<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Sancta Maria Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000449</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Gallow’s Hill, Cratloe, Clare.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>061 357143</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:sanctamarianursinghome@gmail.com">sanctamarianursinghome@gmail.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Olivia English</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Olivia English</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary Moore</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Aoife Fleming: Vincent Kearns</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>31</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
</tr>
</tbody>
</table>
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 to inform a registration renewal decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 29 September 2015 09:30
To: 29 September 2015 17:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection

This inspection was the fourth inspection of the centre by the Authority pertaining to the provider's application for renewal of registration of the centre; three of these four inspections were unannounced.

All of the previous inspection findings were not satisfactory with serious failings identified in core areas including safeguarding, complaints management, medication management, healthcare, and governance and management.

The provider engaged positively with the Authority and articulated her commitment to address the identified failings and ensure that residents received care and services that were safe, evidence based, adequate and appropriate to their assessed needs.

This inspection followed up on the action plan that issued from the previous inspection of the 11 June 2015 but also monitored issues core to previous inspection findings including safeguarding, staffing and the management of complaints.

These inspection findings were satisfactory and the provider had substantially
addressed the failings of concern to the Authority. There was evidence that the provider was actively engaged in the governance and management of the service including the monitoring of the quality and safety of care and services provided to residents.

Based on discussions with staff and a purposeful sample of medical and nursing records reviewed inspectors were satisfied that the provider had and was taking action to ensure that residents were provided with appropriate medical and healthcare including a high standard of evidence based nursing care; recordkeeping was in accordance with professional guidelines.

The provider had implemented systems to ensure that residents were protected by the provider’s medication management procedures. All relevant information in the form of a discharge letter about the resident, their care and treatment following their temporary transfer to the acute services was available to inspectors.

There were 31 residents living in the centre. Residents spoken with understood the role of inspectors and some were familiar with the inspector; residents said that they were “fine” and provided positive feedback on the provider, staff and the care and services provided to them.

At verbal feedback the improvement evidenced was acknowledged by inspectors but very clearly in the context of the previous serious and concerning failings and the ongoing responsibility of the provider for governance that ensured on an ongoing basis the delivery of safe, quality care and services to residents.

A certificate of registration of the centre was granted on the 23 October 2015.

An action plan did issue from this inspection. Of the nine Outcomes inspected the provider was judged to be compliant in four and in substantial compliance with two; the provider was previously in major non compliance with these Outcomes. The provider was judged to be in moderate non-compliance with the three remaining Outcomes; Safeguarding, Health and Safety and Staffing as failings were identified in staff recruitment and training and the identification, assessment and management of all risks.

The provider acts as both provider and person in charge and is referred to as the provider in the body of this report.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The provider had since the 25th June 2015 reassumed responsibility for the roles of both provider and person in charge. Based on these inspection findings inspectors were satisfied that the provider in conjunction with the PPIM (person participating in the management of the centre) had implemented measures to ensure that the care and services provided to residents was safe, evidenced based and effectively monitored.

There was documentary evidence that the provider had communicated the governance structure, roles, responsibilities and reporting relationships to all staff.

There was documentary evidence that the provider had convened two staff meetings since the last inspection at which inspection findings and the actions required to address failings and prevent reoccurrence were discussed with all staff. In addition to the staff meetings formal management team meetings were convened in July and August; inspection findings and the implementation of the action plan again informed the agenda and action plan of these meetings.

The provider continued to complete monthly audits of the quality and safety of care and services provided to residents. This process included consultation with residents in the form of a formal questionnaire. Inspectors reviewed 11 completed in July 2015 and the feedback from residents was generally positive. On speaking with residents inspectors established that requests from residents as articulated at the resident committee meetings were acted on. In addition to the monthly audits specific audits with particular reference to previous inspection findings had been completed including medication management, end of life care and an audit of clinical documentation.

Overall and on balance the findings of the provider from internal review and audits would largely concur with these inspection findings.
Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
A record of each medication administered, signed and dated by the nurse administering the medication was maintained in accordance with professional body guidelines. The provider had implemented a system for auditing the accuracy and completeness of these records. One error was noted by inspectors as discussed in Outcome 12.

Based on a purposeful sample of records reviewed by inspectors an adequate and accurate daily nursing record of the person’s health, condition, treatment given, discussions held and changes made was maintained. The records indicated to inspectors that the care provided was evidence based.

A record of on-going medical assessment, treatment and care provided by each resident’s General Practitioner (GP) was maintained and records were noted to be generated by the GP and clearly segregated from nursing records.

Inspectors requested and the provider readily retrieved all relevant information about the resident, their care and treatment following a resident’s return to the designated centre from another hospital as required by Regulation 25 (2).

As discussed in Outcome 18 the sample of staff files seen by inspectors did not contain all of the documentation required by Schedule 2.

Judgment:
Substantially Compliant
**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):**
No actions were required from the previous inspection.

**Findings:**
The provider confirmed that there was no incident of alleged, suspected or reported abuse.

Residents who spoke with inspectors said that they had no concerns or worries. Residents were familiar with the provider and other staff members and while it was not home said that the centre was "100%".

However, while staff spoken with had a good understanding of abuse and protection measures all staff had not received centre specific training on protection.

Recruitment procedures were not robust and staff were in post without evidence of sufficient vetting as discussed in Outcome 18.

**Judgment:**
Non Compliant - Moderate

**Outcome 08: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
This outcome was not inspected in totality but based on their observations and these inspection findings action was required of the provider to ensure that all risks were identified, assessed and measures and action taken to control, reduce or remove the risk.
Access to the lower ground floor level was facilitated by a lift and stairwell. Access to the stairwell had been risk assessed and was restricted; however, the restricting gate was noted by inspectors to be unsecured at intervals during the inspection.

The provider confirmed that the first floor banister over the stairwell had not been risk assessed.

As discussed in Outcome 12 Medication Management, it was of concern to inspectors that while measures were in place to identify and control a repeated medication management risk, it was not clear what action or learning had occurred to reduce or remove the risk.

**Judgment:**
Non Compliant - Moderate

---

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

**Findings:**
Given the previous serious failings and major non compliance identified, inspectors again reviewed in detail all aspects of the medication management cycle including the purposeful review of specific residents’ medication regimes.

Overall inspectors were satisfied that the provider had implemented measures to ensure that residents were protected by the provider's medication management policies and procedures.

The provider had implemented a weekly audit of the medication trolley and fridge and the management of controlled drugs including accurate record keeping. The maintenance of a record of each medication administered to residents by nursing staff was also audited with one deficit noted in August; there was evidence that the provider had addressed this with the responsible staff member. The provider planned to continue these audits on a quarterly basis.

The inspector reviewed the supply and management of controlled medications and was satisfied that this was in line with the relevant legislation; no errors were noted in the controlled drugs register and the stock balances were correct.

There was evidence that each resident's medication regime was reviewed and amended as required in response to their changing needs by the relevant General Practitioner.
Laxatives were prescribed. Prescribed nutritional supplements were as advised by the dietician; their administration was recorded and where there was an issue with resident refusal or non-compliance there was a supporting nursing and medical record.

The inspector reviewed in detail the medication regime of a large sample of the current residents. No errors were noted between the prescription utilised by the provider and generated by the GP, original prescriptions including hospital prescriptions, the cassette insert and the medications supplied in the cassette. The record of medications administered as completed by the nurse administering the medication were overall and on balance complete and accurate, reflected the prescriber’s instructions and the nursing narrative notes including the rationale for the administration of PRN (as required) medications.

However, some residents had an active prescription for PRN medication that was not in stock; the provider told the inspector that this was because the medication had not been required by the residents. The ongoing requirement for these prescriptions required review by the relevant prescriber.

Where the daily nursing notes recorded that half the prescribed dose of a PRN medication had been administered at the request of the resident, nursing staff had however recorded on the medication administration record that the full dose as prescribed was administered.

The provider confirmed that the practice of general nurse transcribing of medications had ceased as indicated to the Authority but limited transcribing in specific situations was permitted. The inspector reviewed one such transcribed prescription and noted that it had not been countersigned by the relevant GP within the required 72 hour timeframe as stipulated in the provider’s policy. The provider addressed and rectified this prior to the conclusion of the inspection.

The storage of medications in the centre was secure as medications were stored in a locked trolley or locked fridge. However, eye drops which required disposal within one month of opening did not have an opening date recorded on the bottle or box.

Medicines for residents were supplied by a community pharmacy. Medicines were supplied in compliance aids, identifiable information for medicines was available and the pharmacist supplied a record of the medicines dispensed with the aids. All medications supplied were on their receipt checked by two nursing staff against the compliance aid insert and the prescription or on occasion by the supplying pharmacist and nursing staff. The provider’s incident records indicated that the provider’s system of checking medications supplied had identified nine errors in the dispensing/supply of medications since March 2015; five of these errors had been detected since the last inspection on 11 June 2015.

Inspectors acknowledged that the provider’s measures were currently preventing the errors from reaching the resident but there was ongoing risk to residents. It was of concern to inspectors that while measures were in place to identify and control this risk,
it was not clear what action or learning had occurred to reduce or remove the risk. This is actioned under Outcome 8 Health and Safety and Risk Management.

**Judgment:**
Substantially Compliant

---

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

**Findings:**
Inspectors spoke with staff, reviewed the reports of audits including information on the transfer of residents to the acute hospital and based on the information collated and the findings of the last inspection inspectors reviewed a purposeful sample of residents’ nursing and medical records.

Inspectors were satisfied that the serious and concerning failings of the last inspection were addressed. Inspectors were satisfied that the monitoring of resident wellbeing and care interventions were evidence based, that staff facilitated timely access to medical advice, review and treatment and no concerning pattern was identified in the referral of residents to the acute hospital services. There was consistency between medical records, nursing care plans, nursing narrative notes and medication regimes.

Staff said and records indicated that staff sought to ensure that residents had access to timely medical review. The provider confirmed that there was one identified recent failing but in consultation with the resident and their representatives measures were being taken to address this; this would concur with the records seen by inspectors. Overall the records seen indicated that staff monitored resident well-being, were attuned to any changes, appropriately sought medical advice and review, implemented recommended treatments, monitored their effectiveness and provided feedback to the relevant GP. Nursing care plans reflected recommendations from other healthcare professionals and were reviewed and updated in line with the residents changing needs.

Nutritional care plans were supported by dietetic referral; nutritional supplements were based on records seen and staff spoken with administered as recommended, body weight was recorded and monitored at the frequency specified in the care plan. A significant improvement was noted in the maintenance of dietary and fluid intake.
records. The records seen by inspectors reflected the care plan and were completed and maintained as a meaningful monitoring tool. Bowel records were consistently and objectively maintained by staff.

There was regular recording and monitoring of resident’s blood glucose levels and prescribed treatments in consultation with the relevant GP. The nursing plan of care reflected the required interventions including the frequency of blood glucose monitoring.

Inspectors were satisfied that staff sought appropriate advice, professional expertise and a clear clinical rationale prior to the implementation of any care intervention including urinary catheterisation.

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

**Findings:**
The complaints procedure was prominently displayed and the provider confirmed that the complaints policy had recently been reviewed. However inspectors noted that the complaints policy did not reflect the current governance structure of the centre and was not the policy previously reviewed and accepted by the Authority. The provider accepted that this was an error on her behalf and redrafted the policy during the inspection so as to satisfy the requirements of Regulation 34 (1) (c).

The provider said that one complaint had been received since the last inspection and this concurred with records seen by inspectors. Actions were taken by staff to investigate the matter complained of and the record indicated that the matter was satisfactorily resolved.

Residents spoken with said that they had no complaints and if they had they would speak to “Olivia”.

Judgment: Compliant

**Outcome 14: End of Life Care**
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

**Theme:**
Person-centred care and support

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

**Findings:**
Residents had end of life care plans and those seen were person centred and reflected expressed choices and preferences. The provider had implemented explicit records of decisions made to attempt or not attempt resuscitation. It was clear to the inspector from these records that decisions to attempt or not resuscitation were clearly documented, as was how and by whom the decision was made, the date of the decision, the rationale for it and who was involved in the decision-making. Decisions were predominately seen to be based on residents own expressed choices in discussion with their GP, nursing staff and family as appropriate.

**Judgment:**
Compliant

---

**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:**
The provider continued to maintain a planned and actual roster; the roster identified all persons working in the centre and the hours that they worked.

There had been some staff turnover since the last inspection but the provider had contracted nursing hours from a nurse consultancy group and was also in the process of recruiting staff. Based on their observations, these inspection findings and the review of
the staff rota, inspectors were satisfied that the numbers and skill-mix of staff by day and night were adequate to meet the number and needs of the residents and other factors such as the layout of the building. There was further documentary evidence that the provider continued to monitor the adequacy of staffing numbers using a recognised tool.

However, having reviewed a sample of staff files of staff in post, inspectors were not reassured as to the robustness of the providers recruitment procedures as none of the files reviewed contained all of the information specified by Schedule 2. This is addressed here as a non compliance but actioned under Outcome 5 Documentation. Collectively the missing information included;
  - references including references from a person’s most recent employer
  - a full employment history including a satisfactory explanation for any gaps in employment
  - proof of the person’s identity
  - evidence of Garda Síochána vetting.

The provider confirmed and training records indicated that staff had undertaken training on medication management and the completion of clinical documentation as committed to in the providers response to the action plan. However, based on the training records seen and discussion with the provider there were some gaps in staff training including safeguarding, fire safety, manual handling, medication management and responding to behaviours that challenged.

**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:**

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Sancta Maria Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000449</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>29/09/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>15/10/2015</td>
</tr>
</tbody>
</table>

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 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where half the prescribed dose was administered it was recorded on the medication administration record that the full dose as prescribed was administered.

None of the staff files reviewed by inspectors contained all of the information specified by Schedule 2.

---

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
1) All staff Nurses have been advised regarding the accuracy of recording the exact dose of medication administered on the extra space provided on the MARS sheet.

2) All new staff files have now been updated and contain all the required information specified in schedule 2.

Proposed Timescale: 15/10/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All staff had not received centre specific training on abuse.

2. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
All Newly recruited staff have now completed training in the detection and prevention of abuse both online and centre specific. This is a topic that is discussed and refreshed in the centre at every staff meeting.

Proposed Timescale: 15/10/2015

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The restricting gate for the stairwell was noted by inspectors to be unsecured at intervals during the inspection.

The provider confirmed that the first floor banister over the stairwell had not been risk assessed.
3. **Action Required:**
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
1) An automatic closing system for the stair gate has been ordered and we expect same to be in place within the next two weeks (30th Oct 2015)

2) A risk assessment has been completed over the stairwell; same is within recommended height for a Residential setting as per Building regulations 2014 regarding stairwell, ladder, ramps and guards.
Risk assessed as 5 = Green risk (Complete)

**Proposed Timescale:** 30/10/2015

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While measures were in place to identify and control a repeated medication management risk, it was not clear what action or learning had occurred to reduce or remove the risk.

4. **Action Required:**
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**
A meeting with the Pharmacy took place on the 30th September 2015 and the repeated errors were discussed. A risk assessment has been completed on Medication Management and control measures are in place as agreed with the Pharmacist. Same includes communication via telephone between Pharmacy and Nursing home prior to cassette delivery each week to ensure any changes in medication have been implemented prior to delivery, double checking and co-signing on delivery and agreed action to be taken if errors persist. There have been no further errors since the date of Inspection.
Audits of the system will be ongoing.

**Proposed Timescale:** 15/10/2015

**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:
Eye drops which required disposal within one month of opening did not have an opening date recorded on the bottle or box.

The ongoing requirement for some PRN prescriptions required review by the relevant prescriber.

5. 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) The eye drops had been opened the previous day but their packaging which has the date written on them had gotten wet and was disposed of. In the event of reoccurrence of same, dates will be transferred onto individual eye drop bottles

2) On the evening of the Inspection the resident in question was reviewed by her GP and that particular medication was discontinued as it was no longer required. A full audit was done on all other PRN medications on 09.10.15 and one action was required post this audit resulting in another completion of a PRN medicine which had not been required in over 6 weeks.

Proposed Timescale: 15/10/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were some gaps in staff training including safeguarding, fire safety, manual handling, medication management and responding to behaviours that challenged.

6. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
All training has now been completed where gaps were identified. Going forward any New staff employed by the centre will complete training during their induction process and will not be rostered as staff until same is complete.
| Proposed Timescale: 15/10/2015 |