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Coral Haven Residential Nursing Home, OSV-0000331, 19 August 2019

Item Type	report
Citation	Ireland. Health Information and Quality Authority, 'Coral Haven Residential Nursing Home, OSV-0000331, 19 August 2019', [report], Health Information and Quality Authority, 31/10/2019, Nursing Homes, Designated Centre for Older People
Publisher	Health Information and Quality Authority
Download date	2026-03-11 04:27:01
Link to Item	https://hdl.handle.net/20.500.14765/100771

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Coral Haven Residential Nursing Home
Centre ID:	OSV-0000331
Centre address:	Ballinfoyle, Headford Road, Galway.
Telephone number:	091 76 2800
Email address:	accounts@coralhaven.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Coral Haven Residential Nursing Home
Lead inspector:	Catherine Sweeney
Support inspector(s):	
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	52
Number of vacancies on the date of inspection:	8

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 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 monitor compliance with specific outcomes as part of a thematic inspection. 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 August 2019 09:00 To: 19 August 2019 17:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Compliant
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Non Compliant - Moderate
Outcome 05: Suitable Staffing	Substantially Compliant	Compliant
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Compliant
Outcome 07: Health and Safety and Risk Management	Not applicable	Non Compliant - Moderate
Outcome 08: Governance and Management	Not applicable	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an unannounced thematic inspection conducted to determine the standard of care and quality of life for people with dementia living in the centre. The inspection focused on specific outcomes relevant to dementia care, information that had been received by the Office of the Chief Inspector, and followed up on the actions from the previous inspection completed in November 2017. Some of the actions from this inspection had been addressed, however actions relating to the management of complaints and the documenting of fire drills are restated in this report. The person in charge was not on duty on the day of inspection. The inspection was facilitated by the clinical nurse manager. Prior to the inspection, the person in charge completed the provider self-assessment

and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

The centre comprised of four units set out over three floors. The top floor had a 15-bedded specific dementia care unit. On the day of inspection there were 13 residents with a diagnosis of dementia in the unit and a further ten residents who had symptoms of dementia were accommodated within the centre. The inspector tracked the care pathways of residents with dementia and spent periods of time observing staff interactions with residents. A validated observational tool, the quality of interaction schedule (QUIS) was used to rate and record the quality of interactions between staff and residents. Documentation such as assessments, care plans, clinical records, policies and procedures and staff records were reviewed. Residents told the inspector that they were well cared for within the centre. The inspector observed numerous examples of good practice in areas examined which resulted in positive outcomes for the residents.

The inspector found significant gaps in the management and governance system in the centre.

- Systems in place to monitor the effectiveness of the service were incomplete. For example, trends and recommended action plans from external audits had not been developed from data collected.
 - Internal audit systems to monitor clinical outcomes were out-of-date and had not been reviewed.
 - The last recorded care team meeting was dated 28 Aug 2018.
 - Two actions from the previous inspection had not been addressed.
- For these reasons Outcome 7, Health and Safety and Risk Management and Outcome 8, Governance and management were added to the inspection report.

Staff were offered a range of training opportunities, including specific dementia care training courses.

There was a robust safeguarding policy in place. All staff had received training in safeguarding and the prevention of elder abuse. Residents reported feeling safe in the centre.

During this inspection, of the eight outcomes assessed, there were three moderate non-compliances, one substantially compliant and four were complaint. Areas of non-compliances were communicated to the nursing team and are discussed in the main body of the report and set out in the action plan at the end of this report in order to comply 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 2016.

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 Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

Overall, the inspector found that residents healthcare needs were met through timely access to health and social care services which reflected their different care needs. Each resident had individual assessments and care plans in place that reflected their assessed needs and personal preferences. A pre-admission assessment was in place for each resident which detailed their potential social, psychological and physical requirements. All nursing documentation was logged on an electronic documentation system. Consent for care was documented for each resident. All care staff had access to the residents care plans.

A comprehensive assessment was completed for each resident on admission, and as required thereafter. The assessments included dependency level, falls risk, mobility, meaningful activity assessment and a geriatric depression risk assessment.

Care plans had been developed in line with the assessed needs of the resident. There was evidence to confirm that care plans were developed in consultation with the residents and their families. Care plans were detailed and person-centred. Care plans for residents with dementia identified triggers and interventions that were personal to each residents individual symptoms. This was a completed action form the last inspection. Care plans guided care and were reviewed regularly. Nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents up to date needs.

Arrangements were in place to meet the health and nursing needs of residents with dementia. Residents had access to general practitioner (GP) services. A full range of other services was available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services, tissue viability and psychiatry of later life. Chiropody and optical services were also provided. A dentist attended the centre once a year and more often as required.

There was a reported low incidence of wound development. Skin care was well managed within the centre. Wound care plans were reviewed and found to be in line with best practice. The nursing team demonstrated a good awareness of wound identification and

treatment plans. Staff had access to support from a tissue viability nurse when required.

The centre had a system in place to document falls. Inspectors noted that individual falls were well managed. All residents had a falls risk assessment complete and an associated mobility care plan that identified appropriate interventions to reduce the risk of falls. Sensor mats, crash mats and low-low beds were interventions used to manage residents falls risk. There was evidence of fall reviews identifying trends, action plans and recommendations for staff taking place, however, the inspector found that a falls review, which had been previously documented monthly, had not been documented since April 2019. The oversight of clinical incidents will be addressed under Outcome 8, Governance and management.

The centre has a comprehensive policy for monitoring and recording nutritional intake which was seen to be put into practice. Meals were served in four dining rooms throughout the centre. Residents had a choice of which dining room to attend. Meals were observed to be relaxed and sociable occasions. The table settings were attractive and residents told inspectors that they enjoyed having their meals in the dining room. Meals appeared to be wholesome and nutritious and served in an appetising manner. The Inspector observed staff offering choice, encouragement and assistance to residents in a discrete and sensitive manner. Residents spoken with were complimentary regarding the food offered. Fresh drinking water was available throughout the centre.

Medicines were observed to be well managed within the centre. The centre had written policies and procedures in relation to medicines management and the inspector noted that appropriate safe standards were adhered to by nurses.

There was a comprehensive end-of-life policy in place. Staff confirmed that they had access to the support and advice from the palliative home care team. End-of-life care plans were found to be person-centered and detailed the individual preferences of the residents and their families.

Judgment:

Compliant

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There was a robust policy and procedures in place to safeguard and protect residents from abuse in the centre. All staff have received up-to date training on the policies and procedures relating to safeguarding older adults. A review of staff files provided

confirmation that all staff had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016. Staff spoken to demonstrated an awareness of the measures required to safeguard residents with dementia and protect them from abuse. They identified what constituted abuse and the actions they would take if any abuse was witnessed or disclosed to them.

Residents spoken to reported to feeling very safe within the centre and told the inspector that they would feel comfortable speaking to the staff about any concern they may have. Relatives told inspectors that they were assured that their family members were safe within the centre. Relatives spoken with felt assured that their relatives were receiving very good care.

There were systems in place to safeguard residents finances. The centre did not act as a pension agent for any resident within the centre. Where centre management held on to small amounts of cash or valuables, this was done securely and with appropriate safeguarding measures to protect residents finances and property.

The centre promoted a restraint-free environment. Residents were not restricted from moving around the centre and were seen coming and going to different communal rooms throughout the day. A locked front entrance and visitor log book ensured that staff were aware of people coming and going from the building. Bed rails were used minimally, and only at the residents request.

There was a positive approach to the management of behavioural and psychological symptoms of dementia. All staff had completed training in dementia care and management of responsive behaviour. Staff were observed to use non-medicine alternatives in the management of responsive behaviours. Care plans reviewed reflected that this was promoted throughout the centre. A number of residents were prescribed psychotropic medicines on a 'PRN' as required basis. Staff spoken to informed the inspector that these were always administered as a last resort only when other strategies had been trialed and possible underlying causes had been eliminated.

All incidents and adverse events had been documented. However, there were no arrangements in place to investigate and review incidents, recognise trends or identify learning for incidents involving residents. This issue will be addressed in Outcome 8, Governance and management.

Judgment:

Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents had access to advocacy services and the contact details for the local SAGE (support and advocacy service for older people) advocate were displayed. The clinical nurse manager confirmed that a number of residents had availed of the service. A review of the care plans found this to be the case.

All residents have access to a private telephone, local and national newspapers, television and radio. Residents were on the electoral register and were facilitated to vote in elections and referenda in the nursing home, if they were unable to attend their local polling station. Spiritual, religious and cultural practices are facilitated for all residents. The centre has a dedicated chapel and a priest was available to attend the centre regularly to hold Mass.

The inspector noted that the privacy and dignity of residents was well respected. Bedroom and bathroom doors were closed when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms. Adequate screening curtains were provided in shared bedrooms. Visitors were seen to come and go in the centre. There were adequate rooms for residents to receive their visitors in private. Visiting restrictions were in place from 9pm to 9am and at mealtimes to protect the privacy and dignity of residents having their care needs attended to during this time.

There was a structured activities and recreation programme in place for the residents. Two activity coordinators facilitated a full programme of both group and individual activities to promote meaningful social engagement. One activity coordinator was assigned to the dementia specific unit. Activities scheduled included physiotherapy led exercises, relaxation groups, religious prayer services and hymns, puzzles, sing-a-longs, and movie nights. Residents spoken to stated that there was always something to do. The inspector observed the residents engaging positively with the scheduled activities.

The inspector spent a period of time observing staff interactions with residents. A validated observational tool (the quality of interactions schedule, or QUIS) was used to rate and record at 10 minute intervals, the quality of interactions between staff and residents in the communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place for a half hour during morning activities and during the lunch service. An overview of the observations is provided below:

The inspector observed that the quality of interaction observed over a 60 minute period was an overall score of +2, positive connective care. Staff were observed to greet each resident by their preferred names, offered them the choice of where to sit, a choice of preferred food and drinks and a choice of what activities to participate in. All interaction observed was polite, dignified and respectful. The inspector observed staff interacting patiently with a resident displaying agitated symptoms of dementia. Staff were observed to be calm and capable in their care. They used references to residents family members and personal details of the resident to distract and calm the resident. Residents who required assistance with eating were helped in a respectful and dignified manner.

Residents feedback was sought at the residents forum meetings. These meeting were chaired by the activity coordinator and the person in charge. Issues and documented actions from previous meetings were discussed. Topics discussed included emergency procedures, promoting use of call bells and prevention of falls. There was no independent advocate to represent the residents with dementia present at these meetings.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
There is a policy and procedure in place for the management of complaints. The policy is in line with the requirements of Regulation 34, Complaints procedure. However, a review of the complaints log found that the satisfaction of the complainant was not documented for each complaint logged. This issue was identified in the centres previous inspection report.
No review of learning from complaints was available for review.

Judgment:
Non Compliant - Moderate

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
On the day of inspection there were 52 residents living in the centre. Residents dependency levels were assessed using a recognised validated tool. There were 19 maximum, 18 high, 11 medium and three residents of low dependency level, two

residents were in hospital at the time of inspection. One resident was receiving end of life care.

The inspector reviewed staff rosters which showed there was a nurse on duty at all times, with a regular pattern of rostered care staff. The inspector found that the number and skill mix of staff was appropriate to meet the assessed needs of the residents. All mandatory training had been completed by all staff and a yearly schedule of training was in place. All staff had received dementia care training.

Care was supervised by two clinical nurse managers who delegated and supported the nursing and care teams.

The inspector reviewed a sample of staff files and found that they contained all the required documentation as required by the Regulations. Garda Síochána vetting was in place for all staff. Nursing registration numbers were available and up-to-date for all staff. Details of induction, orientation and training certificates were noted on staff files. Staff appraisals were completed for all staff. Staff spoken with confirmed that they had sufficient time to carry out their duties and responsibilities. A review of the staffing files found that recruitment processes were in line with regulation and best practice.

There was a volunteer register was in place which detailed the roles and responsibilities of all volunteers. All volunteers and service contactors had Garda Síochána vetting in place.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The design and layout of the centre was in line with the statement of purpose and meet the needs of all residents. The centre is a three-storey purpose built building. The floors are serviced by a lift and a stairwell. All floors had comfortable and well decorated dayrooms and dining rooms. The centre has 52 single bedrooms and four double bedrooms. There is a specific dementia specific unit on the top floor of the centre which promotes the dignity, well being and independence of residents with dementia.

The dementia specific unit is small in scale, accommodating 15 residents, and decorated in a homely manner. The unit had clear and appropriate signage, grab rails and adequate indoor space to facilitate independent movement. There was a safe, enclosed

outdoor space with a fountain water feature that could be accessed by the residents living in the unit. The dementia specific unit is decorated with appropriate sensory stimulating items such as family trees, memory boards, texture tiles and workshop boards that facilitate residents to explore and interact with their environment.

The centre is well maintained with suitable lighting, heating and ventilation. Appropriate signage was used throughout the designated centre. Bedrooms were found to be of a suitable size and layout with suitable access to toilets bathrooms and showers.

Bedrooms were personalized to reflect the preferences of each residents. Bedrooms in the dementia specific unit were individually identified with photos and pictures depicting their interests and hobbies, to assist residents to recognise their rooms. There was suitable storage, including a lockable cabinet, in place for residents belongings.

Residents had access to safe external spaces. The inspector observed residents moving freely and independently around the centre.

There was a range of specialist equipment such as sit-to-stand hoists, sling hoists and profiling beds. Records reviewed showed that this equipment was checked regularly and well maintained.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

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

Findings:

The centre has a health and safety statement in place. A risk management policy and a risk register containing hazard identification and risk assessment for environmental risks was reviewed and found to be in compliance with Regulation 26, Risk Management.

There were policies and procedures in place in relation to fire safety. The inspector reviewed the fire safety records. There was a fire management policy in place which included detail in relation to fire management. A fire safety register was available for inspection. A record of yearly servicing of the fire safety system within the building and a record of equipment maintenance was available for review. Fire safety procedures and escape route maps were clear and accessible and were available in prominent places around the centre.

Records reviewed showed that while an evacuation procedure drill was documented as part of a fire safety training programme, the drill did not provide assurance that safe

evacuation of residents in the event of an emergency is possible. The registered provider has not provided adequate assurance that staff were aware of the procedures to be followed in the case of a fire as there were no evacuation drills recorded for 2019. This is a restated action from the previous inspection.

The day after the inspection, the clinical nurse manager submitted a comprehensive evacuation drill record which detailed the timing of the evacuation of a full compartment with night time staffing levels, along with the learning outcomes from the drill. This documented provided the assurance required by the Office of the Chief Inspector that the centre had sufficient knowledge and resources for safe evacuation procedure in the case of an emergency.

On-going compliance and management of evacuation drills will be addressed in the action plan at the end of the report.

Judgment:

Non Compliant - Moderate

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

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

Findings:

There is a defined structure of management in this centre. As per the statement of purpose, the person in charge (PIC) is supported by two clinical nurse managers (CNM). The CNM's supervise the delivery of care. Supports services in the home are led by the Human resources (HR) and support services officer. While care standards and care delivery were found to be of a high standard throughout the centre, the Inspector found significant gaps in the overall governance and management systems in place.

The inspector followed up on the actions from the previous inspection completed in November 2017. Continued non-compliance were found in the areas of

- Complaints management
- Documentation of fire drills

The provider had not taken the required action to bring the designated centre into compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland 2016.

While there was evidence of management systems in place to review the quality and safety of care, systems, such as clinical and management audits, had not been update or reviewed since 2018. Incidents, accidents and complaint logs were not audited and

analysed by the management team. External audits, such as the pharmacy audit were in place, however, the key trends and recommendations from these audits had not been identified and incorporated in a quality improvement plan and communicated to staff. The last recorded care staff meeting took place in Sept 2018. A robust and well documented multi-disciplinary team meeting in relation to quality and safety relating to the support staff in the centre was in place, however, the provider or the PIC were not in attendance. The PIC attended a 'head of department' meeting held in May 2019 however actions from this meeting were not communicated to care and support staff.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Catherine Sweeney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Action Plan

Provider's response to inspection report¹

Centre name:	Coral Haven Residential Nursing Home
Centre ID:	OSV-0000331
Date of inspection:	19/08/2019
Date of response:	13/09/2019

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 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

There was no independent advocate to represent residents with dementia present at resident meetings.

1. Action Required:

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

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

An independent advocate to represent residents with dementia has been appointed and a residents meeting with the advocate has taken place on the 28.08.19. This will continue monthly.

Proposed Timescale: 28/08/2019

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

The satisfaction of the complainant is not recorded in the complaints log.

2. 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:

All Complaints will be reviewed to determine if the resident and complainant was/was not satisfied. The nominated person will ensure that all complaints are investigated and the outcome is documented, showing evidence of satisfaction or otherwise.

Proposed Timescale: 20/09/2019

Theme:

Person-centred care and support

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

There is no system in place to review complaints and identify learning from investigations.

3. Action Required:

Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

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

The management team will review complaints/concerns on a monthly basis to identify trends and ensure action plans are in place and communicated to all staff.

Any complaints to be resolved, investigated and feedback given to the complainant within an agreed timescale.

Management will aim to resolve complaints at the earliest stage with a view to improving the service.

Proposed Timescale: 20/09/2019

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

The registered provider did not keep a record of fire evacuation drills available for review.

4. Action Required:

Under Regulation 21(4) you are required to: Retain the records set out in paragraphs (6), (9), (10), (11) and (12) of Schedule 4 for a period of not less than 4 years from the date of their making.

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

A fire evacuation drill took place on the 21.08.19. It was completed using the least amount of staff that would be on duty and involved an entire compartment. It was timed, monitored and evaluated. Fire evacuations/ drills will take place on a regular basis going forward.

Proposed Timescale: 21/08/2019

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

The inspector found significant gaps in the management systems used to effectively monitor the service provided.

5. 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. The provider will ensure that all actions highlighted in this and previous inspections are addressed and completed.
2. External audits will be reviewed by the management team and action plans will be devised. Any recommendations from these audits will be communicated to the staff, implemented and reviewed.

3. Internal audits are to be reviewed and action plans will be developed. These action plans will be implemented and communicated to staff.
4. The management team will review all audits undertaken to identify trends and continuously monitor to ensure a quality service is provided.
5. The format used for MDT meetings in relation to quality and safety will be used throughout all meetings. These will be documented and kept up to date. The care team meetings will recommence following this format.
6. The care team meetings are to be held 3 monthly with the MDT and Heads of departments meetings minutes available for communication.

Proposed Timescale: 01/10/2019