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:	The Lakehouse
Centre ID:	OSV-0005334
Centre county:	Westmeath
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services Unlimited Company
Provider Nominee:	Noel Dunne
Lead inspector:	Louise Renwick
Support inspector(s):	Maureen Burns Rees
Type of inspection	Unannounced
Number of residents on the date of inspection:	2
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 following an application to vary registration conditions. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
08 February 2017 10:00	08 February 2017 20:45

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

The centre had been registered in September 2016 and since then had admitted two residents. The purpose of this inspection was to monitor compliance with the Regulations and Standards now that the centre was operational. Since the centre opened, the provider had applied to increase the numbers of residents from two to seven. The evidence gathered from this inspection, and subsequent action plan response by the provider will assist in the decision making process around this application to increase.

Description of the service:

The written Statement of Purpose for this centre describes the centre as offering residential care (long and short term) to male children and adults with disabilities (age of 17-28) under the heading of:
- intellectual disability
- mental health
- behaviours that challenge (high support)

On the day of inspection, inspectors found that this was a true reflection of what was on offer in the centre. The centre comprises of two separate buildings, one large two

story house and one small cottage. There was a secure garden area to the back of the property for residents' use.

How we gathered our evidence:
Inspectors spoke with one resident living in the centre, the person deputising on behalf of the person in charge, the regional manager and two staff members. Inspectors reviewed documentation such as care plans, personal plans, behaviour support plans, incident records and policies and procedures.

Overall findings:

This inspection found evidence of good outcomes for residents with regards to social care needs, health care needs and medication management. Some examples of good practice:

- transitions into the centre had been planned and well managed
- there was an ample number of staff available to meet the needs of residents, and staffing could be increased if necessary to ensure support for residents
- residents were encouraged to set life goals, and work towards achieving them, such as taking up courses in areas of interest
- the centre offered a homely living environment

Some areas where in need of improvement in the centre. Inspectors had significant concerns regarding the following:

- the management of risk to ensure resident and staff safety
- the use of physical interventions
- the advise of multidisciplinary team members being followed
- the structure in place to manage and oversee the care and support in the centre.

The findings of this inspection are set out in the body of the report. Inspectors found evidence of full or substantial compliance in three outcomes, moderate non-compliance in three outcomes and one outcome evidenced as majorly non-compliant and in need of address by the provider.

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 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):
No actions were required from the previous inspection.

Findings:
Inspectors found evidence of good practice under this outcome, with residents' encouraged and supported to be social and active members of the community.

Each resident had an assessment completed prior to admission, that had been inclusive of sufficient detail to ensure a personal plan could be drawn up which outlined supports. Residents had plans in place, and inspectors noted a focus on life skills, independence building and access to the community. Residents were included in the development of goal setting exercise and these were reviewed by the resident and their keyworker. Key-working sessions were held regularly with residents to discuss any issue regarding their plans and goals.

As well as setting personal goals, each resident had a daily activity planners. Residents in this centre had access to day services provided by NUA health care and some attended up to four days a week. Other examples of good practice regarding residents' social care needs included where residents were supported to apply for home tuition to continue their education, and applying to do a course in a community college in areas of interest. There was a focus on independent living skills such as managing your own money and budgeting.

Inspectors found that the development of personal plans was not fully inclusive of residents' representatives. This was in need of address by the person in charge.

Judgment:

Substantially Compliant

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

Findings:
While some satisfactory systems were in place, significant improvement in the area of risk management was required.

Inspectors found that there was adequate measures and systems in place to protect against the risk of fire in the designated centre. There was a fire detection and alarm system installed along with emergency lighting which were checked and serviced routinely by a fire professional. Fire fighting equipment was in place and checked yearly. Each day a person from the roster was the named fire officer for the shift, and there was evidence that all staff had received training in fire safety including the use of fire fighting equipment. Drills had been conducted with the two residents since the centre opened, and there were written personal evacuation plans for individuals. These plans did not fully reflect the cognitive and physical needs of residents, and inspectors found that the addition of an emergency alarm light had been recommended for a resident who had hearing difficulties. This was planned but not yet in place, however at the time of inspection the centre was staffed with three waking night staff in the main house which could support the resident to be alerted to the alarm in the wait for the piece of equipment.

Inspectors found that infection control practices were good in the centre. For example, there were colour coded cleaning equipment, cleaning products were locked away, paper hand towels in use and the provision of personal protective equipment. Staff received training in infection control every two years as part of their mandatory training modules.

While inspectors found evidence that some actions were taken in response to incidents, overall inspectors found that risk management required significant improvement in the centre to ensure residents' and staff safety.

On review of the incidents recorded in the centre, inspectors were concerned that the recording of incidents was not effectively linked to the identification of possible hazards or risks. For example, records of incidents that threatened the safety of staff and residents were not effectively or swiftly reviewed in light of their potential to reoccur. Significant near misses which could have resulted in serious injury were not escalated or reviewed effectively to ensure appropriate control measures were put in place to reduce the likelihood that they could happen again. For example, following numerous unsafe

incidents in a vehicle, residents and staff were still travelling by car and putting themselves in the same situation. Reviews by allied health care professionals questioned the safety of travelling by car when residents were in a heightened state. The incoming person in charge told inspectors that a different vehicle was needed to reduce the risk.While this new vehicle had been ordered it was not yet in place. Inspectors found evidence of repeated incidents occurring that could have been prevented. This had also been highlighted by the allied health professional's review.

Inspectors found evidence that some significant risks were not being appropriately risk assessed and managed which could jeopardise the safety of residents and staff. For example, the risk of harm to others through the management / monitoring of potential weapons. Similarly, a resident who was a risk of absconding did not have an appropriate risk assessment in place to address this.

Overall, inspectors determined that the systems in place to assess and to manage risks were inadequate. While review mechanisms were in place for incidences, the advise based on these reviews were not followed and did not improve the management of risk in the centre. Where additional controls had been identified, requested and acted upon following some incidents, these were not fully in place at the time of inspection. For example, staff were awaiting a different car for safer travel.

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):
No actions were required from the previous inspection.

Findings:
Inspectors found that there were measures in place to safeguard residents from abuse in the centre.

Inspectors reviewed a recent allegation of abuse that had been submitted to HIQA and found that it had been managed and investigated in line with policy and national guidance. For example, a preliminary screening was conducted, an investigation team appointed to carry out investigation, and resident was debriefed following the outcome.

There were policies in place regarding the protection of children and vulnerable adults. Some changes and updates had occurred recently, and different versions of the policy were in the centre. However, based on the allegation mentioned above, inspectors determined that this was solely a document control issue with a clear process evident in practice.

Inspectors found that residents living in the centre had support and input from a behavioural therapist assigned specifically to the centre. The therapist reviewed any incident reports regarding behaviours of concern, offered advise from this review and used information gathered to further inform multi-elemental behaviour support plans for residents. While this was a positive finding, inspectors were concerned that advise from the behaviour therapist was not being followed or informing daily practice in the centre. For example, the approach for managing the demands of residents, monitoring items bought that could be used harmfully, and in ensuring risk assessments were updated.

Inspectors were concerned that approaches taken to manage behaviour were not always positive in nature or the least restrictive. Inspectors were concerned at the length of time some restrictions on community access and activities had gone on for. When discussed with the incoming person in charge, inspectors were told that these restrictions were to ensure safety. Behaviour support plan did not indicate the maximum time a restriction could be extended for which required review. Inspectors determined the use of reinforcements and interventions required more robust monitoring.

In this centre, the use of physically restrictive interventions was sometimes necessary to safeguard residents from harm. Staff indicated that it was used a last resort, and outlined that they tried other methods prior to the use of a physical hold as outlined in residents behaviour support plans. Inspectors found that the use of physical restraint was in need of improvement to ensure it was safe and in line with best practice. On review of incidents where restrictive practices were necessary, inspectors found at times physical holds could not be done safely for residents. For example:
- Staff were not able to use a physical intervention effectively due to small space in the environment
- Two staff had been injured while engaged in a physical hold

Inspectors also found evidence of unsafe practice during physical interventions which was concerning. For example:
- A resident was restrained on a bed by their arms by two staff
- Physical restraint used to bring a resident to the ground

On discussion with the incoming person in charge, inspectors were informed that some staff in the centre had been sent on advanced training for the use of higher support physical holds, and the remaining number of staff were undergoing this training on the day of inspection. Once training was completed, some residents that had been identified as requiring this higher support would receive it. This was a positive response by the person in charge.

Inspectors did note a reduction in the number of incidents in the month previous to the inspection. This was a positive outcome for residents.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
Resident's healthcare needs were met in line with their personal plans and assessments.

Each resident's health needs were appropriately assessed and met by the care provided in the centre. Residents living in the centre had minimal medical needs and or support requirements. There was evidence that any specific health needs had been identified and suitable medical expertise and allied health care services had been sourced to meet these needs in a timely manner. Detailed health action plans formed part of the residents' personal plans. Up-to-date hospital passports were on file for each of the residents which contained appropriate information to guide hospital staff should a resident require to be taken to hospital.

There was a fully equipped kitchen and dining area in each of the separate living areas. The service had a policy and procedure on diet and nutrition, dated June 2016. The inspectors observed that there was an adequate supply of healthy snacks available and that a range of healthy and nutritious meals were prepared for and by the residents in the centre. There was a meal planner in place and evidence that residents were consulted with regarding foods purchased and prepared in the centre. There was evidence that dietetic advice had been sought and provided in the centre. A nutritional intake log was maintained for both of the residents.

Judgment:
Compliant

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):
No actions were required from the previous inspection.

Findings:
There were systems in place to ensure the safe management and administration of medications.

The processes in place for the handling and storage of medicines was safe and in accordance with current guidelines and legislation. A medication management policy was in place, dated June 2016. There were secure cupboards for the storage of all medicines. A medication fridge was also available. The inspector reviewed a sample of prescription and administration sheets and found that they had been appropriately completed. Staff interviewed had a good knowledge of appropriate medication management practices and medications were administered as prescribed.

Staff had assessed the ability of individual residents to self manage medication and found it was not appropriate for either of the residents to be responsible for their own medications. There were no chemical restraints used in the centre.

There were appropriate procedures in place for the handling and disposal of unused and out of date medications, whereby they were returned to the pharmacy who signed off with staff receipt of same. The inspectors noted there was an appropriate separate secure storage area for the storage of all out of date stock.

There were some system in place to review and monitor safe medication management practices. Medication audits were undertaken on a regular basis by the providers quality team and where issues were identified appropriate actions had been taken.

Judgment:
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):
No actions were required from the previous inspection.

Findings:
This centre was registered in September 2016 with a full time person in charge due to the nature of the needs being supported and the new staff team. At the time of this inspection the person in charge was off duty unexpectedly, and inspectors were informed this person would be returning to work in a different location. The deputy team leader met at the registration inspection had also moved to another designated centre. To deputise for the short term absence the provider had appointed a person in charge half time to oversee the centre.

This person was present during the inspection, could discuss residents' needs and assisted inspectors fully with the inspection process. Since the inspection, the provider had notified HIQA that this person was to become the person in charge for the centre on a half time basis going forward and would also remain the person in charge for another designated centre. This was not an adequate arrangement for the role of the person in charge in this centre.

Inspectors were not assured that the management structures in place were robust enough at this time to ensure the effective governance, operational management and administration of the designated centre. For example, there were deputy team leader roles appointed since the last inspection, however these roles did not have protected time aside from working directly with residents. Not all staff appointed as deputy team leader had been supported to obtain a qualification in social care, had additional training in leadership or management or had experience in managing a centre previously. Given the needs and risks in the centre, a more effective management structure was necessary in the absence of a full time person in charge.

Inspectors found that there were management and review systems in place in the centre. However, inspectors found that these were not appropriately and effectively reviewing the quality and safety of care in the centre. Effective actions were not consistently put in place after there review to promote positive impacts on residents. Inspectors were not assured that there was sufficient and full oversight in place to promote the safe management of risk, the safety of staff and residents and the review of practice in general. Inspectors were cognisant that the absence of a full time person in charge, change to deputy team leaders and unexpected absence of staff had affected the incoming manager's ability to fully oversee the care and support while dealing with unexpected events.

Inspectors found that there were templates and plans in place to meet the requirement of the regulations regarding unannounced provider visits and annual reviews once the centre had been operating long enough for these to take effect.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of

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

Theme:
Responsive Workforce

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

Findings:
There were appropriate staff numbers and skill mix to meet the assessed needs of residents living in the centre. However, staff supervision arrangements required some improvement as did the provision of training.

The staffing levels, skill mix and experience were sufficient to meet the needs of the two residents. The staff team consisted of social care workers and assistant support workers. There was an actual and planned staff roster in place. At the time of inspection, five staff were out on unexpected leave. Regular relief staff were being used to cover this leave which meant that residents had continuity in their care givers. The inspectors noted that the relief staff were rostered on duty with a permanent member of staff. Agency staff were not being used in the centre. It was noted that in the previous three month period, staffing levels had been increased to meet the assessed needs of the residents.

A training programme was in place for staff which was coordinated by the providers training department. There was a training and development procedure, dated June 2016. Training records showed that staff were up-to-date with mandatory training requirements. A formal training needs analysis had not been undertaken. However, the provider had identified specific training required to meet the needs of residents, some of which had been delivered whilst others had not yet been scheduled. For example, hearing impairment training had been identified as required but had not yet been scheduled for staff. It had been identified that advanced physical intervention training was required. Half of the staff team had received this at the time of inspection, with the remaining staff undergoing training on the day of the inspection.

Staff interviewed were knowledgeable about policies and procedures in place. The inspectors observed that a copy of the standards and regulations were available in the centre.

There were recruitment procedures in place that included checking and recording all required information. There was a recruitment and selection procedure, dated June 2016. The inspectors reviewed a sample of four staff files. Inspectors found that practices did not consistently follow the policies in place for safe recruitment practices. For example, staff had been appointed in roles that they did not have the qualifications for as outlined in the providers job description criteria.

The staff records were found to contain the information outlined as required in schedule 2 of the regulations.

There were some staff supervision arrangements in place but the frequency of supervision was not in line with the centres' policy on supervision. The inspectors reviewed supervision records for the staff team and found that supervision had not been undertaken for a small number of staff since taking up the positions. In addition, supervision for other staff had not been undertaken for an extended period.

There were no volunteers working in the centre at the time of inspection.

Judgment:
Non Compliant - Moderate

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:

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Action Plan

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

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-0005334
Date of Inspection:	08 February 2017
Date of response:	13 April 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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One residents' personal plan did not include information of significant importance from their representative.

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 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, 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:
The PIC facilitated a review of Personal Plans [06 April 2017]
The personal plan was updated to include information of significant importance from the resident's representative [07 April 2017]
▪
A standing agenda will be placed on team meetings linked to addressing Personal Plans which require updating following any identified information provided for the resident
▪
All staff to receive refresher training on Personal Planning implementation

Proposed Timescale: 07/05/2017

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:
Systems in place to assess and manage risk were not effectively promoting residents' and staff safety. For example:
- repeated incidents that could have been avoided
- controls not adequate to alleviate risks
- failure to identify potential for reoccurrence

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:
Provide further training and development for the Person in Charge and staff team in risk assessment and the management and ongoing review of risk [Due date: [29 May 2017]
▪
The PIC to undertake a review of the Risk Register to ensure that all the risks have been identified and all actions have been taken to mitigate identified risks [Due date: 29 May 2017]
▪
A standing agenda item to be added to the Safety Committee meeting which specifically asks question of our systems in place in each Designated Centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies [Due date: 28 April 2017].
▪
Senior management and a rota of representatives from the PIC's to take a more

proactive role in the monthly Safety Committee meetings. Their key focus will be on risk management (prevention before mitigation) [Due date: 28 April 2017]

Proposed Timescale: 29/05/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Physical restraint was not always used safely or in line with evidence based practice.

3. 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:
All staff in the Centre to undergo training in Restrictive Practices ensuring awareness upon a restraint been used to reviewed within an appropriate timeframe.

Proposed Timescale: 29/05/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The review of physical interventions did not ensure the promotion of safe practice.

4. 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:
All staff in the Centre to undergo training in Restrictive Practices ensuring awareness upon a restraint been used to reviewed within an appropriate timeframe.

Proposed Timescale: 29/05/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Reinforcements were not always the least restrictive. For example, limited access

outside for a five day period.

5. 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:
All staff in the Centre to undergo training in Restrictive Practices ensuring awareness upon a restraint been used to reviewed within an appropriate timeframe.

Allied Health Professionals to conduct a full review of the Multi Element Behaviour Support Plan and conduct a debrief to the centres team.

PIC, with the support of the Behavioural Specialists, to review all the Restrictive Practises in the Centre.

PIC to review and revise the process and related Policy and Procedures on Restrictive Practices [PL-C-005] and supported by the Director of Services to ensure compliance with National Policy [Due date: 28 April 2017].
.
PIC to update any necessary documentation and thereafter prepare a debriefing for the staff team on practices with an emphasis on every effort being made to ensure non-recurrence of poor practice [Due date: 29 May 2017]

Proposed Timescale: 29/05/2017

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 role of the person in charge was not full time.

6. Action Required:
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

Please state the actions you have taken or are planning to take:
Team Leader to be identified in the Centre fulltime alongside a Deputy Team Leader to support the Regional PIC

Team Leader is to be suitably qualified and experienced given the need of the residents

in the Centre.

Proposed Timescale: 07/05/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an ineffective management structure and inadequate monitoring of the safety and quality of care for residents.

7. 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:
Up until now Nua Healthcare has designated one person as the Provider Nominee for all our Centres. However, as our service has grown it is now evident that this is not a sustainable approach and that responsibility for the service needs to be devolved to experienced senior care professionals who have a relatively small number of Centres under their management. Accordingly, on 23 February 2017 we submitted application to change the Provider Nominee for The Lakehouse. The new Provider Nominee is one of three Area Directors of Operations in Nua Healthcare, has 13 years of experience as a social care professional, including as Team Leader, Regional Manager and Director of Operations. She will be Provider Nominee for 5 Centres at present, including The Lakehouse. She is supported by 3 Regional Managers.

Team Leader to be identified in the Centre fulltime alongside a Deputy Team Leader to support the Regional PIC

Team Leader is to be suitably qualified and experienced given the need of the residents in the Centre.

Proposed Timescale: 29/05/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had qualifications in line with the provider's own job description for roles.

8. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the

statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The Human Resource Department to conduct a full review of the providers Job Description in situ in the Centre.

The staff member has commenced a Management & Development programme internal to the organisation in the interim of gaining the skills required for the current position.

The staff member will work towards a higher qualification commencing Sept 2017

Proposed Timescale: 07/05/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Supervision had not been undertaken for a small number of staff since taking up their positions, whilst for other staff, supervision had not been undertaken for an extended period.

9. 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:
The PIC conducted a full review of the Supervision taking place in the Centre [07 May 2017]

PIC will continue to support staff through supervision on a regular basis as per the Centre's Policy [Ongoing]

The DTL's within the Centre in a supervisory role to receive training in supervision [Due Date: 20th and 21st April]

Proposed Timescale: 07/05/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An identified training had not yet been scheduled for staff to assist them in support residents with hearing impairments.

10. 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:
・ Training that was scheduled at the time of the inspection for a resident with a hearing impairment has taken place [27 March 2017]
・ All staff have trained in Advance MAPA Training [08 February 2017].
・ PIC to regularly conduct and review training needs required in the Centre to meet the resident's needs [Ongoing]

Proposed Timescale: 13/04/2017