

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
<b>Centre ID:</b>	OSV-0003944
<b>Centre county:</b>	Tipperary
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Daughters of Charity Disability Support Services Ltd.
<b>Provider Nominee:</b>	Marie Grimes McGrath
<b>Lead inspector:</b>	Julie Hennessy
<b>Support inspector(s):</b>	Noel Sheehan
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	31
<b>Number of vacancies on the date of inspection:</b>	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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 19 December 2014 10:30 To: 19 December 2014 19:00

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

Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

This inspection was carried out in response to unsolicited information received by the Health Information and Quality Authority (the Authority) on 16 December 2014. The unsolicited information related to allegations of poor practice and practices that could constitute the abuse of residents in specific units. The inspection type was a triggered 'single-issue' inspection relating to 'Outcome 8: Safeguarding and Safety'.

Following receipt of the information, an inspector made contact with the informant to verify and obtain additional details. The Authority subsequently notified the Health Service Executive (HSE) and An Garda Síochána of the allegations. The inspector was also in contact with the Assistant Chief Executive Officer of the Daughters of Charity who had been made aware of an allegation.

The Authority requested immediate action and reassurance from the provider that appropriate action would be immediately taken to ensure the safeguarding of residents in the two identified units. Following several contacts by inspectors to the provider; specific reassurances were given.

Group A comprises four interconnecting bungalows that can accommodate 32 residents. This preliminary inspection focused on the two bungalows in which the allegations had been made. As part of the inspection; inspectors interviewed staff on duty and reviewed documentation pertaining to the areas of concern. Documentation reviewed included daily notes, communication books, personal plans, risk assessments, nutritional information and documentation pertaining to restrictive practices, medication management and behaviours that challenge. Inspectors observed staff interactions with residents. Inspectors reviewed staff rosters to

confirm that no named staff member against whom an allegation had been made was on duty.

Inspectors found evidence to support some but not all of the allegations made by the informant. Evidence relating to a final allegation of forced administration of medication was inconclusive.

Inspectors' findings in relation to the allegations made are contained in the body of this report. As a result of risks identified during the course of the inspection; aspects of three additional outcomes were inspected and are included in this report. The additional risks included for action in this report were at the level of major non-compliance and related to governance and management, staff training and incident management. Actions required by the provider to address these risks are outlined in the action plan at the end of this report.

Given the serious nature of the allegations and findings on inspection the Chief Executive Officer and Assistant Chief Executive Officer of the Daughters of Charity were requested to attend a meeting with the Authority on 22 December 2014 to discuss all matters further. Verbal assurances were given by both parties that residents were being monitored and that satisfactory safeguarding systems had been put in place to ensure the safety and welfare of all residents in their care.

**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:**

Inspectors reviewed a number of aspects of this outcome, as they related to the concern received. Aspects reviewed included systems in place to manage risk and systems in place to manage incidents.

Inspectors found that the management of incidents required improvement. For example; inspectors found that an entry into the incident book on the day of inspection was signed by a supervisor who was not on duty. The entry related to an unexplained bruise on the body part of a resident. The inspector queried how the incident could be reviewed in a timely and appropriate manner if incident books were not being correctly completed. The provider nominee agreed that this was not in line with the procedure for recording incidents. The provider nominee was requested to determine the reason for this practice and provide an explanation in writing to the Authority. The A/CEO subsequently confirmed in writing that the incident book had been completed by a care staff who had signed the supervisor's name in error. The provider nominee has taken steps to address this issue.

**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:**

**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

Inspectors found evidence to support some, but not all of the allegations received by the Authority. Evidence relating to an allegation of forced administration of medication was inconclusive.

Relevant policies were in place, including in relation to the protection of vulnerable adults, restrictive practices, behaviours that challenge, the provision of personal intimate care and residents' personal finances and possessions. There was a nominated person to manage any incidents, allegations or suspicions of abuse in the service and staff were able to identify the nominated person.

Inspectors interviewed six regular and one agency staff. All seven staff were interviewed about each area of concern. General background, training and skill set were established. Inspectors also reviewed documentation relevant to the areas under investigation. Staff interactions with residents were observed.

Each area of concern is outlined below in the manner in which it was received by the Authority. The concerns are addressed in turn and the findings are as follows:

**Forced administration of medication in food:** The evidence was inconclusive. This practice was alleged to have taken place in one bungalow. Inspectors found that the house manager was clear and consistent in her responses as to how medications were to be administered to the individual resident and that she would not tolerate any forced administration of medication. The inspector reviewed the resident's file. The inspector found that there was a clear protocol in place around the administration of medication in food, which was multi-disciplinary. However, the inspector observed an entry in the resident's notes that raised questions in relation to the manner in which medication had been administered to the resident on a recent occasion; this entry was made on a date which supports the information received by the Authority. The house manager had been on leave at this time. In the absence of corroborating witness evidence, it was not possible to deduce the relevance, or otherwise, of that entry.

**Shouting at residents and using inappropriate language (such as name-calling):** Inspectors found evidence, gathered through interviews, to support this allegation in one bungalow. The provider was informed of the nature of the supporting evidence.

**Failing to meet the personal intimate care to residents:** Overall, inspectors did not find any conclusive evidence to support this allegation in either bungalow. One staff member said that on occasion showers could be missed due to lack of staff and staff as a result being too busy. This will be further discussed under Outcome 17: Workforce.

**Failing to respect the resident's dignity and bodily integrity when assisting with intimate care needs:** Inspectors found evidence to support this allegation in one bungalow. The

provider was informed of the nature of the supporting evidence.

Failing to provide residents with opportunities to participate in activities in accordance with their interests, capacities and developmental needs: Inspectors found evidence to support this allegation in one bungalow and also, that residents overall were not provided with adequate opportunities to participate in activities at weekends. In one bungalow, most residents received a day service during the week. One resident did not receive a day service, but inspectors found that that resident was provided with opportunities to participate in activities that were appropriate to his disability and individual needs and wishes. In the second bungalow, two residents did not receive a day service. The inspector reviewed the care plans of the both residents. Both residents had an 'activity timetable'. The person in charge confirmed that the range and scope of activities offered, as per the timetable, were inadequate. Also, there was no record kept of whether activities were completed as per the activity timetable. Inspectors found that in particular, activities at weekends were insufficient. For example, on Saturdays, the activities outlined for one resident consisted of 'foot spa' in the morning and 'relaxation' in the afternoon. On Sundays, the activities consisted of 'relaxation' in the morning and 'bus drive' in the afternoon. Staff said that little activities took place at weekends and that this was due to lack of staffing. One staff member for example, explained that even taking residents for a walk within the campus grounds was a problem.

Failure to ensure that staff members have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour: Inspectors found evidence to support this allegation. Inspectors spoke with a staff member who confirmed that not every resident had a positive behaviour support plan. Inspectors also found gaps in documentation. For example, while minutes from a multidisciplinary team meeting referenced a risk assessment form for the use of bedrails; no risk assessment had been completed for that resident.

Inadequate monitoring and documentation of nutritional intake of residents: Inspectors did not find any substantive evidence to corroborate this allegation on the day of inspection.

Possible financial mismanagement of residents' funds (this was raised in the context of residents' funds being used to buy food that was not being given to the residents): Inspectors did not find any evidence to corroborate this allegation on the day of inspection. All staff interviewed were able to describe a clear system in place that was subject to checks, countersigning and audit in a consistent way.

Staff not supported to raise concerns about the quality and safety of the care and support provided to residents: There were policies and procedures in place for the management of complaints and these were also available in an easy to read version. However, inspectors found evidence to support this allegation in both bungalows. The provider was informed of the nature of the supporting evidence.

Additional issues were identified by inspectors over the course of the inspection. These related to inadequate supervision and insufficient staffing levels:

In one bungalow, inspectors found clear management systems in place. Inspectors interviewed the house manager and found that she was a person of authority and responsibility who had the skills, training and qualifications to effectively manage the house. Inspectors found that the house manager was able to demonstrate that care was delivered in a safe manner when she was on duty. A monitoring inspection had previously taken place in this house.

In the second bungalow, there was no supervisor in the house on the day of inspection. The failing in relation to the provision of adequate supervision will be further discussed under Outcome 14: Governance and Management and Outcome 17: Workforce, and in the associated actions.

Five of the six regular staff interviewed said that there was not enough staff, including nursing staff. Inspectors found examples of negative impacts for residents as a result. For example and as previously mentioned, one staff said that staffing was such a problem that even bringing residents for a walk within the campus was a problem. Some staff said that they had previously raised this issue with senior management. Staffing issues are further discussed under Outcome 14: Governance and Management and Outcome 17: Workforce and in the associated actions.

Inspectors spoke with nursing staff who insisted that, despite the staff shortages, that they were covering the basic care very well and would not tolerate poor care or practices.

**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):**

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

**Findings:**

Inspectors found that improvements were required to the governance and management of the designated centre.

Following the inspection, a feedback meeting was held with the provider nominee and



the Director of Nursing. Areas that required improvement were discussed with the provider nominee and the Director of Nursing at that meeting.

Inspectors interviewed the house manager in one bungalow, who was clear and consistent in relation to how care was delivered when she was on-duty. This bungalow had previously had a monitoring inspection. However, there was no supervisor in the second of the two bungalows on the day of inspection. The inspector had received assurances from the provider that adequate supervisory arrangements had been put in place to manage all four bungalows, including over the weekend and the Christmas period. Inspectors found that this was not the case on the day of inspection. The provider was contacted following the close of inspection in relation to this failure.

Inspectors found that staff members were not consistently supported to raise concerns about the quality and safety of the care and support provided to residents.

**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:**

Improvements were required in relation to staff training, staff mix and staffing levels.

Five of the six regular staff interviewed said that there was not enough staff, including nursing staff. Staff were able to provide specific examples of negative impacts for residents as a result. Staff said that weekends in particular were a problem.

A number of staff said that that it was very difficult to bring residents out at the weekends as there were not enough staff to do so. Examples of negative impacts on residents were previously outlined under Outcome 8: Safeguarding and Safety. Some staff said that they had previously raised concerns relating to lack of resources and lack of activities for residents with senior management.

Inspectors found that staff routines and staffing levels dictated the lives of the residents.

For example, staff in one bungalow stated that all residents were in bed by 9pm and up at 07:30am and that this was due to "routine" and pressures on staff due to staff shortages.

Inspectors found that the person in charge had failed to ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour. Staff were unable to demonstrate clearly how to manage an individual resident's behaviour if it became challenging. Answers were vague and relied on knowing the resident well; answers did not refer to any specific behaviour support plan.

As previously mentioned under Outcomes 8: Safeguarding and Safety and 14: Governance and Management; inspectors found that the supervisory arrangements in place were highly unsatisfactory. This was discussed with the provider immediately following the close of inspection and the provider was required to take immediate action to address the situation.

**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:***

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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
<b>Centre ID:</b>	OSV-0003944
<b>Date of Inspection:</b>	19 December 2014
<b>Date of response:</b>	29 January 2015

### 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:**

The organisation's procedures in relation to the recording, reporting and review of incidents was not being followed.

**Action Required:**

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management

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

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:**

- On the 23rd December 2014 a memo was sent around to all staff to reiterate the requirements for reporting incidents according to DOC 011 policy (appendix 5). Area managers ensuring all incidents are processed as per policy and all incidents will be discussed at team meetings held in all areas.
- The risk management policy was reviewed in 2014.
- The Quality and Risk Officer for the region has commenced an audit for all clinical incidents, and associated documentation including all action plans and risk rating.
- A concern and welfare process, in relation to service users in Group A, commenced on the 19th December 2014 with outcomes from the meetings to include full clinical review, review, multidisciplinary meeting which took place in January 2015 and a training needs analysis which was completed in December 2014. A second meeting to review the process and action plans is scheduled for 25th February 2015.
- Clinical review of Group A was completed by the Assistant Director of Nursing and report received on the 7th January 2015, and recommendations and actions have commenced.

**Proposed Timescale:** 27/02/2015

**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:**

The person in charge had failed to ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

**Action Required:**

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

**Please state the actions you have taken or are planning to take:**

- A lead person has been indicated for each shift in all areas.
- The training needs analysis for all areas will be completed, to ensure compliance with regulatory requirements.
- Continuation of training "Staff support in Behaviour Management workshops" with Principal and Senior Clinical Psychologist on 27/1/15. Further dates to be scheduled

**Proposed Timescale:** 27/02/2015

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The person in charge had failed to ensure that there were adequate measures in place to respect residents' dignity and bodily integrity when assisting with intimate care needs.

**Action Required:**

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

**Please state the actions you have taken or are planning to take:**

- Intimate care guidelines DOCS 064 are an integral part of an individualised care plan. The Assistant Director of Nursing has started a review of care plans for residents.
- The intimate care guidelines DOCS 064 has been reiterated to staff and the Quality and Risk Officer sent around a memo to all staff.
- The Home Managers in Group A have been supernumerary from Monday 19/1/15 to assist among other tasks in ensuring residents dignity.
- The Assistant Director of Nursing is based in St. Anne's 1 day per week to provide guidance on care planning, medication management and all clinical practices to ensure the service user is provided with care in line with best practice.
- A CNM3 will be transferring from the Limerick Service next week for 2 days a week for 3 weeks with the specific function / responsibility of supporting staff in updating care plans and documentation.

**Proposed Timescale:** 27/03/2015

**Theme:** Safe Services

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

Adequate arrangements were not in place to protect residents from all forms of abuse.

**Action Required:**

Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

**Please state the actions you have taken or are planning to take:**

- There are a number of arrangements within the Daughters of Charity Service to protect residents from all forms of abuse, i.e. Complaints Policy DOCS 003, Policy on the protection and Welfare of Vulnerable Adults and management of allegations of abuse DOCS 020, Policy on Bullying & Harassment of Service Users DOC 058, Staff

Communication Policy DOCS 061.

- On the 9th December 2014 the CEO sent a letter to staff to remind them of the abuse policy, and their responsibilities to report any concerns.
- The regional advocacy committee has been tasked to prioritise the development of advocacy services in the Villa's.
- Service users with no family members has been referred to an independent advocacy service.
- All 16 families have been afforded the opportunity to meet with senior management, and have been communicated with by telephone on several occasions.
- A concern and welfare process, in relation to service users in Group A, commenced on the 19th December 2014. These meetings which include a full clinical review and multidisciplinary involvement continue through January 2015. Process and action plans to be discussed at a meeting scheduled for 25th February 2015.
- Training in protection and welfare of vulnerable adults and the management of allegations of abuse will be completed by the 16th February 2015.
- An audit has commenced on all Service User Protection and Welfare reports and will be completed by the end of March.
- Audit completed in January on all NF06 forms.
- All Service Users of Group A will have had a Multidisciplinary team meeting by the 10/02/2015. Minutes will be submitted to HIQA Inspector as part of weekly updates.
- The Assistant Director of Nursing is based in St. Anne's 1 day per week to provide guidance on care planning, medication management and all clinical practices to ensure the service user is provided with care in line with best practice.
- Clinical review has been completed by the Assistant Director of Nursing. Report provided to HIQA on Monday 26th January 2015.
- All staff will have received training on DOCS 020 Procedures for the Protection of Children and vulnerable Adults and the Management of Allegations of Abuse by the 16th February 2015.
- There is a lead person identified on each duty shift since the 20th December 2014.
- An additional Nurse is on duty each night to support the needs of the Service Users.
- Unannounced visits continue. Dates and details to be forwarded to HIQA inspector.

**Proposed Timescale:** 16/02/2015

## **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:**

A clearly defined management structure was not in place. For example, in the first group setting; there was no supervisor in place. In the second group setting; roles and responsibilities had not been clearly defined and staff were unable to identify the person in charge.

**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:**

- There are two managers in place in Group A.
- Both managers have been supernumerary since Monday 19th January 2015 to ensure all recommendations are acted and issues addressed.
- There is a lead person on duty on every shift in all 3 designated centres since the 20th December 2014.
- A CNM3 will be transferring from the Limerick Service next week for 2 days a week for 3 weeks with the specific function / responsibility of updating care plans and documentation.
- Overall structure of the Service is under review and should be completed by 13th February

**Proposed Timescale:** 13/02/2015

**Theme:** Leadership, Governance and Management

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

In the first group setting; there was no supervisor in one of the two bungalows inspected on the day of inspection

**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:**

- There is a lead person on duty on every shift in all 3 designated centres since the 20th December 2014.
- There are two managers in place in Group A.
- Both managers have been supernumerary since Monday 19th January 2015 to ensure all recommendations are acted and issues addressed.
- Overall structure of the Service is under review and should be completed by 13th February

**Proposed Timescale:** 13/02/2015

**Theme:** Leadership, Governance and Management

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

Staff were not consistently supported to raise concerns about the quality and safety of the care and support provided to residents.

**Action Required:**

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

**Please state the actions you have taken or are planning to take:**

- There are a number of arrangements within the Daughters of Charity Service to protect residents from all forms of abuse, i.e. Complaints Policy DOCS 003, Policy on the protection and Welfare of Vulnerable Adults and management of allegations of abuse DOCS 020, Policy on Bullying & Harassment of Service Users DOC 058, Staff Communication Policy DOCS 061.
- On the 9th December 2014 the CEO sent a letter to staff to remind them of the protection and welfare policy, and their responsibilities to report any concerns.
- The ACEO (lead complaints officer) has increased her on site time in St. Anne's for guidance and support for the nominee provider and all staff.
- CEO, A/CEO and Director of HR met with the nominee provider and area managers for residential services on 12th January 2015 in part to reiterate the importance of raising concerns according to policy.
- A/CEO is meeting with senior staff on the 6th February 2015.
- All families were met by the A/CEO and/or the Principal Psychologist on Friday 19th December 2014.

**Proposed Timescale:** 20/02/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Inspectors found that the number and skill mix of staff was not appropriate to the number and assessed needs of the residents. Inspectors found examples of negative impacts for residents as a result.

**Action Required:**

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.



**Please state the actions you have taken or are planning to take:**

- In addition to the clinical audit, and multidisciplinary meetings as indicated in other themes, the Service will commence a full service user review to ensure a clear identification of their individual staff support needs.
- An additional Nurse is on duty each night to support the needs of the Service Users.
- The Quality and Risk Officer has completed a training needs analysis of the staff in Group A and training dates will be scheduled
- A number of Staff Nurses from Group A have attended training on PEG feeding on the 06/01/2015.
- Clinical input continues from the Assistant Director of Nursing on a weekly basis.
- Funding has been secured from the HSE on 16th January 2015 to ensure that all non nursing staff have a minimum training of Fetac level 5.
- Both managers have been supernumerary since Monday 19th January 2015 to ensure all recommendations are acted and issues addressed.
- A CNM3 will be transferring from the Limerick Service next week for 2 days a week for 3 weeks with the specific function / responsibility of updating care plans and documentation.
- CNS in Dementia from Memory Clinic at St. Joseph's Centre, Clonsilla is available from the 04/02/2015 to review the specific needs and activities of a Service User.
- Overall structure of the Service is under review and should be completed by 13th February

**Proposed Timescale:** 12/02/2015