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:	Broadleaf Manor
Centre ID:	OSV-0003397
Centre county:	Kildare
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services Unlimited Company
Provider Nominee:	Shane Kenny
Lead inspector:	Jillian Connolly
Support inspector(s):	Conan O'Hara
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

The inspection took place over the following dates and times

From:	To:
16 February 2017 15:00	16 February 2017 21:00
17 February 2017 10:30	17 February 2017 18:00

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

Outcome 04: Admissions and Contract for the Provision of Services
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management

Summary of findings from this inspection

Background to the inspection:
This was the third inspection of the centre. In May 2016, an unannounced inspection was conducted following the receipt of information of concern about the centre. The inspection found major non compliances in eight out of the eleven outcomes inspected. These included issues which impacted on the safety and well being of residents and included safeguarding, risk management and the management of behaviours that challenge. Inspectors also found that there was inadequate governance and oversight to ensure a safe and good quality service.

Given the serious concerns regarding the quality of service being provided, the provider was requested to attend a regulatory meeting to discuss how they were going to take action to ensure the safety and well being of residents. The provider submitted an action plan to the Office of the Chief Inspector following that meeting.

This inspection was undertaken to ascertain if the actions taken by the provider were effective in improving the quality of service to residents. In addition HIQA had received additional unsolicited information which related to safeguarding, risk management and the overall management of the service. This inspection focused on specific outcomes that relate to the safety of residents and risk management in the centre.

How we gathered our evidence:
As part of this inspection, inspectors met with three residents. Inspectors also met

with staff and reviewed documentation such as residents' personal plans, health and safety documentation and audits. Residents, management and staff facilitated the inspection.

Description of the service:
The designated centre is one house and operated by Nua Healthcare Services. The centre is registered for both male and female residents.

Overall findings:
Inspectors found that the unsolicited information received by HIQA was substantiated. While the provider had taken action following the last inspection, the provider had not ensured that these actions were effective in addressing the concerns around the safety and well being of residents. This is discussed further in the report.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
In May 2016, inspectors found that residents, who had complex support needs, were admitted to the service, without ensuring that the centre could meet their needs. There was also insufficient consideration of the impact of these admissions on other residents, and as a result of the failure to effectively manage behaviour issues, the safety and quality of life of other residents was adversely impacted. Inspectors at that time concluded that the admissions process did not protect all residents from risk.

On this inspection, Inspectors found that poor implementation of the admissions process continued to impacted negatively on the safety and well being of all residents. Inspectors found that nine residents who had complex support needs were living together, however there was little evidence to indicate that they were compatible. Inspectors observed and read accounts of regular incidents in which residents became distressed. This resulted in physical and verbal altercations among residents and residents in the centre were exposed to elevated levels of difficult and challenging behaviour.

Information obtained during the transition and admission process was not used to inform the formal assessments.

On the previous inspection, contracts for the provision of services were not agreed with residents or their representatives. In the action plan at that time, the provider stated that the person in charge would ensure that this was addressed for all residents in the centre. On this inspection, inspectors viewed a contract for the provision of services and found that it had not been signed by the provider, as required.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
In May 2016, inspectors found that there was a high frequency of serious incidents occurring in the centre which compromised the safety of residents. Inspectors found that there was inadequate oversight and management of these incidents. Following the inspection, the provider informed HIQA of the actions that they were taking to identify trends and improve the management of risk.

On this inspection, the inspector found that there continued to be a high level of serious incidents occurring in the centre which were impacting on the safety and quality of life of residents. While the provider had put improved arrangements in place to record the incidents and to identify trends, the provider had not taken effective action to manage incidents and to improve the management of risk in the centre. Overall, inspectors found that the provider had continued to fail to ensure that residents and staff were safe.

Inspectors reviewed numerous incidents and accidents records and found that there continued to be a high frequency of incidents which included physical and verbal altercations. The inspectors were informed that two staff had been assaulted on the first day of the inspection. Inspectors reviewed the accident and incident records and noted that there had been a high level of staff injuries recorded. The Health and Safety Authority had been notified of 13 incidents since May 2016. The impact of injury to staff also impacted on service delivery, due to staff not being able to report on duty.

Inspectors found that there continued to be an inconsistent approach to the review and learning from incidents, and that adequate measures were not being developed to reduce risk and improve safety. There was an absence of comprehensive reviews of individual incidences to identify if control measures had been implemented and whether they were effective. Inspectors found that staff were having to constantly respond to adverse events in an urgent manner with little evidence of proactive, planned management of identified risk.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
In May 2016, inspectors found that the provider had failed to have adequate arrangements in place to protect residents from all forms of abuse. Restrictive practice was not consistently applied in accordance with national policy and behavior support plans did not adequately guide practice. The provider had stated that action would be taken to address these failings however on this inspection, inspectors found that the actions taken did not improve the safety of the service provided. The provider continued to fail to protect residents from all forms of abuse.

Although, the centre had policies and procedures in place for the protection of vulnerable adults and training had been provided to staff, there was a pattern of safeguarding concerns identified by inspectors regarding the compatibility of residents. Residents had been verbally and physically assaulted by other residents within the centre. Residents had expressed fear and demonstrated fear of other residents. For example, residents were hit, shouted at and spat at by other residents. For each individual incident, an interim safeguarding plan had been developed, however, the effectiveness of the interventions were negligible as the incidents continued to occur on a frequent basis. Overall appropriate action had not been taken to ensure that residents could live safely without fear of violence in any form.

Physical and verbal aggression and socially inappropriate behavior was prevalent within the centre. This behavior resulted in a risk to residents. A high level of physical restraint involving two members of staff was used in response to these behaviors. The use of physical restraint had not consistently been approved and documented in advance. Language utilized in reviews by the behaviour team included statements such as the physical restraint was 'likely' or 'appeared' justified. However, there was an undue delay in the provision of a behaviour support plan to guide practice, with 24 incidents of physical restraint occurring prior to this being provided.

Inspectors found that risk assessments and standard operating procedures were, at times, completed in isolation of the appropriate allied health professional. Furthermore, following on from each incident, a review was conducted by the behavior team. The behavior team had made recommendations. However these recommendations were not

consistently implemented.

Inspectors were also concerned about the management of the use of CCTV cameras for monitoring behaviour. Staff stated that the use of this measure had been recommended by the previous service provider. Inspectors observed it to be in use 24 hours a day. The personal plan stated that it was to be used as a reactive strategy only during the presentation of behaviours that challenge, as opposed to a measure that was used continuously.

Judgment:
Non Compliant - Major

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
During the May 2016 inspection, inspectors found that governance and management arrangements were not adequate to ensure a safe and quality service to residents. Following the regulatory meeting with the provider, the provider informed HIQA of improved management and oversight arrangements. On this inspection, inspectors found that while the provider had put a range of management measures in place, they were not effective in improving safety and quality of care in the centre.

The regional manager stated that the provider's audits of the centre had demonstrated significant improvement and that they had reached a compliance rating of over 90% in many areas. However inspectors reviewed a sample of audits and found that they did not adequately identify issues relating to the safe and effective delivery of care and support. For example, a health and safety audit had been conducted in January 2017. The audit identified that the accident and incident records were up to date and concluded that there was compliance with requirements. However the audit did not identify a concern with the number of accidents/incidents in the centre and whether effective and appropriate action had been taken to safeguard residents.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Nua Healthcare Services Unlimited Company
Centre ID:	OSV-0003397
Date of Inspection:	16 and 17 February 2017
Date of response:	18 September 2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Deficits in the admission process impacted negatively on the safety and well being of all residents.

1. Action Required:

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

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

Please state the actions you have taken or are planning to take:
We have concluded that the environment is not suitable for two service users and a safe transition to alternative accommodation is required. In the meantime, we will endeavour to mitigate the incidences of peer to peer abuse by taking the following actions:-

1. Review the Admission process to reconsider the Pre Admission Risk Assessment [Due date: 28 April 2017]
2. Conduct a more comprehensive assessment of need prior to admission [Due date: 28 April 2017]
3. Update the Admissions Policy to take account of the above. [Due date: 28 April 2017].
4. Provide training on the amended Admissions policy. [Due date: 5 May 2017].
5. Implement additional staffing [Due date: Completed on 6 April 2017].
6. Arrange a neuro-psychiatrist review of relevant cases in Broadleaf Manor. [Due date: 28 April 2017]
7. Seek to identify more suitable accommodation for the two services users in question and work on a safe transition plan in line with Clause 5.4 of our Admission Policy [PL-ADT-001]. We have engaged with the HSE and will work towards a timeframe of 2 to 3 months or sooner, but the date of the transitions will depend on the assistance of the HSE in finding the replacement accommodation.

Proposed Timescale: As above.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not signed the written agreement which outlined the terms and conditions in which the resident would reside in the centre.

2. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
There were three agreements not signed on the day of the inspection, as the residents in question refused to sign same. As the service users are adults and have capacity (as not deemed otherwise), this decision was respected by the staff team. Following the inspection, we re-engaged with two of the residents to explain the terms of their agreement and they signed on 1 March 2017 and 13 March 2017. The other service user left our service on 20 March 2017.

We have considered the feedback of the inspector and will take the following actions to ensure our residents better understand the services to be provided to them:-

1. Ensure a written agreement is signed by each service user or their representative prior to the commencement of their placement and where a service user or their representative chooses not to sign the agreement, a note to that effect will be taken and placed on the Service User's file.
2. In instances where a communicative difficulty exists, the Person in Charge (PIC) and assigned key workers to develop communicative aids to help the service user better understand the terms and conditions in which they reside in the Centre.
3. Update the Admissions Policy [PL –ADT- 001] to include points 1 and 2 above. [Due date: 28 April 2017].
4. Ensure the Quality Assurance Department audits each new admission to Broadleaf Manor for the next six months. [Due date: 6 October 2017]

Proposed Timescale: 06/10/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that effective systems were in place for the assessment and management of risk and to protect residents, staff and visitors.

3. 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:
Our current admission process sets out requirement for a comprehensive initial needs assessment, impact assessment, risk assessment and the development of standard operating procedures prior to a new admission into any of our Centres. Our day to day operational work practice requires all staff to remain vigilant in terms of assessing the changing needs of each service user and in particular managing ongoing review of risk. Following a detailed review of the Inspector's finding and feedback, we believe we can make improvements to our risk management systems as follows:

1. 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: 5 May 2017]
2. The PIC to undertake a review all incidents in the last six months and ensure all corrective actions were identified, recorded and followed up [Due date: 20 May 2017]
3. 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:

20 May 2017]
4. Assign one of Nua Healthcare's Regional Managers (RM) who is a highly experienced care professional, to assist the PIC with the specific tasks of reviewing the incidents and the risk register. [This measure was implemented on 6th April]
5. Review and revise the Incident Report Form [Reference FP-107] in light of findings from points 2 and 3 above. [Due date: 28 April 2017]
6. Review the procedures associated with managing escalating risk to include the emergency plans in place to mitigate such risk to acceptable levels. [Due date: 28 April 2017]
7. Prescribe and communicate the actions to be taken in the event of an escalation in risk. Transfer the associated emergency protocol into the service's learning management system along with an associated test paper and deploy to the entire Broadleaf Manor workforce for completion [Due date: 5 May 2017]
8. Develop a tool box of educational aids to assist the PIC and their staff team effectively de-escalate risk [Due date: 5 May 2017]
9. Ensure the behavioural team produces trend analyses weekly and include it within clinical department reports to both the PIC and Provider Nominee. These trend analyses reports must be accompanied by commentary re the action taken to mitigate risk or recommendations and or requests for support to mitigate same [Due date: 20 May 2017]
10. 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]
11. 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].

Proposed Timescale: 20/05/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There had been insufficient action taken to identify and alleviate the cause of residents' behavior. The provider had not demonstrated that restrictions were the least restrictive option and were implemented for the shortest duration of time.

4. 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:
Our current policy on behavioural management sets out the requirements for ensuring

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. However, following a more detailed review of the inspector's finding and feedback, we believe we can make improvements in our behavioural management process, as follows:

1. Debrief the Centre's Team with the learnings from this inspection on the use of MAPA in the overall support of a service user exhibiting behaviours that challenge. [Due date: 5 May 2017]
2. Update the Policy and Procedure on Behaviour Support to include the preparation of an Interim Behaviour Support Plan within 7 days of admission, if required. [Due date: Completed 3 March 2017].
3. PIC, with the support of the Behavioural Specialists, to review all the Restrictive Practises in the Centre. [Due date: 28 May 2017]
4. 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].
5. Provide training to staff on Restrictive Practices policy, if revised. [Due date: 5 May 2017]
6. Audit implementation of the new policy for six months post implementation [Due date 5 November 2017].
7. All staff in the Centre to undergo training in Restrictive Practices [Due date: 5 May 2017]
8. Monitor Restrictive Practises on a Weekly basis. [Due date: Immediate]
9. 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: 5 May 2017]

Proposed Timescale: 20/05/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Insufficient action had been taken to ensure that residents could live safely without fear of violence in any form.

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

Please state the actions you have taken or are planning to take:
Our current policy on Safeguarding sets out rigid requirement for ensuring every effort is made to protect vulnerable service users from any form of abuse. Whist our policy on safeguarding outlines the means through which we facilitate and manage safeguarding concerns, following a more detailed review of the inspector's finding and feedback, we

believe we can make improvements to our overall approach towards safeguarding, as follows:

1. For as long as the peer to peer safeguarding concerns remain, deploy an additional full time equivalent 24 hours a day 7 days a week as a further control measure to ensure the safety of residents [Due date: Completed 7 April 2017]
2. PIC, Safeguarding Officer and members from the Management Team to review all Safeguarding plans for all residents [Due date: Completed 3 March 2017]
3. Incorporate the safeguarding plan as part of the daily handover and include same as a standing agenda item on the Monthly Team Meeting [Due date: Completed 23 March 2017].
4. Provide refresher training on Safeguarding to all staff in the Centre [Due date: 5 May 2017]
5. As referenced above under outcome 4, identify more suitable accommodation for the two services users in question and work on a safe transition plan to alternative accommodation in line with Clause 5.4 of our Admissions Policy [Due date: as noted under Outcome 4].
6. Deliver refresher training for Broadleaf Manor staff on the Policy and Procedure of Vulnerable Persons [Reference PL-C-001] [Due date: 5 May 2017]
7. Debrief the Centre's team on the use of MAPA in the overall support of a service user exhibiting behaviours that challenge [Due date: 20 April 2017].
8. Review and update the Service User Surveys to include a question on how safe they feel in their service and implement any findings immediately thereafter [Due date: 31 July 2017]

Proposed Timescale: 31/07/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management oversight in the centre was failing to ensure that adverse events which impacted negatively on residents were managed effectively and failed to identify and address a range of regulatory failings.

6. 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 Broadleaf Manor. The new Provider Nominee is one of three Area Directors of Operations in Nua Healthcare, has 15 years of experience as a social care professional, including as Team Leader, Regional Manager and Director of Operations. He will be Provider Nominee for 17 Centres, including Broadleaf Manor. He is supported by 4 Regional Managers.

We note the criticism of our internal Quality Assurance audit of Broadleaf. Our auditor's currently gather data on compliance with processes, and this data forms part of management review of care. However, our audit function does not in itself inform the home or management about the quality and safety of care in totality. We recognise the Inspector's finding and we are taking the following steps:

1. Appoint a new head of Quality Improvement. [Completed; starts in May]
2. Retain independent consultants (Health Care Informed) to conduct a comprehensive review of the QA function and, working with the Head of Quality Assurance, assist in developing a full action plan as to how this important part of our management function can be enhanced. [Due date: 30 May 2017].
3. Retain Health Care Informed to undertake a full 18 outcome audit on Broadleaf Manor, the findings of which will potentially inform further corrective actions. [Due date: 30 September 2017].
4. PIC to review all incidents and accidents to ensure all actions have been carried out [Due date: 20 May 2017]
5. Develop new methods for more thoroughly reporting incidents and accidents on a home by home basis up through management and to the Governance Committee, with clear triggers for agreeing and monitoring actions to address any instances of escalating events. [Due date: 31 July 2017]
6. Roll out a cloud based incident and accident reporting tool with real time reporting functionality [Due date: 31 July 2017]

Proposed Timescale: 30/09/2017