing was organised to meet residents' social care needs. A sample of rosters confirmed that the staffing observed on the day of inspection was standard. Staff stated that they felt there was sufficient staff.

Staff had received all mandatory training. However inspectors found that additional training was required to regarding residents' health care needs, positive behaviour support and restrictive practice.

Staff were supervised on a regular basis on a formal basis. Staff stated that they found this a beneficial forum. However, inspectors found that the supervision was static and based on a specific template as opposed to reviewing the needs of residents and the supports they required. This was particularly evident for reviewing the behaviour support staff provided to residents.

There were no volunteers in the centre as of the day of inspection.

Inspectors reviewed a sample of staff files and found they contained all of the information as required by Schedule 2 of the regulations.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors confirmed that the provider maintained personal records for residents as required by Schedule 3 of the regulations. Additional records as required by Schedule 4 were also maintained.

The policies and procedures as required by Schedule 5 were also maintained in the centre and had been reviewed in a three year period.

Judgment:
Compliant

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

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Nua Healthcare Services Unlimited Company
Centre ID:	OSV-0004262
Date of Inspection:	24 and 25 May 2017
Date of response:	28 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff endeavoured to protect the privacy of residents however due to environmental constraints this was not always possible.

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 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
1. One resident in the Centre is to be discharged in a planned manor as agreed with the residents' representatives.
2. Once the resident is discharged a Vary of Condition will be submitted to the Authority for consideration to reduce the number of residents in the Centre from 5 to 4 as max capacity.
3. Once the resident is safely discharged the PIC plans to change the fifth bedroom into a second sitting room for the resident's.
4. The premises currently has an Annex on the grounds and a proposal to be sent to the Authority to include this with in the Statement of Purpose for Tignish House.
5. The proposed use of the Annex would be to use the premises as a games room/sensory area.
6. If the above proposal is approved we believe this will alleviate the environmental constraints in the Centre.

Proposed Timescale: On approval/consultation with the Authority

Proposed Timescale:

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There had been no consideration given to an infringement on an individual's right to free movement.

2. Action Required:
Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

Please state the actions you have taken or are planning to take:
While residents' have high supervision levels as per their high dependency/accessed needs linked to their diagnosis in the Centre a review of individual's Personal Plan, daily planner and weekly planner to take place to ensure no infringement on an individual's right. This needs to be done in accordance with safeguarding all residents in the Centre.

Proposed Timescale: 31/07/2017

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 admissions procedure also did not assess the impact of new admissions on new residents.

3. Action Required:
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 Tignish House, 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 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 Tignish House by July 2017, and all staff shall be required to acknowledge same.

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors reviewed an admission to the centre and found that it did not assess if the

centre could meet the needs of the resident.

4. Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
1. The residents Contract for Provision of Services is under review to ensure the criteria for any residents to move from the Centre is clear for all residents.
2. All residents in the Centre to sign the new Contract of Provision of Services.
3. The updated Contract of Provision of Services will be reviewed at the Centre's team meeting on the 4th August 2017 to ensure all staff are aware of any changes.
4. The key-workers will complete a key-working session with all residents on the new criteria within the Contract Provision of Services.

Proposed Timescale: 31/08/2017

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:
All aspects of personal plans were not informed by the appropriate allied health professional.

5. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
1. PIC to review Personal Plans consistently to assess the effectiveness of the interventions whilst taking into account changes in circumstances and new developments along with each individual's wishes.
2. 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.
3. All residents' to be reviewed by the Clinical Team to include OT assessment where required and continue to be reviewed on an ongoing basis to ensure their clinical and behavioural needs are being met.
4. Staff team meetings to take place on the 14th July 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 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 14th July 2017.

6. Director of Services to oversee the review of Personal Plans in the Centre to include consultation where appropriate with the resident' representatives.

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:
Residents were not consistently supported to meet their maximum potential in line with their personal plan.

6. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
1. 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'.
2. Personal Plans are being reviewed in their entirety to ensure it allows skill building and development for all residents'.
3. Staff team meeting to take place on the 14th July 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'.
4. All of the above points will be discussed at the staff team meeting to take place on the 14th July 2017.
5. Training to be provided to the Key-workers in relation to the identification, recording and effectiveness of personal goals.

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 personal plan of the resident had not been reviewed to identify the supports the resident would require to ensure that the discharge would take place in a safe and planned manner.

7. Action Required:

Under Regulation 25 (4) (b) you are required to: Discharge residents from the designated centre in a planned and safe manner.

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 and the residents'. This review will ensure it identifies the supports the resident identified during inspection would require
2. The resident' transition plan will be develop to support the discharge of the resident in a safe and planned manner.
3. The PIC will ensure that consultation with the residents' representatives continues and that all parties are fully aware of the transition plan.
4. The above points will be discussed at the staff team meeting taking place on the 14th July 2017 to ensure all staff are aware of the updated Personal Plan

Proposed Timescale: 31/07/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre was not suitable to meet the needs of 5 residents

8. Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
7. One resident in the Centre is to be discharged in a planned manor as agreed with the residents' representatives.
8. Once the resident is discharged a Vary of Condition will be submitted to the Authority for consideration to reduce the number of residents in the Centre from 5 to 4 as max capacity.
9. Once the resident is safely discharged the PIC plans to change the fifth bedroom into a second sitting room for the resident's.
10. The premises currently has an Annex on the grounds and a proposal to be sent to the Authority to include this with in the Statement of Purpose for Tignish House.
11. The proposed use of the Annex would be to use the premises as a games room/sensory area.

Proposed Timescale: On approval/consultation with the Authority

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Areas of the centre were not kept in an adequate state of repair.

9. Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
1. The door identified during the inspection that didn't fully close has been repaired on the 13th June 2017 and now closes independently.
2. The bathroom as identified during the inspection that needed to be upgraded works are now planned.

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Areas of the centre were not clean.

10. Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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 July 2017 and continue on an ongoing basis by the walking night staff.
3. All staff will be re-educated on the Cleaning Policy and will sign to acknowledge understanding of same.
4. The Person in Charge / Team Leader or Deputy Team Leader's on duty shall carry out daily cleaning spot checks in Tignish House. All non-conformances shall be highlighted on a daily basis, and actioned immediately. Lessons learned shall be fed back to all staff.
5. The above points will be discussed at the staff team meeting taking place on the 14th July 2017 to ensure all staff are aware of same.

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 did not effectively reduce the risk to residents, staff and visitors.

11. 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 and residents'. 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 14th July 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.
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: 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no records available for the servicing of emergency lighting.

12. Action Required:
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
The emergency lighting in the Centre had been serviced on the 18th May 2017 and recorded in the fire log book, as had all previous servicing records in the Centre. Moving

forward the maintenance technician servicing of emergency lighting will keep records of same on a specific form to be kept in the Centre.

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff checks did not identify that fire doors were not closing effectively or did not account for if fire exits were unobstructed.

13. 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:
The weekly house check form as complete by the PIC or identified staff to be updated to include an area for recording effectiveness of fire doors in the Centre. This form currently includes an area for recording obstructions to fire exits, this form includes actions to be taken if a fault is found.

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient action taken if challenges arose during the fire drills.

14. 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 Tignish House 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.
4. Staff have received training on the use of fire evacuation equipment as identified during previous fire drills. The training took place on the 26 May 2017.
5. The above points will be discussed at the staff team meeting taking place on the 14th July 2017 to ensure all staff are aware of same.

Proposed Timescale: 31/07/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not clear that when restrictive practice was used it was the least restrictive option available.

15. 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 Tignish House 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 where relevant; and the lessons learned provided in relation to evaluation of restraint in Tignish

Proposed Timescale: 31/07/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not clear if proactive strategies were implemented prior to incidents occurring. There were clear factors identified which contributed to incidents occurring. However, these were not considered in reviews of incidents.

16. 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 residents' behaviour.
2. The Person in Charge is responsible for ensuring appropriate referrals for therapeutic interventions are being made for Service User's.
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 14th July 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: 31/07/2017

Theme: Safe Services

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

Residents were not protected from violence of every form in the centre.

17. 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:
1. 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.
2. The Person in Charge is and supported by a two Deputy Team Leader's, with a focus on support of the staff team and ensuring appropriate staff are available and rostered.
3. All staff shall be provided with re-education on Resident Rights, Safeguarding, Vulnerable Residents, and the Use of Restraint.
4. At the staff team meeting on the 14th July 2017 the priorities for safeguarding of all residents are to be highlighted and discussed.
5. 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.
6. 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

Proposed Timescale: 31/07/2017

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 ensure the residents' healthcare needs were appropriately monitored.

18. 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 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 are recorded.
3. Anxiety Management Plans will be reviewed in full in by the Clinical team.
4. 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's.
5. All residents are reviewed regularly by the Clinical Team ensuring residents' health care needs were appropriately assessed and met while monitoring medication.
6. All of the above points will be discussed at the staff team meeting on the 14th July 2017.

Proposed Timescale: 31/07/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no oversight of the daily/weekly nutritional intake to ensure that it was in line with the recommendations identified.

19. Action Required:
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

Please state the actions you have taken or are planning to take:
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. This will include a full review of any residents' dietary plans and updated where relevant.

Proposed Timescale: 31/07/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medication guidance was generic and not reflective of the medication prescribed to the resident.

20. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
1. The Policy and Procedure for the management of medications is being reviewed and when completed will be reissued to all staff within Tignish House and a full review of medication management education shall be undertaken to ensure all relevant staff are

aware of the process.
2. A full medication audit is being scheduled by the Quality Assurance Department to review the medication management practices in the Centre to include guidance documents.
3. All identified Quality Improvements shall be implemented.

Proposed Timescale: 31/07/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose submitted as part of the application to renew the registration of the centre did not contain the accurate information.

21. Action Required:
Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

Please state the actions you have taken or are planning to take:
1. The Statement of Purpose will be reviewed in full to ensure it contains the accurate information.
2. The new Statement of Purpose will be submitted to the Authority for approval once reviewed.
3. The Statement of Purpose will be discussed at the team meeting on the 14th July 2017 to ensure all staff are aware of any changes.

Proposed Timescale: 31/07/2017

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 governance and management systems in place did not ensure the registered provider had adequate oversight of the care and support provided to residents.

22. 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 Tignish House.
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. To strengthen the accountability for practices, the roles and responsibilities of the individuals in Tignish House 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.
5. 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.
6. 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 Tignish House.
7. 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.
8. As above staff shall be required to acknowledge relevant policies and procedures.
9. 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

Outcome 17: Workforce
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Additional training was required regarding residents' health care needs, positive behaviour support and restrictive practice. **23. Action Required:** Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. **Please state the actions you have taken or are planning to take:** 1. Training needs analysis to take place in the Centre by Nua's Director of Training. 2. Training for the following will take place for all staff in the Centre; ・Health care needs, ・Positive behaviour support and ・Restrictive practice.
Proposed Timescale: 31/08/2017
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Supervision was static and based on a specific template as opposed to reviewing the needs of residents and the supports they required. **24. Action Required:** Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised. **Please state the actions you have taken or are planning to take:** 1. Supervision template will be reviewed to ensure it is supporting the needs of the residents. The purpose of which is to ensure the person facilitating the supervision can relate to and therefore provide adequate supervision to the receiving staff team member. 2. The PIC received Supervision Training in August 2015. 3. The PIC and all other DTL's within the Centre in a supervisory role to receive training or refresher training in supervision.
Proposed Timescale: 31/08/2017