

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Earlsbrook House
Centre ID:	OSV-0000033
Centre address:	41 Meath Road, Bray, Wicklow.
Telephone number:	01 276 1601
Email address:	earlsbrook@firstcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	FirstCare Ireland (Earlsbrook) Limited
Lead inspector:	Sheila Doyle
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	56
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 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:	To:
01 October 2018 11:30	01 October 2018 17:30
02 October 2018 09:30	02 October 2018 16:30

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	Non-Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non-Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Substantially Compliant
Outcome 04: Complaints procedures	Substantially Compliant	Non-Compliant - Moderate
Outcome 05: Suitable Staffing	Substantially Compliant	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Compliant
Outcome 07: Health and Safety and Risk Management		Compliant

Summary of findings from this inspection

As part of the thematic inspection process, providers were invited to attend information seminars given by HIQA. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process.

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 Standards for Residential Care Settings for Older People in Ireland. The previous table outlines the centre's and inspector's rating for each outcome.

The inspector met with residents and staff members during the inspection. The journey of a number of residents with dementia was tracked within the service. Care practices and interactions between staff and residents who had dementia were observed using a validated observation tool. Documentation such as care plans, files and staff training records were reviewed.

Earlsbrook House provides residential care for 64 people. At the time of inspection, approximately 50% of residents were living with dementia.

Each resident was assessed prior to admission, to ensure the service could meet their needs, and to determine the suitability of the placement. Residents had a comprehensive assessment undertaken on admission, and detailed person-centred care plans were in place to meet their assessed needs. Some improvement was required to ensure that all residents' records, such as safety checks and food and fluid intake records were complete. Improvement was also required to ensure that care plans were reviewed following consultation with the residents or their families.

There was appropriate staff numbers and skill mix to meet the assessed needs of residents. There was a recruitment policy in place which met the requirements of the regulations. Staff were offered a range of training opportunities including a range of dementia specific training courses.

Action required from the previous inspection relating fire safety had been completed.

Meals and mealtimes required improvements to ensure that adequate assistance was available to residents when required. The provider acted as pension agent for some residents. Plans were in place to have this in line with national guidelines. These plans need to be completed.

Improvement was required to the activity programme to ensure that each resident was provided with opportunities to participate in activities in accordance with their interests and capacities. Some amendments were required to the complaints policy in place and the system for dealing with verbal complaints needs to be made more robust.

These are discussed further in the body of the report and the actions required are included in the action plan at the end.

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):

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

Findings:

Samples of clinical documentation including nursing and resident records were reviewed which indicated that all recent admissions to the centre were assessed prior to admission. A detailed pre-admission assessment was carried out and looked at both the health and social needs of the potential resident.

The assessment process involved the use of validated tools to assess each resident including risk of malnutrition, falls, and their skin integrity. A care plan was developed within 48 hours of admission based on the resident's assessed needs. Care plans were reviewed on a regular basis, however, there was limited evidence that this was done following consultation with the resident concerned, or where appropriate that resident's family.

The management team spoken with discussed plans afoot to introduce assessments of the level of cognitive impairment to monitor resident's journey with dementia.

Documentation in respect of residents' health care was comprehensive and up-to-date. Residents had access to general practitioner (GP) services and out-of-hours medical cover was provided. A full range of other services was available on referral including physiotherapy, occupational therapy, speech and language therapy (SALT) and dietetic services. Chiropody, dental and optical services were also provided either locally or in the centre.

The inspector reviewed residents' records and found that residents had been referred to these services and results of appointments were written up in the residents' notes. When required, the care plans were updated to reflect the recommendations.

The inspector reviewed a sample of administration and prescription records which were now electronically maintained. Because of this, the action required from the previous inspection relating to transcribing practices, was no longer relevant. Support and advice were available for the supplying pharmacy.

Medications that required strict control measures (MDAs) were kept in a secure cabinet in keeping with professional guidelines. Balances checked on inspection were correct.

The inspector was satisfied that each resident was provided with food and drinks at times and in quantities adequate for his/her needs. However, some improvements were required to ensure that meals and mealtimes were an enjoyable experience for all residents. Smaller day rooms had been set up to allow a more homely atmosphere. However, the inspector noted that adequate assistance was not available to residents at meal times. The inspector noted that seven residents in one of the smaller day rooms required assistance. For most of the mealtime, two staff members were in the room. This meant that five residents were not getting the assistance required to enjoy their meal. The meals had been served from the kitchen and the inspector noted that the remaining meals were cold before assistance was available. It was also noted that the table were not set in this room nor were any trays or condiments in use. Drinks were also not provided at the observed mealtime. This was discussed in detail with the management team at the end of inspection.

The system in place was that when required, records were to be maintained of food and fluid intake. However, as identified also at the previous inspection, food and fluid intake records were incomplete.

Validated nutrition assessment tools were used to identify residents at potential risk of malnutrition or dehydration on admission and were regularly reviewed thereafter. Weights were also recorded on a monthly basis or more frequently if required. The inspector saw that residents had been reviewed by a speech and language therapist and dietitian as required. Recommendations from these reviews were documented in the residents' notes.

The inspector visited the kitchen and noticed that it was well organised. The chef on duty discussed the special dietary requirements of individual residents and information on residents' dietary needs and preferences.

There were care practices and facilities in place so that residents received end-of-life care in a way that met their individual needs and wishes. Staff spoken with stated that the centre received support and advice from the local palliative care team. Staff had linked with the hospice friendly hospital (HfH) initiatives such as the use of the spiral symbol to alert others to be respectful whenever a resident was dying.

Staff spoken with confirmed that meals and refreshments were made available to relatives and facilities were set aside if relatives wished to stay overnight.

Judgment:

Non Compliant - Moderate

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:

The inspector found that measures were in place to protect residents from being harmed or abused. Some improvement was required to ensure that safety checks were carried out and documented when restrictive practices were in use.

The inspector reviewed the use of restraint and found that risk assessments were completed prior to use. Additional equipment, such as low beds and sensor alarms, had also been purchased to reduce the need for bedrails. Some gaps were noted in the documentation of alternatives tried prior to use. In addition, there was insufficient evidence that safety checks were carried out in line with national policy as several gaps were noted in the safety check records.

Staff had received training on identifying and responding to elder abuse. There was a policy in place to guide practice. Staff spoken with displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures.

Procedures were in place to ensure that residents were provided with support that promoted a positive approach to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The inspector reviewed residents' files and noted that a comprehensive assessment had been undertaken. Possible triggers had been identified and staff spoken with were very familiar with appropriate interventions to use. Support and advice were available from the psychiatric services.

During the inspection, staff approached residents with responsive behaviours in a sensitive and appropriate manner, and the residents responded positively to the techniques used by staff.

The provider acted as pension agent for some residents. Plans were in place to have this in line with national guidelines. This action needs to be completed. Pocket monies were also being managed for some residents. The inspector checked a sample of balances and found them to be correct. Documentation such as receipts and details of each transaction were maintained.

Judgment:

Non Compliant - Moderate

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:

The inspector was satisfied that residents were consulted on the organisation of the centre. There was evidence that feedback was sought from all residents on an ongoing basis, regarding the services provided. Some improvement was required to ensure that all interactions resulted in a positive outcome for residents and that their privacy and dignity was consistently respected.

As part of the inspection, the inspector spent a period of time observing staff interactions with residents with a dementia. The observations took place in the dayrooms. Observations of the quality of interactions between residents and staff for selected periods of time indicated that 46% of interactions demonstrated positive connective care, 8% reflected task orientated care, 30% indicated neutral care, 4% indicated protective and controlling care while 12% of interactions classed as institutional or controlling care. These results were discussed with the management who attended the feedback meeting.

Generally, staff were seen to give an explanation to residents before they offered support and assistance. However, the inspector noted one staff member putting clothes protectors on residents without asking permission.

Otherwise, the inspector found that satisfied residents' privacy and dignity was respected. Staff were observed knocking on bedroom and bathroom doors. Adequate screening was available in shared rooms. The inspector observed staff interacting with residents in an appropriate and respectful manner, and it was clear that staff knew the residents well.

There were no restrictions to visiting in the centre and many residents were observed spending time with family or friends.

A comprehensive activity assessment was completed for each resident and this included details of residents' likes and dislikes, previous interests and hobbies. Some dementia appropriate activities were available. This included music, games and crafts. One to one activities, such as hand massage, were carried out for residents who did not wish to engage in group activities. The inspector did note however that, outside of the group activities, although a staff member was in the dayroom with residents, there was minimal interaction and a lot of missed opportunities for communication.

The person in charge had recently recommenced the residents' meetings and the centre was currently sourcing advocacy services to represent residents at these meetings if required.

Judgment:

Substantially Compliant

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Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
Some improvement was required to ensure that the complaints of all residents, including residents living with dementia, were listened to, and acted upon and there was an effective appeals procedure.

There was a complaints procedure in place and it was on display. Some amendments were required to the policy in place. For example, it did not reference the nominated person to ensure that all complaints were appropriately responded to, as required by the regulations.

In addition, the inspector noted that complaints addressed immediately were not logged. This meant that any learning could not be identified, and was not in line with the policy in place.

Action required from the previous inspection, relating to complaints documentation, had been addressed.

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:
The inspector was satisfied that at the time of inspection there were appropriate staff numbers and skill mix to meet the assessed needs of residents including residents with dementia.

Some improvement was required to ensure that staff files were complete and staff were

available at times when residents required assistance such as the meal times as described earlier.

The inspector reviewed a sample of staff files and saw that all documents required by Schedule 2 were not in place. For example, one of four files reviewed did not have a satisfactory explanation for gaps in employment as required by the regulations. Assurance was given by the person in charge that Garda Síochána (police) vetting was in place for all staff.

All staff were supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

An actual and planned roster was maintained in the centre with any changes clearly indicated. The inspector reviewed staff rosters which showed that absences were covered. Ongoing recruitment was in place to fill vacancies as they arise.

The provider and person in charge promoted professional development for staff and were committed to providing ongoing training to staff. A training matrix was maintained. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. Training on dementia and responsive behaviours was also provided. Records read confirmed all staff had completed mandatory training in areas such as safeguarding and prevention of abuse, fire safety and moving and handling. The inspector saw that additional training was planned for the coming months.

There were no volunteers in the centre at the time of inspection.

Judgment:

Substantially Compliant

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

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

Findings:

The centre is a three-story building located in a busy town. It originally was two period buildings which have been extended to accommodate 64 residents.

There were 48 single bedrooms, and 8 twin rooms and some of each have en-suite facilities. Most bedrooms was appropriately decorated and contained personal items such as family photographs, posters and pictures.

Two passenger lifts provide access to the first floor and chairlifts were provided to

provide access to areas not accessible by passenger lifts. Other accommodation included four homestead areas incorporating a kitchenette, dining space along with a day room area. There was also a small oratory, a smoking room, a treatment room and a hairdressing salon. A family room was also provided along with a suitably sized kitchen. Laundry facilities were located within the premises. Some office space was also provided.

Call bells are provided in all areas and although the current system is occasionally causing difficulties, this had already been identified by the provider and plans put in place to address the issues.

Two internal courtyards were available to residents. While storage space remained limited, action required from the previous inspection relating to adequate space for soiled laundry had been addressed with more regular collections by the laundry company.

The inspector noted that work had been undertaken in several areas to make the premises more dementia friendly. For example, several of the bedroom doors had been decorated to reflect a front door and different colours were also in use. In addition, memory aids were available throughout the centre while some old artefacts were also on display.

Residents told the inspector they were happy with their bedrooms while others commented that they like the various rooms that they could sit in.

Some off-street parking was available.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

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

Findings:

The inspector followed up on the actions from the previous inspection. A fire safety consultant had been engaged by the provider. A visual inspection suggested that the actions required from the previous inspection had been completed. The registered provider representative also stated that all requirements had been met. The Office of the Chief Inspector received written confirmation signed by a competent person, confirming that centre is in compliance with all fire safety regulations.

The inspector saw that fire servicing records and training records were up to date.

Judgment:
Compliant

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:

Sheila Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Earlsbrook House
Centre ID:	OSV-0000033
Date of inspection:	01 and 02 October 2018
Date of response:	13/11/2018

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 01: Health and Social Care Needs

Theme:

Safe care and support

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

There was limited evidence of consultation with the resident concerned, or where appropriate that resident's family, prior to care plan reviews.

1. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise

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

it, after consultation with the resident concerned and where appropriate that resident's family.

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

Each resident has a named nurse responsible for engaging with residents and their families. Per policy each resident has their care plans reviewed and discussed with either the resident or their families as appropriate. Following feedback from the inspection, consultation with this resident and their family in relation to care plans by nursing staff commenced and is ongoing.

Care plans are completed for all new residents as per our policy.

The PIC will continue to audit care plans on a monthly basis and provide feedback to Nurses and CNMs in relation to actions required. The PIC will provide updates to the Group Director of Operations as part of the monthly operations meeting. Inclusion of residents and or families in care planning will be monitored within the audit going forward.

Proposed Timescale: 31-01-2019

Theme:

Safe care and support

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

Adequate assistance was not available which resulted in some meals getting cold. It was also noted that the tables were not laid in one dining area. nor were any trays or condiments in use. Drinks were not provided at the observed mealtime.

2. Action Required:

Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

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

On the second day of the inspection, at mealtime, an emergency occurred with a resident in another area of the home, resulting in less staff being available to support mealtime in the day room observed by the Inspector. That said, following the inspection it was decided to review mealtimes in consultation with our Kitchen Manager, and a new system of serving has been agreed so that mealtimes are approached in a more socially conducive manner with meal times to be available in two sittings. To support this initiative the home is investing in additional catering equipment, for this day room, and providing an additional table for drinks and condiments. This new initiative will provide staff with more than adequate time to provide assistance to residents at mealtime as required.

Mealtime audits and food survey audits are completed monthly to ensure residents and or their families have the opportunity to give feedback on the revised system.

Proposed Timescale: 31-12-2018

Theme:

Safe care and support

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

Adequate assistance was not available to residents at meal times.

3. Action Required:

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

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

As mentioned above, on the second day of the inspection, at mealtime, an emergency occurred with a resident in another area of the home, resulting in less staff being available to support mealtime in the day room observed by the Inspector. As we plan to introduce a two-meal time sitting arrangement, this new system of serving in this day room, will provide staff with more than adequate time to provide assistance to residents at mealtime as required.

Proposed Timescale: 31-12-2018

Theme:

Safe care and support

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

The system in place was that, when required, records were to be maintained of food and fluid intake. However, as identified also at the previous inspection, food and fluid intake records were incomplete.

4. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

The PIC and CNM have reviewed and communicated to staff the importance of recording foods and fluids and reminders are in place at handover. The PIC and CNMs will monitor this action and ensure records are complete and maintained.

Proposed Timescale: Completed 31.10.18

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Restrictive practice use was not consistently in line with national guidelines.

5. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

The PIC and the care team in the home, have been actively seeking to reduce the use of restraining bedrails in consultation and agreement from residents and families, and have made great strides in the area. A further full review has occurred with the OT and PIC on the 7th of November, and a plan of trialling a further reduction in bedrail and lap belt use by some residents has commenced, and will be ongoing. This will be carried out in consultation with the GP, and agreement from residents and families.

Proposed Timescale: 31-01-2019

Theme:

Safe care and support

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

Complete the process to ensure that all pensions are managed in line with national guidelines.

6. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

The PIC and Financial team reviewed the actions required and have completed all processes whereby pensions are managed in line with the National Guidelines.

Proposed Timescale: Completed 01.11.2018

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:

Improvement was required to ensure that all interactions resulted in a positive outcome for residents.

7. Action Required:

Under Regulation 09(2)(a) you are required to: Provide for resident's facilities for occupation and recreation.

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

A further review of the activities timetable will be carried out by the Social Care Leaders and feedback will be provided to the PIC. A more regular monthly meeting will occur between the Social Care Leaders and the CNM's/PIC to review and further develop resident activities where possible. Feedback from residents and families regarding activities, will be discussed at resident/family meetings.

Proposed Timescale: 31.12.2018

Theme:

Person-centred care and support

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

A staff member was seen putting clothes protectors on residents without asking their permission.

8. Action Required:

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

Ongoing staff communication and education regarding the importance of gaining consent from residents prior to using a clothing protector has been conveyed to all staff with reminders at handover and staff meetings. The CNM's are conducting a monthly audit of staff interaction in lounges during meal times, to achieve consistency.

Proposed Timescale: 30.11.2018

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:

Complaints addressed immediately were not logged.

9. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions

taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

The complaint that was identified by the Inspector was logged on the day with all appropriate actions taken. All complaints are logged as per our policy with monthly reviews as part of the governance meeting with the PPIM.

Proposed Timescale: Completed 01.11.2018

Theme:

Person-centred care and support

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

Some amendments were required to the policy in place. For example, it did not reference the nominated person to ensure that all complaints were appropriately responded to, as required by the regulations.

10. Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

The policy has been amended and includes the nominated person to deal with complaints.

Proposed Timescale: Completed 30.10.2018

Outcome 05: Suitable Staffing

Theme:

Workforce

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

One of four files reviewed did not have a satisfactory explanation for gaps in employment as required by the regulations.

11. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in

Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

The file identified by the inspector has been updated to comply with the regulations by PIC. The PIC will monitor files to ensure employment gaps have satisfactory explanations recorded.

Proposed Timescale: Completed 08.10.2018