<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Powdermill Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000270</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Gunpowdermills, Ballincollig, Cork.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>021 487 1184</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:powdermillnursing.home@gmail.com">powdermillnursing.home@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>Joseph Peters</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Joseph Peters</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Enjoy Berey</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Col Conway</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Mary O'Mahony</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>39</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
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</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 Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 04 February 2014 07:30
To: 04 February 2014 17:30
From: 05 February 2014 08:00
To: 05 February 2014 17:00

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

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
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<tbody>
<tr>
<td>Outcome 03: Suitable Person in Charge</td>
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<td>Outcome 05: Absence of the person in charge</td>
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<td>Outcome 06: Safeguarding and Safety</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Medication Management</td>
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<td>Outcome 10: Reviewing and improving the quality and safety of care</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 18: Suitable Staffing</td>
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</table>

Summary of findings from this inspection
A monitoring inspection of Powdermill Nursing Home was undertaken by the Health Information and Quality Authority (the Authority) on 16 January 2013 and 17 January 2013. The inspectors found that residents appeared to be well cared for and their health needs were met, however, areas were identified as requiring improvement and these included:

• the statement of purpose and the policies on elder abuse and personal property
• some infection control and health and safety practices
• management of medication errors
• nursing care plans
• restraint practices and monitoring of residents when restraint was used
• the premises
• written agreements with volunteers

A single issue inspection had also been undertaken on 21 June 2013 in relation to management of an identified complaint. Inspectors found the complaint had generally been well investigated; however, improvements were required in regard to timely contact with the resident's medical practitioner and the recording of
complaints.

All previous inspection reports can be viewed on the Authority’s website www.hiqa.ie, using centre identification 0270.

This inspection was unannounced and the purpose was to monitor regulatory compliance and progress with the required actions from the previous inspections. This inspection took place over two days and inspectors met with some residents and staff, observed practices and the premises, reviewed documentation such as residents' nursing records, residents' medical records, accident /incident log, complaints log, staff training records, policies and procedures and staff files.

Inspectors had serious concerns during this inspection for the care and welfare of residents due to inadequate precautions being in place for any resident that smoked. The provider was issued an immediate action plan on day two of inspection and the Authority received a written response from the provider within the required time frame.

Inspectors found there had been some progress with some of the required actions from the previous two inspections of the centre in 2013. The action plans at the end of this report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Judgement:
Compliant

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

Findings:
A written statement of purpose was available in the centre and the document contained all of the information that is required as per Schedule 1 of the Regulations.
### Outcome 03: Suitable Person in Charge

*The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.*

**Theme:**  
Leadership, Governance and Management

**Judgement:**  
Non Compliant - Major

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

**Findings:**  
The provider confirmed that approximately two weeks prior to this inspection the person in charge/director of care had finished in the post. Inspectors were informed that as an interim measure the clinical nurse manager was covering the vacant post in an acting capacity.

An inspector reviewed evidence of activity to recruit a suitable person in charge.

### Outcome 05: Absence of the person in charge

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**  
Leadership, Governance and Management

**Judgement:**  
Compliant

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

**Findings:**  
The Authority had received the required written notification that the post of person in charge/director of care had become vacant. Suitable arrangements had been put in place as an interim measure as already outlined in Outcome three.
**Outcome 06: 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.*

**Theme:**  
Safe Care and Support

**Judgement:**  
Non Compliant - Moderate

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

**Findings:**  
An inspector reviewed the elder abuse policy and the document outlined what procedures to follow in the event of an allegation of abuse. Inspectors were satisfied that appropriate procedures were in place to manage an allegation of abuse and staff that inspectors spoke with were aware of what action to take in the event that an allegation of abuse was made.

In the provider’s response to the previous inspection report it was stated that by 29 March 2013 updates for all staff would be provided regarding elder abuse and any new staff member would receive training within one month of commencing employment. A record of training for elder abuse was provided to inspectors and it indicated that training had been provided for staff. However, the records indicated that some staff had not received an update and a staff member that had begun employment in October 2013 had not received training.

An inspector reviewed the record keeping of residents' finances and they were maintained in a transparent manner and records were in place listing residents personal property.

**Outcome 07: Health and Safety and Risk Management**

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

**Theme:**  
Safe Care and Support

**Judgement:**  
Non Compliant - Major

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

**Findings:**
In relation to the provider ensuring sufficient care was provided to maintain the welfare of any resident who smoked, inspectors found evidence that residents were at potential risk of injury. While written smoking risk assessments had been completed for the residents that smoked, each resident was not comprehensively assessed to determine any possible hazards. The degree of risk to themselves or others was not clearly documented and smoking care plans for the individual residents did not state how cigarette lighters were to be managed. There was evidence that potential risks were not being managed appropriately in the smoking room, for example, the provider could not confirm if two of the three chairs were fire retardant. The chair that was identified as being fire retardant had visible burn marks on the cover and there was not a call bell or a fire blanket within close proximity of this chair. The provider was issued an immediate action plan in regard to ensuring adequate precautions be put in place against the potential risk of injury to any resident that smoked.

In the provider’s response to the previous inspection report in relation to ensuring reasonable measures be taken to prevent potential injury to any person in the centre, it was stated that gloves would be stored safely and the sluice room door would be fitted with a key pad lock. Inspectors found gloves were no longer stored in a way that residents could gain easy access and a key pad lock had been installed on the sluice room door. However, there was a risk of injury to residents as the door to the staff facility was left open and residents could gain access to potential hazards.

There were not written health and safety policies and procedures relating to the health and safety, including food safety of residents, staff and visitors, as required by article 30 of the Regulations.

An up-to-date health and safety statement for the centre was available and it identified potential hazards and the required controls in the centre.

An inspector reviewed the written current risk management policy and it did not contain all of the information as required by article 31 of the Regulations. It did not include the precautions in place to control the specified risks: a resident being absent without leave, assault, aggression, violence, and self harm. Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents was also not included. There was evidence that the risk policy was not implemented throughout the centre, for example, it was stated that ongoing risks would be monitored and the risk register would be updated. However, the risk register had not been updated since 2011 and the provider confirmed that the monitoring of ongoing risks was not always recorded. There was clear evidence that some priority risks were not vigilantly monitored on a regular basis.

Training records confirmed that opportunities had been provided for some staff to attend moving and handling training, however, not all staff had received moving and handling training.

Inspectors noted there was fire equipment available throughout the centre and a review
of the fire safety log and records indicated that fire equipment and fire system checks had been undertaken by an external fire safety company. Inspectors were informed that daily fire checks were undertaken. However, on the first day of inspection it was noted on the first floor that access to some of the fire extinguishers was obstructed, an evacuation chair was not kept clear and a fire exit 'running man' sign was not illuminated. It was also noted a fire exit 'running man' sign was not illuminated on the ground floor main corridor. Access to the fire safety equipment and escape routes were rectified by management after it was brought to their attention by an inspector. Fire safety training records indicated that fire safety training and drills had been provided for some staff, however, not all staff had received fire safety training.

In relation to infection control practices inspectors noted an adequate supply of personal protective equipment (PPE), anti-microbial hand gel dispensers and waste bins. However, appropriate measures were not being taken to prevent and control infection as parts of the centre were visibly dirty and this included the sluice room and some of the en suite toilet and shower facilities. The poor state of repair of some of the floor coverings and shower walls also posed a potential infection risk.

**Outcome 08: Medication Management**  
*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**  
Safe Care and Support  

**Judgement:**  
Non Compliant - Major  

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

**Findings:**  
On the previous inspection in January 2013 it was found that appropriate and suitable practices were not in place in regard to the administration of medicines and improvements were required in regard to the management of medication errors. A sample of medicine prescriptions were reviewed on this inspection and medication storage and administration practices were also observed.

The centre had medication management policies and procedures. An inspector found medicines were appropriately stored, there was photo identification available for each resident and there was evidence that medication prescriptions were reviewed by medical practitioners. However, there remained a real risk of medication errors and potential injury to residents due to administration practices that were not in accordance with relevant nursing professional guidelines or with the centre's own medication management polices and procedures. For example, medicine prescriptions were being transcribed and there was only one nurse's signature to indicate it had been checked as
correct against a medical practitioner’s prescription. It was noted that there were corrections written over some doses of medicines. There was clear evidence that some medicines were being administered to residents without a transcribed prescription being signed and authorised by a medical practitioner in a timely manner. The actual administration times of medicines in some cases did not correlate with the administration times that were recorded. There were four evenings in a row when some residents had no signature on their medicine administration records indicating whether their medicines had actually been administered or not. An inspector also noted that some nutritional supplements were being administered without them being prescribed. There was no evidence to suggest that any of these practices had been identified as near misses or that nursing staff medication administration practices were being monitored.

**Outcome 10: Reviewing and improving the quality and safety of care**

The quality of care and experience of the residents are monitored and developed on an ongoing basis.

**Theme:**
Effective Care and Support

**Judgement:**
Non Compliant - Moderate

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

**Findings:**

During the inspection in January 2013 it was found there was not a system in place for consistently reviewing the quality and safety of care and services provided to residents. In the provider’s response to the inspection report it was stated that regular audits of practices and systems of work would be put in place by the end of May 2013. Inspectors did not find evidence that regular review and evaluation of practices and systems of work had been in place since the end of May 2013, however, there was evidence that review activity had commenced in January 2014.

An inspector was given the reports of four audits that had been undertaken between 6 and 7 January 2014. They indicated reviews of environmental hygiene, infection control, medication storage and administration practices, health and safety practices and the general condition of the premises. Areas for improvement had been identified, however, it was not clear who was responsible for progressing the necessary improvements and by what time frame. Inspectors found evidence during this inspection that many of the improvements that had been identified had not been completed.

The provider informed an inspector that since 21 January 2014 an external contractor had been engaged for 10 hours a week to undertake quality review activity. A written summary of the work that had been undertaken between 21 and 30 January 2014 was
provided to the inspector and it outlined that some staff files, the complaints policy and log, end of life care policy and some nutritional practices had been reviewed.

An inspector was informed on this inspection that weekly clinical data was maintained of rates, for example of, falls, use of restraint, episodes of challenging behaviour and use of sedation. The acting person in charge informed an inspector that she reviewed this information; however, there was no documented evidence of this or any specific action/s being taken following analysis of occurrence rates.

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

*Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents 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

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
On this inspection there was evidence that residents continued to have regular access to medical practitioners, allied health services as required, such as, physiotherapy, speech and language therapy, dietician services and occupational therapy.

On the previous inspection in January 2013 it was found that there was not a high standard of nursing care in regard to recording nursing assessments of residents, the documentation of the use of bed rail restraint as well as the ongoing monitoring of residents. In the provider’s response to the previous inspection report in relation to provision of a high standard of evidence based nursing care, it was stated that each resident would have an assigned nurse to complete and update individual residents' nursing care plans and to follow up on each resident's assessed needs. Inspectors found on this inspection that these required improvements had not been fully implemented.

As already addressed in outcome seven, improvements are required in regard to ensuring safety is maintained for those residents who smoke.

Inspectors reviewed a sample of residents’ clinical nursing assessments, residents' nursing care plans and residents' daily nursing notes. Recognised nursing assessment
tools had been used and assessments of resident’s activities of daily living were in place as were nursing care plans. In some instances the nursing documentation was not up-to-date and reflective of the current status of a resident and their required needs. This situation had been identified during some of the audit activity that had been undertaken in January 2014, as referred to in outcome 10. Inspectors found that in the case of an identified resident, incorrect information was recorded in the resident’s daily nursing notes regarding this resident’s actual status and there was not clear evidence that this resident’s nursing care needs were prioritised in a timely manner. The acting person in charge confirmed that there were inconsistencies in some of the residents' nursing notes and they were not always up-to-date and reflective of the actual care that was required and/or being provided. It was also noted by inspectors that residents’ daily nursing progress notes were not always timed by nursing staff, which is not in line with professional guidelines and it was therefore unclear what time some nursing actions were actually undertaken.

In regard to the outstanding action from the January 2013 inspection of ensuring any resident that required the use of bed rail restraint should have an up-to-date risk assessment in place, there was evidence of bed rail assessments being in place but in the sample that were reviewed they were not all up-to-date.

There was evidence that residents were provided with opportunities to engage in group or one-to-one activities, staff were employed specifically to facilitate activities and there was a timetable of activities on notice boards listing what was available and on what days of the week. Information was available in residents' records that identified what previous interests and hobbies a resident had and what their abilities and interests would be to partake in the activities programme. However, inspectors found that social and recreation care plans were not up-to-date for all residents. The acting person in charge also confirmed this was the case.

**Outcome 12: Safe and Suitable Premises**

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

**Theme:**
Effective Care and Support

**Judgement:**
Non Compliant - Major

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

**Findings:**
During the two days of inspection it was noted by inspectors that the centre was warm...
and some of the actions from the inspection in January 2013 had been completed in regard to the premises. These included: some of the walls and doors on the first floor had been painted, metal 'kick plates' had been installed on some of the doors, new floor covering had been installed in the laundry and a new staff facility had been created. While new sluice equipment had been installed inspectors noted that one of the sink units was rusty.

Dining room and lounge furniture was maintained in a good state of repair.

Actions that remained outstanding from the inspection in January 2013 were provision of: adequate storage space, suitable external grounds and clean premises maintained in a good state of repair.

Inspectors noted that floor covering was not maintained in a good state of repair in: the Barges corridor, the Millrace corridor, the communal toilets off Millrace corridor, the communal toilet on the first floor, the dining room and bedrooms; one, two, four, five, 11, 15, 16, 25, 26 and 27.

Paintwork and/or plaster work was also not maintained in a good state of repair in: the Barges corridor, the dining room, bedrooms; five, nine, 14, 17 and 19, the ceiling of the communal toilets off Barges corridor, the communal toilets off Millrace corridor and the Millrace corridor walls.

There were no bedside lockers in the twin bedroom numbered 15 and bedroom furniture was not maintained in a good state of repair in bedrooms 12, 18 and 25.

Window and/or bed screening curtains were either not adequate or not maintained in a good state of repair in bedrooms four, nine, 12, 14, 15, 20 and 24.

Some of the toilet and washing facilities required maintenance work on tiles, tile grouting, shower walls and some grab rails were rusty.

Some parts of the external grounds were not suitable for the safe use by residents as there was broken outdoor furniture.

There was potential for privacy and dignity to be compromised for some residents who shared triple bedrooms as well as residents in the twin room on the first floor due to the design and layout of the bedrooms.

**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

**Judgement:**
Non Compliant - Major
Outstanding requirement(s) from previous inspection:
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
An inspector read the complaints log and as required by the Regulations a record of complaints was maintained that detailed the actual complaint, any actions taken and the complainant's level of satisfaction.

An inspector reviewed a copy of the complaints policy and procedures and the document was displayed in a prominent place. The inspector was informed that a review of the policy had been undertaken on 24 January 2014 and it had been identified that the actual process for appealing an outcome was not clearly stated and the nominated person for managing appeals did not have their contact details listed. The inspector concurred with these findings.

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.

Theme:
Workforce

Judgement:
Non Compliant - Major

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

Findings:
Since the inspection in January 2013 written agreements had been put in place with three volunteers.

Duty rosters were maintained for all staff and at the time of inspection the rosters indicated that there were sufficient staff scheduled to work to meet the needs of the current residents. The absence of a permanent person in charge has been addressed in Outcome three. The acting person in charge and provider confirmed that additional nurses were being recruited as the centre was functioning without the required full time equivalent (FTE) nurses as there were seven FTEs when there needed to be approximately nine. Some of the nursing staff were working significant overtime in order to cover the required nursing hours.

Training records indicated that in 2013 staff had been provided with opportunities to
attend relevant updates, such as, management of challenging behaviour, nutrition in the older adult, housekeeping, basic food training and hand washing. The status of elder abuse awareness training has already been addressed in outcome six with manual handling and fire safety training already addressed in outcome seven.

Inspectors reviewed a sample of the records retained on staff files. Gaps were found in some staff employment histories, one staff member did not have evidence of medical fitness and had two references instead of three written references and there was also no documented evidence that the authenticity of references had been verified.

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

**Report Compiled by:**

Col Conway  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Centre name: Powdermill Nursing Home
Centre ID: ORG-0000270
Date of inspection: 04/02/2014
Date of response: 14/04/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 03: Suitable Person in Charge

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
At time of inspection a permanent person in charge was not in post.

Action Required:
Under Regulation 15 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge is a nurse with a minimum of three years experience in the area of geriatric nursing within the previous six years.

Please state the actions you have taken or are planning to take:
The provider is going to continue to use all methods at his disposal to recruit a permanent, suitably qualified director of care. Until such time a person is appointed our clinical nurse manager whom has nine years consecutive gerontology experience will provide day to day leadership. She is supported by the appointment of a former director

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
of nursing for ten hours per week who has been appointed as the training and audit officer.

The provider will continue to use all methods at his disposal to recruit a person in charge as a matter of urgency.

Proposed Timescale: 27/06/2014

**Outcome 06: Safeguarding and Safety**

**Theme:** Safe Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training in elder abuse awareness.

**Action Required:**
Under Regulation 6 (2) (a) you are required to: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Please state the actions you have taken or are planning to take:
There is now a training officer in place since January 2014 which illustrates our commitment to ongoing training. A full audit on staff training has been completed and a training programme for the year is up and running. The appointment of new staff will be notified immediately to the training officer who will then ensure that a staff member receives adequate training in a timely manner in order to ensure compliance with all regulations as they apply. Our policy on elder abuse will be changed accordingly to incorporate this education time-frame.

Proposed Timescale: 14/04/2014

**Outcome 07: 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:
There were not written health and safety policies and procedures relating to the health and safety, including food safety of residents, staff and visitors.

**Action Required:**
Under Regulation 30 you are required to: Put in place written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.

Please state the actions you have taken or are planning to take:
Current policies are being reviewed to ensure compliance with Regulation 30. A specific food safety policy will be drafted that complies with the Regulation.
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<th>Theme: Safe Care and Support</th>
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<tbody>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>Not all staff had received the moving and handling training updates that they required.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
<td>Under Regulation 31 (4) (f) you are required to: Provide training for staff in the moving and handling of residents.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>The centre has a physiotherapist who is FETAC level six approved to provide training in house for all our staff. In addition she advises the staff and ensures compliance with best practice in patient moving. The training officer is now planning for all staff to have training well in advance of the expiry of present training.</td>
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<tr>
<th>Proposed Timescale: 14/04/2014</th>
<th>Theme: Safe Care and Support</th>
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<tbody>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>There was evidence that the risk management policy was not fully implemented throughout the centre.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
<td>Under Regulation 31 (1) you are required to: Put in place a comprehensive written risk management policy and implement this throughout the designated centre.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>A comprehensive written risk management policy will be developed and implemented. The risk management register is a comprehensive document that details all the known risks in the centre and the actions required to minimise and reduce the risk at all times. All incidents that occur are recorded in writing on an incident report forms to ensure that we are doing all that is practicable to reduce or eliminate the risk. A risk management policy will be updated and a systematic training of all staff beginning with team leaders will be rolled out and will be included in the training plan for 2014.</td>
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<th>Proposed Timescale: 27/06/2014</th>
<th>Theme: Safe Care and Support</th>
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<tbody>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>The risk management policy did not include the precautions in place to control the</td>
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specified risks: a resident being absent without leave, assault, aggression, violence, and self harm.

**Action Required:**
Under Regulation 31 (2) (c) you are required to: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

**Please state the actions you have taken or are planning to take:**
The risk register will be reviewed to include the precautions in place to control the specified risks outlined in the inspection report. When this is complete a training for all staff will take place to ensure awareness and compliance with our policy and procedures. There currently exists specific care plans for residents assessed to be at risk of absconscion.

**Proposed Timescale:** 30/05/2014

**Theme:** Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The written risk management policy did not include the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

**Action Required:**
Under Regulation 31 (2) (c) you are required to: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

**Please state the actions you have taken or are planning to take:**
The policy will be reviewed to include the above specified risks.

**Proposed Timescale:** 30/05/2014

**Theme:** Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a potential risk of injury to residents as the door to the staff facility was left open.

There was potential risk of injury to residents as appropriate measures were not being taken to prevent and control infection in the sluice room, in some of the en suite toilet and shower facilities and with the poor state of repair of some of the floor coverings and shower walls.
**Action Required:**
Under Regulation 31 (4) (a) you are required to: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

**Please state the actions you have taken or are planning to take:**
Signage has been placed on the door of the staff changing area to keep it closed at all times. The sluice room which was renovated in 2013 and fitted with all new fixtures and fittings will be assessed to ensure that infection control measures are in place. A specific nurse will be identified within the nursing home with responsibility to advise on infection control. Two of the senior household staff will be attending an infection control course on 11 June 2014 to assist them in their understanding of infection control.

**Proposed Timescale:** 18/04/2014
**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Adequate precautions against the potential risk of injury to any resident that smoked had not been taken. The degree of risk to themselves or others was not clearly documented and inspectors found that residents with high risk factors did not have the appropriate controls in place to keep them safe while smoking.

**Action Required:**
Under Regulation 31 (4) (a) you are required to: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

**Please state the actions you have taken or are planning to take:**
The two chairs that could not be verified as fire retardant were removed immediately from the building to prevent further use in the smoking room. Awaiting fire certification from the manufacturer who has confirmed third chair is fire retardant. Daily check that all furniture in the smoking room is made of fire retardant material and no flammable material in the room or being worn by residents.

A fire extinguisher was in place outside the smoking room. An independent fire consultancy company who installed and services the fire alarm and fire extinguishers were asked to visit the centre and advise. They recommended a full length fire blanket to be placed in the smoking room. In addition they recommended as an extra precaution placing a fire extinguisher in the smoking room. New fire equipment was installed on 7 February 2014. Visual inspection daily that equipment is in place.

A call bell was installed in the smoking room. The inspection team suggested that additional call bells could enhance patient safety in the event of a sudden fire. I concur with this view. The nurse call bell engineer is booked to come and install a new call bell. Daily check that the call bells are working. Risk assessment to be reviewed monthly or when there is a change or an increased risk of harm or danger to the residents. It was also decided to put a new sign on the wall beside the orange string of the call bell to
remind residents, staff and or visitors how to use the alarm.

A risk assessment for each smoker was completed on 6 February 2014. It was agreed that the assessment could be improved on as the risk assessments did not have the control measures listed clearly. Four smoking aprons were purchased and one was placed in the smoking room. They appear cumbersome and residents were unwilling to use them. Provider will discuss this with the residents and explain the purpose of the apron. There may be an option to personalise the apron to encourage use. Flammability of residents' clothing or disposable continence wear will be assessed and residents will be encouraged not to wear pyjamas or night wear in the smoking room.

Fire Induction Training has been modified to emphasize the risks for residents in the smoking room. All health care staff should have an induction on the specific risks associated with smoking, and the control measures now being adopted. This training should ensure that staff are trained in fire prevention and know what to do in the event of a fire. Staff have been asked to visually check all residents in the smoking room when they are passing by. Fire Warden to be appointed daily and to complete daily check of building including the smoking room. New staff member received the revised induction training on 8 February 2014. All care staff apart from those on annual leave to receive this training by 14 February 2014. All other staff to be trained by 28 February 2014. This has started already as staff are made aware of the risks and new control measures and will be ongoing for a week. Audit to be undertaken weekly to monitor compliance.

All accidents and near misses to be recorded on the incident report form. This may include burns in the clothing or furniture. A copy of the Authority's safety alert 001/2012 to be put on display in the smoking room as part of the education process for residents and staff.

Review frequently the risk assessment for each resident who smokes (at least quarterly) and ensure that the control measures in place are being put in to practice daily. Further review of all risk assessments and action plans submitted to the Authority to be discussed by the director of care and the provider, and at least one staff nurse and health care worker. Any outstanding actions to be implemented and any new suggestions/improvements recorded. To be reviewed by the director of care frequently and any new risks are to be documented and suitable control measures to be put in place. Review weekly for the next four weeks and monthly thereafter.

**Proposed Timescale:** 09/02/2014

**Theme:** Safe Care and Support

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

On the first floor access to some fire extinguishers was obstructed, an evacuation chair was not kept clear and a fire exit 'running man' sign was not illuminated.

A fire exit 'running man' sign was not illuminated on the ground floor main corridor.
**Action Required:**
Under Regulation 32 (1) (c) (v) you are required to: Make adequate arrangements for reviewing fire precautions, and testing fire equipment, at suitable intervals.

**Please state the actions you have taken or are planning to take:**
The fire equipment is checked by an independent consultant and serviced quarterly as per fire Regulations. A fire warden has been appointed to ensure that daily and weekly checks are carried out to ensure that all fire equipment is in place and working. This is recorded in the Fire and General Register. The daily fire checks will now include a check on the “running man” signs.

**Proposed Timescale:** 14/04/2014

**Theme:** Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff required fire safety training updates.

**Action Required:**
Under Regulation 32 (1) (e) you are required to: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

**Please state the actions you have taken or are planning to take:**
The training officer is currently concentrating on the mandatory fire training for all staff and this will be completed by July 2014. In addition all new staff receive fire induction training commensurate with their role and responsibilities.

**Proposed Timescale:** 01/07/2014

**Outcome 08: Medication Management**

**Theme:** Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Administration practices were not in accordance with relevant nursing professional guidelines or with the centre’s own medication management policies and procedures.

**Action Required:**
Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

**Please state the actions you have taken or are planning to take:**
It is recognised that there is a need for audit of daily administration of medication to
residents and to include receiving and dispensing of medications in accordance with relevant legislation. Nursing staff will be updated and educated in accordance to best practice regarding the safe care of residents. The policy will be pivotal in the induction programme of new nurses employed as will communication through email and regular weekly staff meetings with the person in charge.

Medication audits will be developed and implemented in relation to medication management and errors and a responsible person for corrective action and weekly reports to clinical governance committee will be put in place for monthly clinical governance meetings.

Following the inspection discussions were held with the person in charge and the primary GP in the centre. An urgent meeting was held with the person in charge, the pharmacist and the audit officer. It was agreed at this meeting that the pharmacy would provide the centre with a computer generated prescription sheet based on the prescription supplied monthly by the GP’s. Any changes to a resident’s medication will be immediately notified to the pharmacist and changes to the prescription sheet will be made accordingly. This system is currently in place and is being monitored closely and to date is proving to be safe and effective and compliant with legislation.

It has been highlighted to all nursing staff the importance of signing for all medication administered and a full audit of medication management has taken place to include supervision of a medication round.

It is accepted that some small number of residents were given a type of nutritional supplement on the day of inspection that had not been prescribed for them. These residents had however been prescribed a supplement of larger volume rather than not being prescribed any supplement at all. This anomaly has now been corrected and all residents on nutritional supplements are now getting a supplement suited both to their needs and their ability to ingest same.

The problem of residents not being administered their medication at the prescribed time is difficult to address. There are 40 residents in the NH and even with two nurses administering medication concurrently a medication round can still take up to two hours. Therefore it is unavoidable that some residents may not get their medication at the exact prescribed time.

Proposed Timescale: 31/05/2014

Outcome 10: Reviewing and improving the quality and safety of care

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was not a system established that showed consistent review of the quality and safety of care and the quality of life of residents.

Action Required:
Under Regulation 35 (1) (a) you are required to: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

**Please state the actions you have taken or are planning to take:**
It is noted that the centre did not have completed written evidence of regular audits to support compliance with legislation requirements to support best nursing practices delivered to our residents.

We will endeavour to implement a system of work to ensure safe practices as well as continuous audit and review and implementation of safe practice based on evidence based practice. This will entail review of current policies and practices and development of a systematic action plan for implementation and continuous review.

**Proposed Timescale:** 31/05/2014

**Theme:** Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was not a system established that improved the quality and safety of care and the quality of life of residents.

**Action Required:**
Under Regulation 35 (1) (b) you are required to: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

**Please state the actions you have taken or are planning to take:**
We will develop a strategy to ensure compliance with regulatory requirements in developing resident focused care plans that will be continuously updated in order to meet the changing needs of the individual resident. An audit of a selection of care care plans was completed on 26 February 2014 and a report was produced on 7 March 2014 for the provider and person in charge. Clear time frames for completion of outstanding items was issued to the nurses. There will be a training session on care planning for all nurses where they will be given the key skills to complete adequate and satisfactory care planning. Clear time lines for timely review will also form part of the training which will also address the minimum three monthly review and the necessity to update a care plan to meet the changing needs of the resident.

**Proposed Timescale:** 31/05/2014

**Theme:** Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence of an established system for consistently reviewing and improving the quality and safety of care as well as the quality of life of residents.
**Action Required:**
Under Regulation 35 (2) you are required to: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.

**Please state the actions you have taken or are planning to take:**
We need to undertake in-house research to ensure that we can develop an adequate system of measuring the quality of life of each resident with particular emphasis on those residents who for physical or cognitive reasons may be unable to express a view. This will begin with a meeting with the residents and ask them formally how we can assess how they rate their quality of life. Each resident is a unique person that we take great pride in listening to and assist them to enjoy their retirement. The next residents meeting will be held on 17 April 2014 to discuss this issue and to listen to the residents. This will be the starting point to develop a system of improving the quality of life of residents. The appointment of a resident advocate is anticipated as another pillar on which to build an impartial assessment. This appointment should be made within six weeks.

**Proposed Timescale:** 20/06/2014

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

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was not a high standard of nursing care in relation to written assessments of residents, updating of residents' care plans, documentation of monitoring residents' progress and timing nursing entries using the 24 hour clock.

**Action Required:**
Under Regulation 6 (3) (b) you are required to: Provide a high standard of evidence based nursing practice.

**Please state the actions you have taken or are planning to take:**
The high standard of nursing care that has been provided is not reflected in the nurse care plans in some instances, therefore, in order to show and provide evidence that high standard of care has been delivered we need to improve the nursing documentation:

Nurses will familiarise themselves with professional guidelines with record keeping and use the guidelines to improve the documentation.

The designated nurse will review two care plans each per month with view to completing seven as allocated over a three month period

Where an individual nurse is having difficulty formulating care plans or nursing documentation they can attend documentation workshops. This will be done on an individual basis as well as in a group setting.
**Proposed Timescale:** 31/07/2014  
**Theme:** Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Social and recreation care plans were not in place for all residents.

**Action Required:**  
Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

**Please state the actions you have taken or are planning to take:**  
An audit of care plans will be carried out by the person in charge to ensure that social and recreational plans are in place for all residents in a timely manner. Activities are taking place in accordance with each residents assessed needs. The activity coordinators will continue to liaise with the key nurse assigned to each resident to formulate this plan.

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**Proposed Timescale:** 09/05/2014  
**Theme:** Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Not all residents had their care plans reviewed when their individual condition or situation changed.

**Action Required:**  
Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

**Please state the actions you have taken or are planning to take:**  
Care plans will be updated in a timely manner as needs of the resident change. Specific care plans will be added and discontinued as their present condition indicates, as well as the three monthly routine review.

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**Proposed Timescale:** 09/05/2014

**Outcome 12: Safe and Suitable Premises**  
**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There were bedrooms that compromised the privacy and dignity of residents based on
the design and layout of the bedroom space.

**Action Required:**
Under Regulation 19 (3) (e) part 2 you are required to: Provide adequate private accommodation for residents.

**Please state the actions you have taken or are planning to take:**
The privacy and dignity of each resident is respected by all staff and the general positivity of the residents reflects their contentment in what is “their home”. The bedrooms that may have compromised privacy and dignity have been inspected by a competent architect who will advise on improvements. New curtains have been installed in bedroom four and a systematic replacement of the curtains in all shared bedrooms has begun.

**Proposed Timescale:** 27/06/2014

**Theme:** Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Floor covering was not maintained in a good state of repair in: the barges corridor, the millrace corridor, the communal toilets off millrace corridor, the communal toilet on the first floor, the dining room and bedrooms; one, two, four, five, 11, 15, 16, 25, 26 and 27.

Paintwork and/or plaster work was also not maintained in a good state of repair in: the barges corridor, the dining room, bedrooms; five, nine, 14, 17 and 19, the ceiling of the communal toilets off barges corridor, the communal toilets off millrace corridor and the millrace corridor walls.

Bedroom furniture was not maintained in a good state of repair in bedrooms 12, 18 and 25.

Window and/or bed screening curtains were either not adequate or not maintained in a good state of repair in bedrooms four, nine, 12, 14, 15, 20 and 24.

Some of the toilet and washing facilities required maintenance work on tiles, tile grouting, shower walls and some grab rails were rusty.

**Action Required:**
Under Regulation 19 (3) (b) you are required to: Ensure the premises are of sound construction and kept in a good state of repair externally and internally.

**Please state the actions you have taken or are planning to take:**
The floor coverings are and have been systematically repaired over the last four years. There are now only four bathrooms/en suites to be completed. The communal toilets in the barges were completely renovated in 2013 including a new sluice room, a new floor in the laundry and en suites included new shower traps. This work is ongoing and immediate repairs are being carried out. Flooring repairs will begin immediately and
replacement of the dining room floor will be completed by 18 July 2014. Plaster work and grab rails will be repaired by 30 April 2014 and painting and decorating has been ongoing since February 2014.

<table>
<thead>
<tr>
<th>Proposed Timescale: 18/07/2014</th>
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<tr>
<td><strong>Theme:</strong> Effective Care and Support</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some areas in the centre were not clean.

**Action Required:**
Under Regulation 19 (3) (d) you are required to: Keep all parts of the designated centre clean and suitably decorated.

**Please state the actions you have taken or are planning to take:**
We have consulted with a company who have conducted a survey of the house keeping. All areas have been surveyed and a thorough cleaning plan for both daily light cleaning and daily deep cleaning will be produced. This will mean that each bedroom, living room and all communal areas will receive a daily clean and a weekly deep clean. The plans will be product, equipment and area specific. Supervisor check sheets will be produced which will enable the supervisor to monitor the hygiene standards throughout the home. All cleaning chemicals will be supplied with locked dosing equipment to enable correct and safe dosing of all chemicals. Initial staff training will take place on 16 April 2014 and this will just cover the basics of the products and dispensers. Follow up training will be scheduled before the end of April 2014.

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<th>Proposed Timescale: 30/04/2014</th>
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<td><strong>Theme:</strong> Effective Care and Support</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was inadequate storage space for equipment.

**Action Required:**
Under Regulation 19 (3) (l) you are required to: Ensure suitable provision for storage of equipment in the designated centre

**Please state the actions you have taken or are planning to take:**
Equipment that is not being used will be removed. Staff will be given clear instructions regarding where equipment can be stored. External storage areas will be re-organised to ensure that supplies are easily accessible.

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<tr>
<td><strong>Theme:</strong> Effective Care and Support</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The external grounds are not suitable for the safe use by residents.

**Action Required:**
Under Regulation 19 (3) (o) you are required to: Provide and maintain external grounds which are suitable for, and safe for use by residents.

**Please state the actions you have taken or are planning to take:**
The front of the nursing home is the designated area for residents and it contains a paved courtyard with large potted plants, a gazebo with seating arrangements which is enshrined with creeping plants and surrounding shrubbery. A manicured lawn with carefully extended footpaths allow residents to not only visually enjoy the beautiful grounds but to enjoy the aroma of the roses and flowers. A water fountain creates the sounds in the garden of peace and tranquillity. A raised deck allows residents to leave the centre and sit outside when weather permits. Furthermore they can walk this part of the garden without supervision as it is tastefully enclosed in a natural wood railing. The grounds at the rear of the nursing home are currently being designed to provide further enjoyment for the residents and will be open for supervised access when completed. Already a steel hand rail has been fitted as well as additional seating areas to enable residents to sit and enjoy the experience. A vegetable garden on raised beds is being redesigned to ensure easier access for residents.

**Proposed Timescale:** 27/06/2014

<table>
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<th><strong>Outcome 13:</strong> Complaints procedures</th>
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<tr>
<td><strong>Theme:</strong> Person-centred care and support</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not clearly state how an outcome of a complaint will be appealed and there were no contact details for the nominated person for appeals.

**Action Required:**
Under Regulation 39 (2) you are required to: Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centres policies and procedures.

**Please state the actions you have taken or are planning to take:**
The complaints policy has been amended to include the current information on the independent appeals process.

**Proposed Timescale:** 14/04/2014

<table>
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<th><strong>Outcome 18:</strong> Suitable Staffing</th>
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<tr>
<td><strong>Theme:</strong> Workforce</td>
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<tr>
<th>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</th>
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<tr>
<td>There was not an adequate amount of nursing staff employed to work in the centre.</td>
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**Action Required:**
Under Regulation 16 (1) you are required to: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
An additional staff nurse has been recruited. A staff nurse who is currently working part time will have completed her studies in June 2014 and will then return to full time employment.

**Proposed Timescale:** 14/04/2014

**Theme:** Workforce

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<th>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</th>
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<td>Some of the required documents were not maintained on staff files and had not been sought before staff commenced employment.</td>
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**Action Required:**
Under Regulation 18 (2) (a) and (b) you are required to: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.

**Please state the actions you have taken or are planning to take:**
All staff files will be complete with documents specified in Schedule 2 and any new staff will be sent a copy of Schedule 2 prior to employment commencing to ensure they are aware of the documents that are needed.

**Proposed Timescale:** 30/05/2014

**Theme:** Workforce

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<th>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</th>
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<td>There was no evidence to suggest that the authenticity of staff references had been verified.</td>
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**Action Required:**
Under Regulation 18 (2) (c) you are required to: Put in place recruitment procedures to ensure the authenticity of the staff references referred to in Schedule 2.

**Please state the actions you have taken or are planning to take:**
All staff engaged in recruitment have been instructed to read our recruitment policy and
implement the terms of the policy. All telephone references will be recorded in writing. No appointment will be finalised until satisfactory references have been authenticated and signed by the staff member verifying the reference. The recruitment policy will be reviewed and amended to include policy on receipt and verification of references.

**Proposed Timescale:** 14/04/2014