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 Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003944
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Breda Noonan
Lead inspector:	Julie Hennessy
Support inspector(s):	Noelle Neville;Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	30
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. 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:
07 January 2016 09:00	07 January 2016 17:00

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

Outcome 07: Health and Safety and Risk Management
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the seventh inspection of this designated centre. This monitoring inspection was carried out following the receipt of a notification of concern of a resident submitted by the person in charge of the centre to the Authority. The notification of concern related to an adverse clinical event. This inspection was a triggered or 'single-issue' inspection in relation to Outcome 11, Healthcare Needs. Where relevant or where risks were identified, aspects of other outcomes have been included in this report.

The provider was directed to complete an investigation into the adverse clinical event. The report of the investigation is due to be submitted to the Authority on 15 January 2016.

The purpose of this inspection was for inspectors to seek re-assurances that residents' healthcare needs were being appropriately assessed and met by the care provided in the centre.

St. Anne's Residential Service Group A comprises four interconnecting dormer bungalows (or 'units') and is a congregated setting. The centre can accommodate 31 residents and mainly provides a service for residents with a severe to profound intellectual disability. Two residents were in hospital at the time of inspection. The statement of purpose for the centre states that new admissions can be admitted to this centre.

Inspectors reviewed a sample of files pertaining to residents with the highest

healthcare needs in the designated centre and spoke with the person in charge and area manager. Based on the sample of residents reviewed, inspectors found that residents' healthcare needs were being assessed and met by timely access to healthcare services and appropriate treatment.

In addition, inspectors found improvement in residents' healthcare plans and the implementation of recommendations related to the delivery of healthcare to residents since the previous inspection.

A major non-compliance was however identified on the day of inspection. There was no identifiable person in charge of the centre on the day of the inspection. Gaps in relation to the supervision of the centre had also been identified at an inspection as far back as December 2014 and following that inspection, the Authority had received assurances in writing from the provider that there would be an identifiable person in charge of the designated centre at all times. Inspectors found that this was not the case on the day of this inspection. The provider was required to take immediate action to address this matter and provide re-assurances that their previous response would be implemented in full. The provider responded to the immediate action letter appropriately and within the required timeframe. A new roster was drawn up by the close of inspection that ensured that a suitably competent person would be identified as a lead person to manage the centre at all times.

In addition, other issues relating to governance and management previously identified in the centre had not been adequately addressed. It has not yet been demonstrated that the person in charge had the required supports to enable her to effectively monitor and supervise the quality and safety of care being delivered to residents.

Additional non-compliances were identified in relation to incident recording and review, risk management and the delivery of staff training to meet the assessed healthcare needs of residents. Findings are detailed in the body of this report and should be read in conjunction with the actions outlined in the action plan at the end of the report.

The provider was unavailable on the day of inspection and attended a feedback meeting in the Authority's head office shortly after this inspection.

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 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:
Two aspects of this outcome were inspected and these related to risk management and incident management. Non-compliances were identified in relation to both areas.

For example, a number of risk assessments held in residents' files were found to be beyond their review date. Information relating to risk within two residents files was contradictory. For example, for a resident with mobility needs, an occupational therapist had assessed the risks associated with assisted moving and handling of a resident as 'high-risk', a subsequent risk assessment completed in the centre assessed the risk as 'low-risk'. The person in charge confirmed that a risk level of low was inaccurate and the same resident's mobility needs had gradually being increasing over the previous few months.

Risk assessments were in place and training in risk assessment had taken place since the previous inspection. However, further improvement was required in relation to risk management and this is further elaborated on in the context of clinical risk management under Outcome 11, Healthcare Needs. The Authority had been notified of an unexpected death of a resident as a result of an adverse clinical event. Inspectors found that for another resident who required enteral feeding via percutaneous endoscopic gastrostomy (PEG), there was no risk assessment relating to the risk of aspiration nor was this risk considered in the resident's care plan.

Also, a number of risk assessments held in residents' files were found to be beyond their review date. Clinical risk assessments tools were not always applicable to this setting, resulting in an under-estimation of risk. Examples were found whereby information relating to risk within files was contradictory.

Inspectors reviewed incident books from the four units that comprise the designated centre. Incidents were being recorded as required. However, a number of failings were identified in relation to incident management and these were discussed with the person

in charge on the day of inspection.

For a number of incidents, it was not documented what follow-up action had been taken to prevent a re-occurrence or to demonstrate learning. Not all incidents had been reviewed by the person in charge in a timely manner and in accordance with the organisation's incident management policy. An incident that occurred in October 2015 had not yet been reviewed at the time of this inspection on 7 January 2016.

While the Authority had been notified of an unexpected death of a resident in the centre, an incident report form had not completed in the centre for this adverse clinical event.

In addition, the process for following up on adverse clinical events was not clearly outlined in the incident management policy.

Judgment:
Non Compliant - Major

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
Inspectors reviewed a sample of files and healthcare plans pertaining to residents with the highest healthcare needs in the designated centre. Based on this sample, inspectors found that overall residents' healthcare needs were being appropriately assessed and met by the care provided in the centre. Gaps were identified in relation to required checks and observations and training to meet residents' healthcare needs. In addition, a recommendation from an occupational therapist was outstanding by almost one year.

At the previous inspection, it was identified that healthcare plans were not being kept up-to-date nor did they direct the care to be given to residents. In addition, following hospital treatment, medical information did not always inform a plan of care for the resident.

At this inspection, improvement was found in relation to healthcare plans. Plans were clear and comprehensive and clearly directed the care to be given to each individual resident. The person in charge told inspectors that training and support had been provided to staff in relation to the delivery of care in accordance with residents'

healthcare plans and that staff understanding of how to implement healthcare plans was increasing.

Where a resident had received hospital treatment, advice and instructions given on discharge from the hospital were clearly captured and were being implemented by staff.

Residents had access to a general practitioner (GP), medical and surgical consultants and diagnostic facilities and tests.

Daily reports were maintained by nursing and care staff. Inspectors observed however that there was no entry in the daily records pertaining to a day in which a resident was admitted to hospital. The evidence reviewed did not indicate that this was anything other than poor record-keeping. Entries pertaining to the previous day were detailed and demonstrated that staff recognised clinical deterioration and were responsive to such signs. The same resident had access to their GP in a timely manner. Specialist medical support and advice had been sought and provided.

Where residents received nutritional support via percutaneous endoscopic gastrostomy (PEG), a care plan was in place. While the care plan contained detailed information, improvements were required. Neither the care plan nor the guidelines pertaining to PEG indicated what to do to prevent foreseeable complications, such as what to do in the event of a resident vomiting. Some gaps in checks and observations required to prevent infection and maintain the best possible health for residents with a PEG tube were noted, including in relation to stoma site care, syringe replacement and recording of bowel movements. In addition, the risk of aspiration was not addressed either within the same resident's care plan, as required in accordance with the organisation's nutrition and hydration policy and/or within a risk assessment.

For a sample of other residents with nutritional needs, a dietary plan was in place, regular weights were recorded and risk assessments were available in relation to the risk of choking and aspiration of food. However, while weights were regularly recorded for residents with nutritional needs, they were not recorded in accordance with relevant best practice guidelines available in the centre. For example, for a resident who received nutritional support via PEG and required their weight to be recorded weekly, staff had not ensured that the resident was weighed in the same type of clothes, at the same time of the day and using the same scales. A recent weight recording from 21.11.2015 indicated that the resident had experienced weight loss. A recent entry included a note that read "weighing scales unpredictable". As a result, it was not possible to determine the accuracy of the recorded weights and whether that resident's weight was being maintained within acceptable parameters.

Clinical risk assessments were in use and included risk assessments relating to the risk of pressure sore development, malnutrition, dehydration and falls. However, inspectors found that not all risk assessment tools used were appropriate. The risk assessment tool in use for the prevention of falls was not validated for use for a younger person with an intellectual disability in a non-acute setting. As a result, the risk of falling for a younger resident was underestimated and not consistent with other available information within that resident's file that identified that the resident "has an extremely unsteady gait and has had a number of falls".

Where a resident was losing weight and at risk of malnutrition, a recent assessment had been completed by a clinical nurse specialist in nutrition and a clear plan was in place, including at what point a review by a dietician would be required.
The area manager told inspectors that only qualified nurses looked after residents who received nutritional support via PEG tubes. The majority of nurses had attended training in relation to care of the stoma and PEG tube replacement with the remaining nurse scheduled for training that month.

However, inspectors found that not all staff had received training that met the assessed needs of residents in order to support residents with nutritional needs to eat and drink and to prevent against the risk of choking. More than half (21 of 51 or 53%) of staff had not received training in relation to the relevant course run in the centre, which was entitled "identification and management of feeding, eating, drinking and swallowing disorders in children and adults with an ID (intellectual disability) and dysphagia". Seven staff members that required this training were non-nursing staff. This action can be found under Outcome 17, Workforce.

Gaps relating to access to allied health care were identified under Outcome 5 on the previous inspection and were followed up on this inspection. Overall, inspectors found improvement since the previous inspection in this area.

Residents who required review by a speech and language therapist (SALT) had been reviewed since the previous inspection both in relation to communication and dietary needs.

Residents who required review by an occupational therapist (OT) had been reviewed and a number of reviews had been completed since the previous inspection. However, of the sample reviewed, one action was still outstanding. A report by the OT dated 11 February 2015 identified that a resident's specialist chair that had been removed from the centre due to inadequate storage facilities. The OT report emphasised that this chair was essential to support that resident's posture and strongly recommended that the chair be returned to the centre. The person in charge confirmed to inspectors that this specific specialised chair was not currently in the centre.

Where residents were at end-of-life, a care plan was in place that clearly outlined medical and personal preferences in the event of a resident's condition deteriorating. Links with palliative care teams had been established where required.

Judgment:
Non Compliant - Moderate

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:
A major non-compliance was however identified on the day of inspection. On arrival at the centre, inspectors found that all persons identified as being in charge of the centre or participating in the management of the centre were on leave. Staff were not able to identify who was in charge. The area manager providing senior cover was not aware that there was no identifiable lead person in the centre that day. Of note, there was no arrangement in place to ensure that there was a lead person to take responsibility for ensuring the effective management of the centre at all times. Gaps in relation to supervision arrangements in this centre were identified as far back as an inspection in December 2014 and following that inspection, the Authority had received assurances in writing from the provider that there would be a lead person in charge of the designated centre at all times and two house managers in place. Inspectors found that this was not the case on the day of inspection. The provider was required to take immediate action to address this matter and provide re-assurances that their previous response would be implemented in full. The provider responded to the immediate action letter appropriately and within the required timeframe. A new roster was drawn up by the close of inspection that ensured that a suitably competent person would be identified as a lead person in the centre at all times.

The person in charge, who was on leave on the day of inspection, subsequently chose to attended the centre to participate in this inspection.

The person in charge is a nurse in intellectual disability nursing and holds a BSc (Nursing). The person in charge has previous experience in working at clinical nurse manager level. The role of the person in charge was full-time and the post was dedicated to this centre only. The person in charge reports to the CNM3, who in turn reports to the provider nominee.

At the time of the previous inspection, the person in charge had only recently commenced in that role. Due to the short time-frame that the person in charge was in the role, inspectors were not in a position to determine the effectiveness or otherwise of those arrangements.

At this inspection, it was found that the person in charge demonstrated effectiveness in her role. As outlined under Outcome 11, improvement was noted in relation to the meeting of residents' healthcare needs. Arrangements in place pertaining to protecting residents' privacy and dignity had been reviewed and were being monitored by the person in charge. Regular unit meetings were being held. Training had taken place in relation to risk assessment and care planning. Manual handling techniques had been

reviewed. New arrangements had been introduced in relation to the ensuring residents' equipment would be regularly cleaned and properly maintained.

At the previous inspection, it was identified that the person in charge was also acting as the house manager for two of the four units while that house manager was on leave. In addition, it was not fully demonstrated that the person in charge had the required supports necessary to enable her to fulfil her role, particularly in terms of nursing and multi-disciplinary input.

Since the previous inspection, specific support had been provided by the CNM3 and members of the multi-disciplinary team. However, inspectors found on-going issues relating to the governance and management of the centre. At this inspection, while the person in charge was no longer acting in a house manager role, at any one time over the course of the previous 12 months, one of the two house manager posts in the centre had been vacant (while a house manager was on leave). In addition, there had not been any increase in nursing numbers, although recruitment was on-going. The person in charge told inspectors that the on-going house manager absences and difficulties in nurse recruitment were having an impact on her ability to effectively monitor and supervise the quality and safety of the service. This is particularly relevant given the high level of non-compliance in the centre identified in seven previous inspection reports. The unsatisfactory supports are evidenced in this inspection by gaps in completing required healthcare checks and observations, daily nursing notes and incident records.

Judgment:
Non Compliant - Major

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

Findings:
One aspect of this outcome was inspected relating to residents' healthcare needs.

As previously mentioned under Outcome 11, inspectors found that not all staff had received training that met the assessed needs of residents in order to support residents with nutritional needs to eat and drink and to prevent against the risk of choking. More

than half (21 of 51 or 53%) of staff had not received training in relation to the relevant course run in the centre, which was entitled "identification and management of feeding, eating, drinking and swallowing disorders in children and adults with an ID (intellectual disability) and dysphagia". Seven staff members that required this training were non-nursing staff.
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:

Julie Hennessy
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 Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003944
Date of Inspection:	07 January 2016
Date of response:	29 January 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 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:
As outlined in the findings under this outcome and Outcome 11: Healthcare, further improvement was required in relation to risk management. Where a resident received enteral feeding via percutaneous endoscopic gastrostomy (PEG), there was no risk assessment relating to the risk of aspiration nor was this risk considered in the

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

residents' care plan. A number of risk assessments held in residents' files were found to be beyond their review date. Clinical risk assessments tools were not always applicable to this setting, resulting in an under-estimation of risk. Examples were found whereby information relating to risk within files was contradictory.

1. 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:
For all residents in the centre who receive their nutrition via a percutaneous endoscopic gastrostomy risk assessments relating to the risk of aspiration will be completed and support from the speech and language therapist will be sought for this. These assessments are completed on 26/01/2016.

The Person in Charge and keyworkers in the centre will review the risk assessments in place for all residents and ensure that they are all up to date with review dates set.

The Nominee Provider will source alternate clinical risk assessment tools to assess risk. The Person in Charge will arrange for the Occupational Therapist and manual handling instructor to revise the manual handling and mobility needs of residents and risk assessments will be reviewed by the Person In Charge, Occupational Therapist and manual handling instructor. On review of the risk assessments the Occupational Therapist assessment and its findings and recommendations will form a key part of the review.

Proposed Timescale: 16/02/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of failings were identified in relation to incident management:

Not all incidents had been reviewed by the person in charge in a timely manner and in accordance with the organisation's incident management policy. An incident that occurred in October 2015 had not yet been reviewed at the time of this inspection on 7 January 2016;

The process for following up on adverse clinical events was not clearly outlined in the incident management policy;

For a number of incidents, it was not documented what follow-up action had been taken to prevent a re-occurrence or to demonstrate learning;

While the Authority had been notified of an unexpected death of a resident in the centre, an incident report form had not completed in the centre.

2. 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:
All incidents since inspection have been reviewed in a timely manner by the Person in Charge. Follow up to each incident and control measures to reduce likelihood of reoccurrence will be recorded and shared with all staff.

The Nominee Provider has referred the incident management policy to the Quality and Risk Officer to revise and ensure that the process for following up on adverse clinical events is clearly outlined in the incident management policy.

An incident form for the unexpected death of a resident has been documented and recorded on an incident form since inspection.

Proposed Timescale: 29/02/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Gaps were identified in relation to the provision of appropriate health care for each resident, having regard to each resident's personal plan including:

Required healthcare checks and observations were not always completed in accordance with residents' healthcare plans or best practice guidelines.

Where a resident had been admitted to hospital, there was no entry in that resident's daily record.

3. 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:
Daily records for all residents will be documented in their formative recording notes to include if a resident is transferred to hospital.

All staff will be met by the Nominee Provider, Director of Nursing and Person in Charge regarding the healthcare checks and observations to ensure that all are recorded appropriately and in line with best practice guidelines.

Proposed Timescale: 26/01/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all allied health recommendations had been implemented in a timely manner. Of the sample reviewed, one action pertaining to a specialised chair was outstanding for 11 months.

4. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
All allied health recommendations will be reviewed by Clinical Nurse Manager 3 and Person in Charge to ensure that all recommendations are implemented. The outstanding chair is on order by the Occupational Therapist for one resident. The chair was ordered pre this inspection by Occupational Therapist and is being made to meet residents requirements and will be delivered when completed.

Proposed Timescale: 18/03/2016

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 management structure in the designated centre was not clearly defined to identify the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision. There was no arrangement in place to ensure that there was a lead person to take responsibility for ensuring the effective management of the centre at all times.

5. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
The duty roster on a daily basis now indicates who the contact person is in the centre since 07/01/2016. The Nominee Provider has liaised with the Person in charge and H.R. Director and Chief Executive Officer and recruitment has commenced for additional management grades to be employed in the centre to ensure more effective line of authority and accountability are in place in the centre. Since inspection the centre has one vacant manager post which the service is currently auctioning.

Proposed Timescale: 31/03/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems in place in the designated centre did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. In particular, on-going house manager absences and difficulties in nurse recruitment were having an impact on the ability of the person in charge to effectively monitor and supervise the quality and safety of the service.

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:
The Nominee Provider, Person in Charge and H.R. Director have met re management in the centre. Recruitment has commenced for the appointment of additional management grades to be employed for this centre to support the Person in Charge. There are interviews on 27/01/2016 for the post of Staff Nurse, successful candidate will be appointed immediately once garda vetting and references are in order. There is a further advert published on Sunday 24/01/2016 for Nurse recruitment.

The organisation has a Clinical Nurse Manager 3 post vacant, recruitment is underway to fill this vacancy.

Since inspection a Clinical Nurse Manager 1 post has become vacant in the centre, the organisation is actively endeavouring to fill this post as quickly as possible.

Proposed Timescale: 31/03/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training that met the assessed needs of residents in order to support residents with nutritional needs to eat and drink in a safe manner and to prevent against the risk of choking.

7. 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 will be delivered to all staff on 16/02/2016 and 23/02/2016 on Dysphasia by a Speech and Language Therapist, this includes supporting staff to ensure all measures are taken to prevent incidents of choking.

Training will be delivered to all staff in managing incidents of choking on the 16/02/2016 and the 23/02/2016.

Proposed Timescale: 23/02/2016