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:	A designated centre for people with disabilities operated by Nua Healthcare Services
Centre ID:	OSV-0005180
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services
Provider Nominee:	Noel Dunne
Lead inspector:	Mary Moore
Support inspector(s):	Louisa Power
Type of inspection	Announced
Number of residents on the date of inspection:	6
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 announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
30 May 2016 08:45	30 May 2016 18:30

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

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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection
This inspection was the third inspection of the centre by the Health Information and Quality Authority (HIQA). The inspection was undertaken to monitor compliance with the regulations and standards and further to an application by the provider to vary one condition of registration. The provider wished to increase the maximum numbers of persons to be accommodated in the centre from six to eight.

The previous inspection was unannounced and undertaken to monitor compliance in relation to medicines management further to a desktop review by inspectors of notifications submitted by the person in charge in line with Regulation 31 (1) (d). Inspectors were satisfied that failings identified on that inspection were substantially addressed by the provider and person in charge.

How we gathered our evidence
The inspection was primarily facilitated by the person in charge and the regional director of operations. Inspectors also met with the front-line social care and nursing staff on duty. Inspectors met with four of the six residents residing in the centre as two residents were on a planned social outing to Dublin zoo with staff.

Inspectors reviewed records including medicines management records, residents' records, health and safety and fire safety records and staff related records. Inspectors reviewed the premises including the proposed accommodation required to extend the capacity of the centre.

Description of the service
The premises is a domestic type two storey premises with separate self contained cottage, both premises were extensively refurbished by the provider prior to occupation by residents. The premises was situated in a scenic rural location where transport is required to access all amenities. Inspectors saw that three vehicles were available to staff and residents.

Residential services are provided to adults with complex and high support needs. Inspectors were satisfied that the service provided was as outlined in the document titled statement of purpose and function. There was evidence that staff supported residents in an individualised manner to pursue meaningful and personalised lifestyles.

Overall findings
There was evidence that the provider and staff sought to support residents with complex and challenging needs to live full and meaningful lives. There was evidence of improvement since the last inspection in the areas of medicines management and in the development of personalised healthcare plans for residents. Inspectors noted that the residents present in the centre during the inspection were comfortable in their environment, with staff and with the presence of the inspectors.

Residents were still in the process of transition into this service as it was only operational since late 2015. There was evidence of improved general functioning and social integration for residents but also of residual challenges particularly due to behaviours that challenged and posed risk to others. Failings were identified and action was required by the provider so as to safely support staff and residents to achieve the overall objective of the centre.

Management plans in relation to behaviour support required review to ensure that they provided effective guidance to staff. Review was required of the implementation timeframe of these plans to ensure that they were in place in a timely manner and as proportionate to the behaviours exhibited. Clarity was required as to the ownership of the development and monitoring of these plans as those seen were unsigned.

Risk assessments, protocols and practice had not all been reviewed following incidents to reduce the risk of reoccurrence.

Robust monitoring was required to ensure that all incidents that required notification to the Chief Inspector were notified.

Inspectors reviewed 10 Outcomes and the provider was judged to be complaint with three, in substantial compliance with four and in moderate non- compliance with three; Safeguarding and Safety, Health and Safety and Risk Management and the Submission of Notifications to the Chief Inspector.

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

Findings:
There was a suite of documentation maintained for each resident; this included for example the resident's medicines management folder, a daily information folder, a life skills folder and the resident's personal plan. Inspectors saw that the latter was based on a detailed assessment of the health, personal and social care needs of the resident. From this assessment both strengths and areas requiring support were identified and the required plan was put in place. Assessments and plans seen were person-centred and respectful in tone and content. The personal plans folder addressed core areas such as residents' social care needs, health needs, daily occupation, communication, community inclusion, goals and safeguarding.

Required actions and goals were identified in the personal plan as were responsible persons and completion timeframes, progress was monitored monthly.

In the plan, from their observations and staff spoken with, there was evidence that the objective of the plan was to meet the assessed needs of the residents and support their personal and general development. There was a theme of improved functioning and social inclusion in the records seen and evidence to support this in practice. For example on the day of inspection two residents were on a day trip to Dublin zoo, another resident went to the beach with staff and the remaining residents were seen to go with staff as they choose to the local town. Staff confirmed that as outlined in the support plan residents were now engaging in activities such as swimming, horse-riding and gardening, shopping and socialising in the local community. Staff reported and residents were seen to have developed skills in activities of daily living.

Transition plans were utilised for the admission and transition of prospective residents.

However, what was not clear from the plan was how the residents participated in the development of the plan or how the format of the plan made the plan accessible to the resident. These deficits were also seen to have been identified in the providers own review of the service in March 2016.

Judgment:
Substantially Compliant

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:
The original premises was a spacious two-storey domestic type property located on a private site in a rural location. Inspectors reviewed this premises at the time of the original application for registration and were satisfied that the design and layout of the building was suited to its stated purpose and would promote resident privacy, dignity and independence.

While the statement of purpose stated that the house was not suited to meeting the needs of residents with mobility requirements the provider had provided a lift to enhance and ease accessibility for residents as opposed to meeting a specific requirement of any resident.

Each resident was provided with their own private bedroom. Bedrooms were spacious, provision was made for personal storage and each bedroom offered en-suite sanitary facilities.

Additional sanitary facilities were provided on both the ground floor and first floor.

Adequate communal space that included choice was provided for the number of residents to be accommodated and was homely and welcoming in presentation.

The kitchen and dining area was combined and provided sufficient space, equipment and facilities.

Adequate provision was made for storage and facilities were available for the laundering of residents personal possessions.

The proposed additional accommodation was an independent split-level building in close proximity to the main premises. The facilities manager walked the premises with the inspector and confirmed that extensive refurbishment works had been undertaken to ensure that it was suited to its stated purpose and met relevant regulatory requirements.

This premises was to provide accommodation for two additional residents. The inspector saw that it had been refurbished and fitted to a high standard, was homely in presentation and was suited to its proposed purpose and function. At ground floor level adequate communal, dining, kitchen and utility space and facilities were provided. Sanitary facilities were also provided off the utility space.

Accommodation for residents and staff was provided at first floor level. There were three bedrooms one of which offered en-suite sanitary facilities with shower, toilet and wash-hand basin. There was an additional separate sanitary facility again with shower, toilet and wash-hand basin adjacent to the other two bedrooms.

The premises was complete, fitted and furnished and ready for occupation.

Judgment:
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:
Measures were in place to promote and protect the health and safety of residents, staff and others. These measures included policies and procedures, systems of review and monitoring, and a health and safety forum.

There was a centre specific health and safety statement in place signed as read by 36 staff between December 2015 and March 2016.

There was a policy in place for risk management. This risk management policy addressed the measures and controls in place to address the risks specified in Regulation 26(1) (c) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations

2013. The policy also included a comprehensive range of work related and centre specific risk assessments, the existing controls and any further measures required to reduce and/or manage the identified risks. There was evidence of controls such as the provision of handrails and grab-rails, the restriction of first floor windows and one-to-one staff supervision for residents.

Inspectors saw that as required by the risk management policy risk assessments and risk management protocols as they pertained to individual residents were contained in residents' personal files.

There were systems in place for recording, reporting and investigated accidents and incidents that occurred in the centre. Inspectors reviewed a cross-sample of these records. Based on this review inspectors were not satisfied that there was sufficiently robust review of a significant incident where a resident had swallowed a foreign object, to demonstrate how the existing controls to manage the known risk had failed, what learning was required from this incident and what if any additional controls were required to prevent a reoccurrence. In relation to this and other incidents reviewed inspectors were not satisfied that there was always consistent and sufficient review of risk assessments, protocols and practice in response to accidents and incidents. For example there was no risk assessment seen for the storage of, access to and disposal of personal protective equipment (PPE). Staff did describe PPE controls to inspectors and inspectors did not see any practice on the day of inspection that placed residents at immediate risk. Again in response to incidents recorded a review of risk assessments and resident specific protocols was required for both the safety of residents and staff for travelling in the centre vehicles.

Staff undertook weekly health and safety inspections of the physical environment and the vehicles utilised by staff and residents. Vehicles were leased from a car hire company who were responsible for the servicing of the vehicles.

Inspectors reviewed the minutes of the meeting held in March 2016 of the health and safety forum and saw that feedback was provided to each centre on identified failings as was an action plan with responsible persons and timeframes. There was evidence of the progress of required actions by the person in charge.

There was a policy addressing potential resident absence without leave from the centre.

There was a centre specific emergency plan that included alternative accommodation for residents in the event of an emergency.

Inspectors saw that both buildings were serviced by an automated fire detection system, emergency lighting, break-glass fire alert units and prominently placed fire fighting equipment. Certificates of inspection and testing of these systems at the prescribed intervals were in place, most recently for May 2016. In addition there was a protocol in place for staff to undertake daily, weekly and monthly checks of the fire safety measures. Actions issued at the time of the initial registration had been addressed.

Training records indicated that fire training including centre-specific training had been provided to all proposed staff prior to the opening of the centre and again in January

and April 2016.

Records seen indicated that simulated fire drills had been completed on a monthly basis from January to March 2016. However, it was not evident from these records what time drills had been undertaken at, if a full evacuation of the premises had been undertaken and if so if this had been achieved within the recommended safe timeframe as the time required to evacuate was not recorded.

Judgment:
Non Compliant - Moderate

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 measures in place to safeguard residents from harm and abuse including policies and procedures referenced to national guidance, staff training, designated persons, risk assessments and systems for reporting and investigation.

Residents did have plans providing guidance to staff on the provision of support during personal/intimate care.

Risk assessments were seen for the management by staff of any disclosures of alleged abuse made by residents.

However, a record seen by inspectors and dated 22 April 2016 read as an allegation of mistreatment by staff. However, the person in charge while providing a rationale for the allegation also confirmed that the allegation had not been viewed, notified to HIQA, screened or investigated as an allegation of physical and psychological mistreatment by staff.

Based on the stated purpose and function of this house residents did exhibit behaviours that were a risk to themselves, staff and other residents. Records seen by inspectors indicated that behaviours that posed risk of harm and injury particularly to staff were

regular in occurrence. Behaviour support plans were in place. These plans detailed the type of behaviour exhibited and interventions to be used by staff to de-escalate the behaviour. The plans seen were therapeutic and respectful in their approach and in the tone and language used. Staff spoken with were familiar with the plans, with known triggers for behaviours and how to reduce the risk of a behaviour related incident. Staff described positive risk based programmes of activation, socialisation and meaningful occupation.

Given the nature of the behaviours, the records seen indicated and staff spoken with confirmed that staff also had to frequently implement physical interventions up to firm physical holds for the protection of themselves and others. There was a policy in place on the use of physical restrictive interventions. Records were maintained of each occurrence of physical restrictive intervention, the reason for it and its duration. Notification of the use of physical restrictive interventions had been submitted to HIQA. Based on the records seen inspectors were satisfied that the use of physical restrictive intervention's was clearly based on the risk posed at that time and/or when alternative techniques had failed.

However, the use and the specifics of physical intervention/restraint were not included in the behaviour management plans seen. This required robust review and clear guidance for staff particularly in the context of the opinion offered by the behaviour therapist following a review in March 2016 of incidents. It was stated that some physical holds used by staff should be a last resort only and may not have been the most appropriate hold to adopt at that time.

Accident and incident records recorded the administration at times of prescribed 'as required' medicines in response to behaviours that challenged and posed risk. However, all of the behaviour management plans seen did still not include 'as required' psychotropic medicines as an intervention and did not give guidance to staff in relation to the appropriate and time administration of these medicines. Post this inspection the provider reiterated to HIQA its procedures for the development of behaviour support plans, the role of the behaviour therapist and that of any medicines prescriber such as the psychiatrist and how consequently these procedures meant that medicines were not included in the behaviour support plan but were identified on medicines related records. However, what was required based on these inspection findings was one integrated multi-disciplinary behaviour support plan that included all recommended and sanctioned interventions, therapeutic and reactive.

Clarity was required in practice as to the timeliness of the implementation of multi-element behaviour support plans. The person in charge confirmed that one resident who very clearly required such a plan did not have one at the time of this inspection. Information on behaviours and their management was included in the personal plan. It was confirmed for inspectors that there was a twelve week timeframe of assessment and multi-disciplinary input prior to the formulation of the multi-element behaviour support plan. However, the providers own review of the service in March 2016 had deemed the centre to be significantly non-compliant in the area of behaviour supports due to the absence of a multi-element behaviour support plan for a resident admitted in December 2015.

It was unclear who had devised and agreed the plans and all proposed interventions as those seen were unsigned.

Judgment:
Non Compliant - Moderate

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 had an established pattern of the submission of required notifications to the Chief Inspector. The person in charge had submitted any information requested further to notifications received.

However, there was evidence on inspection that all incidents had not been notified. These included an allegation made by a resident of mistreatment and the ingestion of a foreign object by a resident.

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

Findings:
Inspectors saw that staff had collated details of resident's healthcare needs and past medical history. From this information and their own assessment staff had compiled healthcare based plans that outlined the supports required to maintain resident health and wellbeing. There was documentary evidence that based on their assessed needs

residents had access as required to their general practitioner (GP) and staff also accessed the out-of-hours medical service as necessary. In addition residents had ready access to or had been referred to multi-disciplinary supports, much of which was available directly from within the organisation. Inspectors saw that residents were referred as appropriate to psychiatry, psychology, behaviour therapy, occupational therapy, speech and language therapy, neurology, diabetic clinic and chiropody. Plans were in place for optical and dental review.

Nursing input was available in the centre and also from the community nursing service. Staff monitored body weight, vital signs such as blood pressure levels and maintained food intake charts as appropriate. There was evidence of blood profiling by the GP to ascertain general well-being and of ongoing monitoring and amendments made to medicine regimes by both the GP and the psychiatrist.

There was evidence that where a healthcare related target was set that staff supported a resident to achieve this.

There was evidence that one resident was refusing healthcare interventions including GP review. Refusal was recorded and there was no evidence available to inspectors of any current negative impact of this. This will however, require ongoing monitoring. Improvement in healthcare assessment and planning was noted by inspectors since the last inspection. However, further review of healthcare related documentation and plans was needed as plans were not in place for each identified need such as mobility. An eating and drinking plan was not referenced in the information to accompany a resident to hospital; staff were aware of the plan and had the required interventions.

Action was required on the timely follow-up on reports from multi-disciplinary reviews. The report of a review undertaken in January 2016 was still not available to the centre at the time of inspection. Action was also required where reports and recommendations had issued but had not been implemented. For example the person in charge told inspectors that recommendations made by the occupational therapist were not required in practice by the resident; this required review and MDT agreement.

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

Findings:
Medicines for residents were supplied by a local community pharmacy. Staff confirmed that the pharmacist was facilitated to meet his/her obligations to residents in accordance with the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. There was a medicines management policy which detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines.

Medicines to be kept at room temperature were stored securely. Staff confirmed that medicines requiring additional storage and documentation controls were not in use at the time of the inspection. Medicines requiring refrigeration were now stored in a refrigerator that could be locked and a system was in place to monitor the reliability of the refrigerator used to store medicines.

A comprehensive and individualised assessment had been completed for each resident which took into account cognition, communication, reception and dexterity. Four levels of support were outlined in relation to medicines management. At the time of the inspection, all residents required full support with medicines management (level 3). A personalised medicines management plan had been developed for each resident which outlined the resident's individual preferences in relation to medicines administration and the level of support to be provided in relation to medicines management.

Compliance aids were used by staff to administer medicines to residents. Resources were available to the nurse staff to confirm prescribed medication in the compliance aid with identifiable drug information.

There was a system in place for the reviewing and monitoring of safe medicines management practices. Staff with whom the inspector spoke confirmed that there was a checking process in place to confirm that the medicines received from the pharmacy correspond with the medication prescription records. A weekly check was undertaken of the stock levels and expiry dates of 'as required' medicines. There was a weekly audit of medicines management practice which examined a number of areas related to medicines management, receipt, storage, disposal, staff training and administration.

Medication management plans for the administration of an emergency medicine in the event of seizure activity had been reviewed since the last inspection and now provided clear guidance to staff on the parameters of the administration of the medication, recovery times and when the assistance of the emergency services was required. Staff spoken with were aware of the specifics of the plan and confirmed that they had received the required medication administration training. Staff reported that this plan was working effectively for the resident and for staff.

Residents requiring other specific medicines to manage their well-being such as the maintenance of safe blood sugar levels were also seen to have detailed management plans in place.

A sample of medication prescription and administration records was reviewed. Medication administration records identified the medications on the prescription and allowed space to record comments on withholding or refusing medications. However,

two recording errors by staff were noted by the inspector. The time of administration was not recorded in one instance. A medicine due to commence on the 31 May 2016 was recorded as administered on the 26 May 2016.

A number of residents required support to manage behaviours that challenge and inspectors reviewed a sample of care plans for residents who were prescribed 'as required' psychotropic medicines for the management of challenging behaviour. Accident and incident records indicated that 'as required' medicines had been administered. However, all of the management plans seen did not still include 'as required' psychotropic medicines as an intervention and did not give guidance to staff in relation to the appropriate and time administration of these medicines. This failing is addressed and in Outcome 8; Safeguarding and safety.

A sample of medication incident forms were reviewed and the inspector saw that errors were identified, reported on an incident form and there were arrangements in place for investigating incidents. Learning from incidents was clearly documented and preventative actions including feedback to staff and further training were seen to be implemented.

Judgment:
Substantially Compliant

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:
Inspectors reviewed the statement of purpose submitted with the application to vary a condition of registration. The statement contained all of the information required by Regulation 3 and Schedule 1 and reflected what was evidenced in practice by inspectors.

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:
Inspectors were satisfied that the provider had selected appropriate persons and had a clear management structure in place both in the centre and from a wider organisational perspective. On a day to day basis the centre was managed by the person in charge supported by one of two deputy team leaders and in collaboration with the regional director of operations. Staff spoken with were clear on their own respective roles and responsibilities, their reporting relationship and the wider governance structures.

The person in charge worked full time and confirmed that the operational management of this centre was her substantive role; she was not responsible for any other designated centre. The person in charge was suitably qualified and experienced. The person in charge had up to date training in the required areas of medication management, manual handling, fire safety, protection of residents and other areas such as hand hygiene, epilepsy, communication, food hygiene and person centred planning. The person in charge articulated knowledge of the legislation and her statutory responsibilities. The person in charge demonstrated accountability for the service and the quality and safety of the supports and services provided to residents.

The person in charge confirmed that she had ready access to her line manager, the regional director of operations; they also met formally on a monthly basis.

An on-call management system operated each day after 17:00hrs and at weekends. There was evidence in records seen such as accident and incident records that staff did access this support as required. The person in charge reported that the deputy team leaders worked a rota between them which meant that either the person in charge or one of the deputy team leaders were on duty each day in the centre.

Based on their observations and as seen in residents' individual plans there was evidence available to inspectors that the centre was sufficiently resourced to ensure the effective delivery of care and support.

The person in charge confirmed that staff were facilitated to raise any concerns and observations at regularly convened staff meetings; the regional director also attended some of these meetings. There was evidence available to inspectors that staff did

exercise their personal responsibility for the quality and safety of the care and support provided to residents and did bring matters of concern to the attention of the provider.

There was documentary evidence that the provider did support and as appropriate performance manage staff.

The person in charge said that staff were formally supervised on a monthly basis.

As the centre was operational only since October 2015 an annual review of the quality and safety of care and support had not taken place. An unannounced visit however, as prescribed in Regulation 23 (2) had been undertaken in March 2016 and the report was available as required for inspection. Inspectors were satisfied that this was a comprehensive process of review that set clear benchmarks for the required quality and safety standard. Compliance in core areas such as medicines management, residents' personal plans, health and safety, admissions and governance was measured. A detailed action plan, feedback, responsible persons and completion timeframes were all specified. There was evidence in the report of both good practice and where failings were identified. These failings concurred with some of the failings identified by the last HIQA inspection and would therefore support the transparency of the providers own process of review. There was also evidence that areas of non-compliance had been addressed such as in the formulation of health care plans.

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):
No actions were required from the previous inspection.

Findings:
The person in charge confirmed that while the plan was to manage the staffing arrangements for the centre collectively, a staffing presence was to be maintained in the proposed new unit at all times as while in close proximity to, it was separate to the main building.

Inspectors were satisfied that staffing numbers, skill-mix and staffing arrangements were planned, monitored and utilised so as to meet the assessed needs of residents. There was a planned increase in staffing numbers in line with the proposed increase in resident numbers. For example the current night time staffing arrangement of two "waking" staff was confirmed to increase to three "waking" and one sleepover staff. The person in charge and the regional director of operations confirmed that the required staff were recruited from the existing cohort of relief staff and were therefore familiar with the centre and the residents. Relief staff worked only for the provider and no agency staff were employed. Based on their observations inspectors were satisfied that agreed staffing arrangements such as one-to-one staff supports were in place and there were sufficient staffing resources to facilitate individual resident choices and preferences.

Based on the stated purpose and function of the centre the staff skill-mix included the daily presence of a registered nurse in intellectual disability nursing.

There was documentary evidence of current registration with the nursing regulatory body.

The staff rota was prepared by the person in charge on a monthly basis but it was in addition reviewed and monitored by both the regional director and the human resources department.

Staff files were available for the purpose of inspection and the sample reviewed were substantially complaint with the requirements of Schedule 2. There was a self-declaration but no evidence of Garda Síochána vetting in one staff file but this was made available to inspectors on the day after the inspection. A further staff file however, did not contain evidence of a reference from the person's most recent employer.

There was evidence in staff files of core relevant education including nursing and applied social studies. There was evidence that staff had attended mandatory training in fire safety, manual handling, responding to behaviours that challenged including the management of actual physical aggression, and safeguarding. Other training completed by staff included medication management training, first aid and understanding and supporting those with a diagnosis of autism.

Judgment:
Substantially 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:

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Nua Healthcare Services
Centre ID:	OSV-0005180
Date of Inspection:	30 May 2016
Date of response:	27 June 2016

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:
What was not clear from the plan was how the format of the plan made the plan accessible to the resident.

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

1. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
A full review of residents personal plans will be completed to ensure that the Personal Plan action plans are available in an accessible format.

Proposed Timescale: 22/07/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
What was not clear from the plan was how the residents participated in the development of the plan.

2. Action Required:
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:
A full review of residents personal plans will be completed to ensure that residents involvement in their personal plans is evident.

Proposed Timescale: 22/07/2016

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:
Inspectors were not satisfied that there was sufficiently robust review of a significant incident where a resident had swallowed a foreign object, to demonstrate how the existing controls to manage the known risk had failed, what learning was required from this incident and what if any additional controls were required to prevent a reoccurrence.

In relation to this and other incidents reviewed inspectors were not satisfied that there was always consistent and sufficient review of risk assessments, protocols and practice in response to accidents and incidents.

3. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
PIC to ensure that following any significant incidents that risk assessments are reviewed and updated accordingly to clearly outline controls to be implemented to manage the risk.

Proposed Timescale: 16/07/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident from the records of simulated fire drills what time drills had been undertaken at, if a full evacuation of the premises had been undertaken and if so if this had been achieved within the recommended safe timeframe as the time required to evacuate was not recorded.

4. 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:
The template and criteria for recording of fire drills is to be revised to include the timeframe that the drill was completed at and the duration that was required to complete the drill.

Proposed Timescale: 22/07/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use and the specifics of physical intervention/restraint were not included in the behaviour management plans seen.

All of the behaviour management plans seen did still not include 'as required' psychotropic medicines as an intervention and did not give guidance to staff in relation to the appropriate and time administration of these medicines.

Clarity was required in practice as to the timeliness of the implementation of multi-element behaviour support plans.

It was unclear who had devised and agreed the plans and all proposed interventions as those seen were unsigned.

5. 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 review of the Policy and Procedure surrounding the implementation of Multi-Element Behavioural Support plans will be completed to ensure clarity surrounding the timelines of implementation, the guidance within and the the sign off of the plans surrounding behaviours that challenge.

Proposed Timescale: 22/07/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A record seen by inspectors and dated 22 April 2016 read as an allegation of mistreatment by staff. However, the person in charge while providing a rationale for the allegation also confirmed that the allegation had not been viewed, notified to HIQA, screened or investigated as an allegation of physical and psychological mistreatment by staff.

6. Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
Training to be completed with the staff team surrounding safeguarding and the required notification in line with legislation and policy.

Proposed Timescale: 22/07/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence on inspection that all incidents had not been notified, this included the ingestion of a foreign object by a resident that required medical review in hospital.

7. Action Required:
Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

Please state the actions you have taken or are planning to take:
PIC to ensure that all notifications are completed in line with legislation.

Proposed Timescale: 07/07/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence on inspection that all incidents had not been notified. These included an allegation made by a resident of mistreatment.

8. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
PIC to ensure that all notifications are completed in line with legislation.

Proposed Timescale: 07/07/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The report of a review undertaken in January 2016 was still not available to the centre at the time of inspection. Action was also required where reports and recommendations had issued but had not been implemented.

Plans were not in place for each identified need such as mobility. An eating and drinking plan was not referenced in the information to accompany a resident to hospital.

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

Please state the actions you have taken or are planning to take:
A full review of all MDT reports to ensure all reports are on file and that a review of all recommendations are completed and documented. A review of all Hospital passports to

ensure that all needs are identified and guidance is provided surrounding area's that residents require support when attending hospital.

Proposed Timescale: 22/07/2016

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:
Two recording errors by staff were noted by the inspector. The time of administration was not recorded in one instance. A medicine due to commence on the 31 May 2016 was recorded as administered on the 26 May 2016.

10. 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:
Medication Management training to be completed with staff team.

Proposed Timescale: 22/07/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One staff file did not contain evidence of a reference from the person's most recent employer.

11. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
A review of personnel files to be completed to ensure all references are on file.

Proposed Timescale: 22/07/2016