

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Moorehall Lodge Drogheda
<b>Centre ID:</b>	OSV-0000737
<b>Centre address:</b>	Dublin Road, Drogheda, Meath.
<b>Telephone number:</b>	041 981 8400
<b>Email address:</b>	sean.mccoy@mhliving.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Moorehall Healthcare (Drogheda) Limited
<b>Provider Nominee:</b>	Sean McCoy
<b>Lead inspector:</b>	Jillian Connolly
<b>Support inspector(s):</b>	Leone Ewings
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	101
<b>Number of vacancies on the date of inspection:</b>	7

## **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
- to carry out thematic inspections in respect of specific outcomes
- 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 wellbeing 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. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

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 2 day(s).

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

From:	To:
15 June 2015 19:30	15 June 2015 00:00
16 June 2015 11:00	16 June 2015 15:30

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

Outcome 02: Governance and Management
Outcome 07: Safeguarding and Safety
Outcome 09: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 13: Complaints procedures
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

Moorehall Lodge Drogheda is a nursing home located in Co. Meath. The nursing home is one of two nursing homes operated by Moorehall Healthcare Limited. The centre is registered to provide residential services for 108 individuals.

The statement of purpose and function refers to the six individual units of the designated centre as houses and the organisation is structured around the 'Household' model. Inspectors were informed that the communal areas were designed for residents' convenience and comfort and built on the principals of home. Inspectors observed that the features of the model included each house having their own front door inclusive of post box and door bell. Each house also had a kitchenette and a homemaker which was a staff member who was employed to exclusively ensure that the communal areas of the house were homely and needs outside of care activities were met, such as ensuring that residents could have a cup of tea whenever they wished or that activities were available throughout the day.

Each of the six houses have a specific purpose depending on the needs of the residents residing there. Two of the houses provide long term care and two of the houses provide long term care for individuals with a diagnosis of a cognitive impairment such as dementia. One of the houses provides respite care and one of the houses provides convalescent/ transitional care.

This was the fifth inspection of the designated centre since its initial registration in 2012 and the first unannounced inspection. The previous inspection was conducted in February 2015 and inspectors followed up on the matters arising on this inspection. The Authority had also received unsolicited information since February 2015. The core issues arising were staffing levels, access to Allied Health Professionals and the management of complaints. A provider led investigation has been completed at the request of the Authority. Inspectors reviewed the investigation report submitted to the Authority. Inspectors found that the investigation had utilised a clear methodology which included consultation with all stakeholders. The information regarding access to Allied Health Professionals had not been substantiated. The provider stated that they were assured that staffing levels were adequate. Improvements were identified in the system regarding the management of complaints. On this inspection, Inspectors observed practice, reviewed documentation and spoke with residents and staff. Inspectors concurred with the findings of the provider that improvements were required in the systems for the management of complaints. Evidence also supported that residents had sufficient access to Allied Health Professionals. However the findings of this inspection evidenced that there were insufficient staffing in the designated centre at night.

Seven outcomes were inspected on this inspection. Inspectors found that the actions as stated by the provider in the action plan resulting from the inspection in February 2015 in respect of Safeguarding and Safety were satisfactorily addressed and therefore compliance was identified.

Substantial compliance was identified in the Health and Social Care Needs of residents however improvements were required in the care planning documentation. Moderate non - compliance was identified in the Governance and Management systems, Resident's privacy and staffing levels. Due to deficits identified in the administering of medication major non - compliance was identified.

The action plan at the end of the report identifies areas where mandatory improvements are required in order to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 02: Governance and Management***

***The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.***

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The management structure of the designated centre consists of the provider nominee who is the Chief Executive of the organisation. The person in charge is the director of care and reports directly to the Chief Executive Officer. On the day of inspection, inspectors were informed that there were currently three care managers in the centre, one care manager holds a permanent post and two care managers were recorded as 'acting care managers.' The care managers report directly to the person in charge. Each care manager was delegated the responsibility of each floor, two houses, within the centre. There were also auxiliary supports available for the designated centre inclusive of human resources, administration and maintenance. Inspectors were assured that the appropriate resources were in place for the management of the centre during the hours of 8.00 to 20.00.

However, inspectors determined that improvements were required in the centre for the arrangements from 20.00 – 8.00 hours. The Statement of Purpose states that the Person in Charge or the Care Manager is on duty seven days per week between 08.00 hours to 17.00 hours. From a review of the rosters, inspectors confirmed that this occurred in practice. From 17.00 hours to 08.00 hours a nurse is nominated as 'the single point of contact for all houses' and the person in charge provides out of hours contact. Inspectors observed this is practice, however were not assured that the system of a nominated nurse being the 'single point of contact' was an effective system due to the staffing levels in the area they were responsible for.

Inspectors observed the nominated nurse on the night of inspection attending to each of the individual houses, to gather the pertinent information regarding the residents residing in the centre on the night of inspection. Whilst this is evidence of positive communication, it also resulted in the nurse being absent from the area that they were responsible for, when this was occurring. This resulted in three care staff supporting

twenty residents over two houses. Eleven of the residents had an assessed dependency level of maximum dependency, six were documented as have a high dependency, two were assessed as having a medium dependency and one resident was recorded as having a low dependency. All of the residents were diagnosed as having a cognitive impairment. Considering this was a peak time for residents being supported to retire to bed, inspectors found that there was a risk present as two staff were regularly required to support residents to go to bed.

The risk was further increased, in the two houses, post 21.00 hours as the staffing reduced to two care staff and one staff nurse to support the residents. However the nurse had the responsibility for administering medication to twenty residents within this time alongside being the single point of contact for all six houses. Inspectors determined that this was an unsatisfactory supervisory arrangement.

Inspectors reviewed the systems in place to ensure that the services required were safe and effective. The centre has a system in place in which the provider nominee, the person in charge from this designated centre and the person in charge from the sister nursing home meet weekly to review the care provided. Inspectors were also informed that the provider nominee is also available for informal support if necessary. The provider nominee was absent at the time of inspection, however the chairman of the board was available in their absence. There was also a system of auditing in place. However, notwithstanding the systems in place inspectors determined a review was required to ensure that they were effective. For example, as evidenced in Outcome 9, significant deficits were identified on the practices regarding medication management practices. There was also insufficient staffing from 21.00 hours within the designated centre. The last audit of medication had been conducted in February 2015. There was also no clear system in place for ensuring that the staffing levels were determined based on the needs of the residents, particularly in the areas designated to provide respite and convalescence/transitional care. As stated previously and further evidenced in Outcome 18, staffing levels were insufficient on the night of inspection.

**Judgment:**

Non Compliant - Moderate

***Outcome 07: 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 provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.***

**Theme:**

Safe care and support

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

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

**Findings:**

An action identified on the registration inspection, was that evidence did not

demonstrate that when medication was administered to residents as a result of a resident presenting as agitated or confused that it was the least restrictive option. Inspectors were assured that this had been appropriately addressed since the previous inspection. An audit had been conducted in March 2015 regarding the restrictive practice. Training had also been scheduled for staff to attend in this area by the end of June 2015.

Inspectors reviewed a sample of residents' files that had been prescribed medication as required in response to agitation and confusion. There were plans of care created to guide staff on alternative methods to utilise prior to administering the medication. If the medication was administered the rationale for same was clearly documented and there was evidence that in some instances medication had not been administered as the proactive strategies utilised by staff were effective. It was also evidenced that the medication was discontinued once no longer deemed necessary.

**Judgment:**

Compliant

***Outcome 09: Medication Management***

***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The designated centre had policies in place for the appropriate procedures to be followed regarding the prescribing, administering and storing of medication. The evidence identified on this inspection however demonstrated that the policy was not implemented in practice.

Inspectors reviewed the prescription records of residents and determined that they contained all of the necessary information, inclusive of the name of the resident, a photograph of the resident, the name of the medication, the dosage, the time of administration and the method of administration. However, inspectors found that the administration of medication was inadequate. Of the sample of prescription sheets reviewed by inspectors, residents' medication was prescribed for 21.30 hours. Inspectors observed that medication that was prescribed for 21.30 hours was still being administered after 22.30 hours with the last medication administered at 23.13 hours. The times recorded for administration was also not clear. For example, inspectors observed medication being administered to a resident at 23.05 however on review of the administration sheet; it was challenging to determine the time recorded. Inspectors queried this with the person in charge who confirmed that it was difficult to ascertain and potentially read 21.05 or 01.05. Inspectors also observed all medication being recorded as administered prior to the resident receiving the medication. The

administering nurse was regularly interrupted to assist with supporting residents to retire to bed, whilst administering medication, which presented a risk of a medication error. Medication is stored in a locked cupboard in a communal space, inspectors observed the keys being regularly left beside the cupboard whilst the room was unattended and in some instances in the lock of the cupboard. Medication was also placed in front of a resident at 21.15 hours. The resident self-administered the medications at 23.00 hours. There was no individual or collective risk assessment in place to ensure that this was a safe practice for the resident and for other residents in the area.

Inspectors reviewed the system in place for the management of controlled drugs. They found that the register had been signed by two registered nurses at the commencement of each shift, in line with best practice and that controlled drugs were stored in a safe location.

There had been four medication errors reported since the registration inspection in February. Of these two involved controlled drugs. This further evidenced that there were deficits in the systems regarding the administration of medication. Inspectors informed management of the deficits during the feedback meeting and stated that a review of the supervision arrangements was required inclusive of the auditing systems.

**Judgment:**

Non Compliant - Major

***Outcome 11: Health and Social Care Needs***

***Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.***

**Theme:**

Effective care and support

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

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

**Findings:**

The designated centre utilises a computerised system for completing the assessments and plans of care for residents. In February 2015, a failing of regulation 5 (3) was identified as there was an absence of care plans in place for residents who experience confusion or agitation. Of the sample of files reviewed the appropriate care plans were in place and informed of the appropriate supports required. However, inspectors found that improvements were required in other areas of the care planning process in order for compliance to be achieved. Therefore this action is repeated at the end of this report.

Of the sample of personal plans reviewed, inspectors determined that residents had the appropriate assessments in place. For example, there were manual handling, falls risk assessments, risk of developing pressure sores and nutritional assessments in place for residents. There were also assessments in respect of the social care needs of residents which, in the main, identified their likes and dislikes such as reading and watching television. However for some residents, there was an absence of care plans in place to address the social care needs of residents. There were also improvements required to the plans of care in place to evidence that the assessed needs of residents were being met. For example, residents who were assessed as being at risk of developing pressure sores had plans of care in place stating 'repositioned regularly' however it did not specify parameters of what would be considered regular.

Inspectors reviewed the access residents had to a General Practitioner and Allied Health Professionals. Evidence supported that when residents required the support of an Allied Health Professional such as physiotherapy or speech and language therapy, a referral was submitted in a timely manner. Therefore the information received by the Authority was not substantiated. There was also evidence that residents had been assessed and the recommendations included in the plans of care of residents. Residents who were accessing the service for transitional care stated that they had been supported in their rehabilitation by Allied Health Professionals which significantly increased their ability to return to their home.

**Judgment:**

Substantially Compliant

***Outcome 13: Complaints procedures***

***The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The designated centre has the appropriate policies and procedures in place regarding the management of complaints, inclusive of personnel nominated to manage all complaints or incidents of dissatisfaction and personnel to review that all complaints are managed in line with the centre's policies and procedures. Inspectors reviewed the record of complaints maintained in the designated centre and found that any recorded complaints were managed in line with policy and procedure. However, inspectors determined that improvements were required in relation to staff recognising what constitutes a complaint, as per the policy of the organisation, and ensures that it is reported in line with same. For example, there was an incident in which a family member had expressed a concern regarding an aspect of care of their relative. Staff had

documented the incident in the daily progress notes of the resident however there was no evidence that the incident was communicated to the person in charge in line with policy.

**Judgment:**

Substantially Compliant

***Outcome 16: Residents' Rights, Dignity and Consultation***

***Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The Statement of Purpose of the Designated Centre states that the centre is 'committed to providing high quality safe services' and 'are determined to preserve the dignity, individuality and privacy of residents and do this in a manner that is sensitive to their ever-changing needs.' Inspectors observed staff to engage with residents in a dignified and respectful manner, and residents communicated to inspectors that staff were 'good' and 'very accommodating'. As 98% of the rooms are single rooms which are en suite, residents are supported to engage in activities of daily living in a private space. Inspectors also observed staff knocking on residents' bedroom doors prior to entering.

Improvements were required, in the systems in place, to ensure that the aim of the organisation is implemented in practice and compliance with regulation achieved. The storage of policies, procedures and personal plans are stored in a secure cupboard within the communal living area of the centre. The centre also utilises an electronic system for the creation and maintenance of residents' assessments and personal plans of cares. Inspectors observed that the appropriate safeguards such as passwords and automatic locking were in place in respect of same. Inspectors observed the information being communicated between staff completing the day shift and staff commencing the night duty. This information was communicated utilising the computer system as a point of reference. However due to the location of the computer, this resulted in personal information of residents inclusive of medical needs being discussed in an open area. In one area, inspectors observed five residents and seven relatives in the area. Inspectors found that whilst the information communication was a necessity, the location of same was inappropriate. As stated in Outcome 9, inspectors observed the cupboard which stored medication to be left open, and observed medication to be left on a side board. The medication had the name of the resident printed on the label therefore compromising the privacy and dignity of the resident.

The centre has a policy in place to guide staff on receiving visitors in the designated centre. There is also a private area on each floor of the designated centre for residents to meet visitors. Residents stated that staff were very facilitating to their visitors. Inspectors observed relatives in the centre and found that they were very comfortable within the environment and familiar with the staff.

**Judgment:**

Non Compliant - Moderate

***Outcome 18: Suitable Staffing***

***There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. 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. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.***

**Theme:**

Workforce

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

No actions were required from the previous inspection.

**Findings:**

Inspectors reviewed a sample of rosters and confirmed that there was a planned and actual roster within the designated centre. The staffing of the centre during the inspection was reflective of the rosters. Inspectors found that the staffing levels in place from 08.00 hours to 20.00 hours were sufficient and ensured that the needs of the residents were being met. However, a review was required of the staffing levels from 20.00 hours. There were 101 residents in the designated centre during the course of the inspection. The service provided in each house varies dependent on the needs of the residents. As stated in Outcome 2, the staffing levels in the two houses for residents with a diagnosis of a cognitive impairment were insufficient as the staff nurse responsible for the care of the twenty residents, also was the point of contact for all houses within the designated centre.

Inspectors observed the practices from 20.00 hours and found that there was also insufficient staffing in other houses to meet the needs of residents as:

- Nurses administering medication were regularly interrupted to assist with supporting residents to go to bed, which resulted in medication being administered outside of times prescribed and also increased the risks of medication errors
- The communal areas were regularly left unsupervised whilst staff supported residents who required the assistance to go to bed

In one of the houses nine of the residents required the assistance of two staff for all

manual handling tasks and twelve of the residents required the assistance of one staff. From 21.00 hours, there was one staff nurse and one care staff on duty. A review of the rosters evidenced that this was occasionally the compliment from 20.00 hours. Staff confirmed that it was 'busy' until approximately 23.30 hours. Inspectors observations supported this viewpoint, as following 23.30 hours all of the residents had been supported to go to bed.

As stated previously, there was no clear system in place to ensure that staffing numbers and skill mix were at all times appropriate to the assessed needs of the residents and the size, layout and purpose of the residential setting. In addition the supervisory arrangements at night were not safe. Inspectors informed management of the findings during the course of the inspection and at feedback. Prior to leaving the centre, inspectors were presented with evidence that as of that evening one additional member of staff was on duty until 02.00 hours.

**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:***

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<sup>1</sup>

<b>Centre name:</b>	Moorehall Lodge Drogheda
<b>Centre ID:</b>	OSV-0000737
<b>Date of inspection:</b>	15/06/2015
<b>Date of response:</b>	27/07/2015

### 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 Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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 02: Governance and Management

#### Theme:

Governance, Leadership and Management

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

The resources available from 20.00 hours were insufficient to ensure priority needs are met, inclusive of inadequate supervision arrangements.

#### Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of

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

purpose.

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

1. Additional staffing hours were put in place on the 2nd day of the inspection to address the needs identified
2. A dependency/staffing model created to monitor dependency levels and staff hours required with a particular focus on short term beds.
3. Communications with teams and team leaders reviewed and strengthened to ensure staff are able to communicate pressures in an effective way
4. Observations undertaken across the 24 clock to monitor pressures and practices.
5. Formal meeting structures reviewed between Registered Provider and PIC and other key parts of the organisation to strengthen management approaches and supervision.

Proposed Timescale: 1. 16/6/2015  
Points 2-5 completed on the 25/7/2015

**Proposed Timescale:** 25/07/2015

**Theme:**

Governance, Leadership and Management

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

Deficits in the safety and quality of the service provided had not been identified through the management systems in place.

**Action Required:**

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

1. Model of nominated nurse between 20.00 and 8.00 is in place to provide a key contact as part of our emergency planning. Therefore this nurse does not go around to each household to receive a handover. PIC and Care manager on call between these hours to provide support.
2. PIC has set up system whereby management team now spread their working week to include evenings and twilight hours to provide supervision, support and monitor practices.

**Proposed Timescale:** 25/07/2015

**Outcome 09: Medication Management**

**Theme:**

Safe care and support

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

Inspectors observed the medication to be stored unsecurely.

**Action Required:**

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

1. All nurses were met to reinforce the centre's medication management policy and procedure including practice for storing medications securely in each Household.
2. Medication management training delivered again by lead pharmacist for all nurses
3. Competency assessments of all nurses to be completed and outcomes of which will inform 1:1 management supervision between PIC and nurses.
4. Random medication management observations undertaken across the centre
5. All medication management incident reports to be reviewed by the RP and PIC on a monthly basis or before if required.
6. All medication management audits to be reviewed by the RP and PIC on a monthly basis.
  1. Completed on the 17/6/2015
  2. Completed on the 23/7/2015
  3. To be completed by the 30/9/2015
  4. Completed on the 23/7/2015
  5. To be completed by the 30/7/2015

**Proposed Timescale:** 30/09/2015

**Theme:**

Safe care and support

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

Medication administration practices were unsafe

**Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

1. All nurses were met to reinforce the centre's medication management policy and procedure for the safe administration of medication.
2. Medication management training delivered again by lead pharmacist for all nurses
3. Competency assessments of all nurses to be completed and outcomes of which will inform 1:1 management supervision between PIC and nurses.
4. Random medication management observations undertaken across the centre

5. All medication management incident reports to be reviewed by the RP and PIC on a monthly basis or before if required.
  6. All medication management audits to be reviewed by the RP and PIC on a monthly basis.
- Proposed Timescale:
1. Completed on the 17/6/2015
  2. Completed on the 23/7/2015
  3. Completed on the 30/9/2015
  4. Completed on the 23/7/2015
  5. 30/7/2015

**Proposed Timescale:** 30/09/2015

### **Outcome 11: Health and Social Care Needs**

**Theme:**

Effective care and support

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

There was an absence of care plans for individuals in respect of their social care needs. There was also improvement required to care plans to ensure that they contained the necessary information.

**Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

1. Electronic care records upgraded on Thursday 16th July. This upgrade assists with the recording of health and social care needs in care plan.
2. Random spot checks of care plans (particularly for those on short term care) being undertaken by care management team.
3. Care plan audits to monitor quality and content of care records.
4. 1:1 PIC and Nurse management supervision to check quality of care records
5. In RP and PIC formal monthly meeting to randomly sample care records

**Proposed Timescale:** 30/07/2015

### **Outcome 13: Complaints procedures**

**Theme:**

Person-centred care and support

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

Not all complaints were maintained by the nominated person.

**Action Required:**

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

1. Complaints policy updated and all staff informed of procedure for dealing with complaints.
2. Upgraded electronic care record now has a function to record complaints
3. Audits and spot checks by Care Managers to ensure that all complaints are being dealt with as per policy
4. All complaints and quality concerns reviewed monthly by RP and PIC

**Proposed Timescale:** 25/07/2015

**Outcome 16: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

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

Inspectors observed staff communicating personal information of residents in communal areas.

**Action Required:**

Under Regulation 09(4) you are required to: Make staff aware of the matters referred to in Regulation 9(1) as respects each resident in a designated centre.

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

1. Observations of handovers conducted in all Households. Outcomes reviewed by RP and PIC and resulting Action Plan created and implemented to ensure ongoing compliance.
2. Ongoing observations and audits to be reviewed by RP and PIC on monthly basis.

**Proposed Timescale:** 13/07/2015

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

Evidence supported that there were insufficient staff in the designated centre from

20.00 hours.

**Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

1. Staff levels increased to levels to meet need
2. Dependency/staffing model developed to inform future rosters.

Proposed Timescale:

1. 16/6/2015
2. 23/7/2015

**Proposed Timescale: 23/07/2015**