**Health Information and Quality Authority**
**Regulation Directorate**

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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|---|---|
| **Centre name:** | Haven Bay Care Centre |
| **Centre ID:** | ORG-0000235 |
| **Centre address:** | Ballinacubby,<br>Kinsale,<br>Cork. |
| **Telephone number:** | 021 477 7328 |
| **Email address:** | helen.oregan@havenbay.ie |
| **Type of centre:** | A Nursing Home as per Health (Nursing Homes) Act 1990 |
| **Registered provider:** | Haven Bay Care Centre Limited |
| **Provider Nominee:** | Owen O'Brien |
| **Person in charge:** | Yvonne McCarthy |
| **Lead inspector:** | Geraldine Ryan |
| **Support inspector(s):** | Col Conway |
| **Type of inspection** | Unannounced |
| **Number of residents on the date of inspection:** | 71 |
| **Number of vacancies on the date of inspection:** | 1 |

## 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 inform a registration decision. 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: |
|---|---|
| 03 December 2013 08:30 | 03 December 2013 16:00 |
| 04 December 2013 08:25 | 04 December 2013 17:30 |

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

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| Outcome 01: Statement of Purpose |
| Outcome 02: Contract for the Provision of Services |
| Outcome 03: Suitable Person in Charge |
| Outcome 04: Records and documentation to be kept at a designated centre |
| Outcome 05: Absence of the person in charge |
| Outcome 06: Safeguarding and Safety |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Medication Management |
| Outcome 09: Notification of Incidents |
| Outcome 10: Reviewing and improving the quality and safety of care |
| Outcome 11: Health and Social Care Needs |
| Outcome 12: Safe and Suitable Premises |
| Outcome 13: Complaints procedures |
| Outcome 14: End of Life Care |
| Outcome 15: Food and Nutrition |
| Outcome 16: Residents Rights, Dignity and Consultation |
| Outcome 17: Residents clothing and personal property and possessions |
| Outcome 18: Suitable Staffing |

**Summary of findings from this inspection**

The purpose of this inspection was to inform a registration renewal decision, to monitor ongoing 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 and inspect premises based on the provider's application to vary condition seven of the registration by applying to increase of the bed capacity from 72 beds to 79 beds. The original complement of residential accommodation included 70 single bedrooms and one two-bedded room.

Inspectors noted that a warm, inclusive environment existed in the centre resulting in positive outcomes for the residents. Residents stated how happy they were in the

centre and were very complimentary of the care received. Relatives aired their satisfaction of the care their relatives received and of how they were kept informed and included in their relatives' care. Staff spoken with by the inspector exhibited an in-depth knowledgeable about the residents and their backgrounds and were observed caring for residents in a respectful manner while maintaining residents' privacy and dignity.

The actions generated from the inspection on 20 November and 21 November 2012 May 2013 were completed in a satisfactory manner.

As part of the inspection, inspectors met with residents, relatives and staff members. A number of relatives completed questionnaires prior to the inspection and the feedback was positive and complimentary in regard to all aspects of the service provided. The inspectors observed practices and reviewed documentation such as the statement of purpose, residents’ contracts of care, care plans, medical records, the menu, accident logs, complaints log, records of residents finances and personal belongings, policies and procedures and staff files.

On the day of inspection, the inspectors were satisfied that the nursing and other healthcare needs of residents were met.

The action plan at the end of this report identifies where some improvements are required to meet the requirements of the Regulations and the Authority's Standards.

**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:**
The statement of purpose consisted of a statement of the aims, objectives and ethos of the designated centre and a statement as to the facilities and services which were to be provided for residents. There was evidence that the statement of purpose was kept under review and readily available for residents and staff to read.

As per the conditions of the current registration certificate, the maximum number of residents to be accommodated in the centre was 72.

Inspectors noted, on the day of the re-registration inspection, that the ethos as described in the centre's statement of purpose was actively promoted by all staff.

**Outcome 02: Contract for the Provision of Services**
*Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.*

**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:**
The inspector reviewed a sample of the residents' contracts of care and noted that all were signed and dated by the resident or their representative within a month of admission. The contract set out the services to be provided. All fees relevant to care and accommodation were included in the contract. Details of any additional items that may incur an extra charge were included.

**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:**
Compliant

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

**Findings:**
The person in charge (PIC) was employed full-time and was a nurse with a minimum of three years experience in the area of nursing of the older person within the previous six years. The PIC demonstrated clinical knowledge to ensure suitable and safe care and was engaged in the governance, operational management and administration of the centre. There was a clearly defined management structure that identified the lines of authority and accountability.

Residents spoken with by the inspector were aware of who was in charge of the centre and voiced how kind and approachable the PIC was and that they could talk to her anytime. Residents' relatives spoke of the support they received from the PIC and stated that they could access her anytime. It was evident to the inspector that the PIC had in-depth knowledge of all residents and their care needs. The PIC displayed a commitment to the delivery of person-centred care. There was evidence that she had attended a comprehensive range of post graduate training to Masters level and provided in-house training to staff on, for example; dementia, advanced care directives, continence and the prevention of elder abuse.

Staff stated how they felt supported by the PIC and senior management and stated that they felt their opinions were valued.

Throughout the re-registration inspection the PIC demonstrated knowledge of the Regulations and the Authority's Standards. There was evidence of a number of projects, initiated by the PIC, which were either in progress or completed and evidence of how the outcomes enhanced the lives of the residents.

**Outcome 04: Records and documentation to be kept at a designated centre**
*The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).*

**Theme:**
Leadership, Governance and Management

**Judgement:**
Compliant

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

**Findings:**
Residents' records were completed in a satisfactory manner and were easy to retrieve.

The centre had an up to date directory of residents (Schedule 4).

A comprehensive record of all money or other valuables was maintained. This is captured under Outcome 6.

Inspectors reviewed a sample of residents' medical records (Regulation 25) and noted that all residents were regularly reviewed. Records pertinent to residents were kept secure but easily retrievable.

Inspectors reviewed the centre's operating policies and procedures and noted that the centre had policies as per the requirement of the Regulations. The centre-specific policies reflected the care given in the centre and informed staff with regard to up to date evidenced best practice or guidelines. Inspectors noted that not all information relating to residents was kept up to date in the residents' care plans. This is discussed further under Outcome 11.

The PIC informed the inspector that residents to whom records referred could access them.

Residents' records and general records were kept for not less than 7 years after the resident to whom they related to ceased to be a resident in the centre. The centre had an up to date policy in relations to the creation of, access to, retention of and destruction of records. Inspectors noted that records relating to inspections by other regulators (fire/food safety) were maintained.

Staff spoken to by the inspector were aware of the polices and were involved in policy development and review. There was evidence that this was discussed at staff meetings.

There was evidence that the centre was adequately insured against accidents or injury to residents, staff and visitors and the provider ensured that out-sourced providers were appropriately insured. Insurance cover was in place against loss or damage to the assets and delivery of the service and against loss or damage to residents' property.

The PIC was aware of the records that must be maintained by the centre and there was evidence that records were regularly audited for completeness and accuracy.

Residents spoken to by the inspector were aware of records maintained about them and knew they could access them at any time.

**Outcome 05: Absence of the person in charge**
*The Chief Inspector is notified of the proposed absence of the person in charge from the designed 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:**
There were suitable arrangements in place for the management of the designated centre in the absence of the PIC. The PIC informed the inspector that a key senior manager was the identified person to act as PIC in the event that she may be absent and was aware of her responsibility to inform the Authority of any absence in the event of an emergency or for 28 days or more.

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

**Findings:**
The centre had an up-to-date policy on, and procedures in place for, the prevention, detection and response to abuse which staff were trained on. Staff spoken to by the inspector knew what constituted abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse. Staff were clear whom to report any incidents to and voiced how they would not hesitate to report any concerns they may have in relation to the safety of the residents and quality of the service.

The provider and PIC monitored the systems in place to protect residents and ensured that there were no barriers to staff or residents disclosing abuse. It was evident that senior management promoted a culture of quality and safety by ensuring that all staff in the service had a responsibility to manage risk to ensure the safety of the residents.

Residents informed the inspector that they felt safe in the centre.

Procedures were in place to ensure that incidents were appropriately investigated and responded to in line with the centre's policy. There was evidence that senior management had applied these procedures in a timely manner, within the last 12 months. A clear pathway of the procedures employed concurred with the centre's policy. However, more attention was required to ensure that the follow up meetings in regard to disciplinary issues and the conclusions of such issues were formally documented.

The operations manager informed inspectors that the centre acted as a pension agent for two residents. An inspector reviewed the records and found that any funds retained on behalf of residents were properly accounted for. Dual signatories were evident on all financial lodgements or withdrawals. The centre had a policy with regard to safeguarding resident's finances.

**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 - Minor

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

**Findings:**
The centre had policies and procedures relating to health and safety. There was an up-to-date health and safety statement.

There were procedures in place for the prevention and control of infection. Alcohol hand gels, disposable gloves and aprons (unobtrusively placed in designated white wall

mounted presses), were appropriately located. Staff were observed availing of protective equipment (PPE) when engaging in personal care or housekeeping practices and were observed using sanitising hand gel in a manner that complied with best practice. Staff adhered to the centre's dress code.

Clinical waste and containers for used sharps and needles were stored in a secure manner and the inspector saw evidence of an arrangement in place for the collection of clinical waste by an approved external agency.

The inspector spoke with the housekeeping supervisor. She was very knowledgeable in regard to procedures on cleaning residents' bedrooms and en suites. A colour coded cleaning system was in use. Inspectors noted that the levels of cleanliness and housekeeping, decor and furnishings were of a high standard. Ample supplies of wall mounted graduated dispensers for cleaning products were available. Schedules of cleaning were available and were regularly updated. Deep cleaning schedules ran in tandem with the daily cleaning. A schedule of updating decor, painting and refurbishment was ongoing.

The inspector reviewed the risk management policy and noted that it covered the identification and management of risks (as specified in Regulation 31), the measures in place to control risks and arrangements for identification, recording, investigation and learning from serious incidents. The risk register was up to date and identified, assessed and outlined the management of clinical and environmental risks. However, while assessments for residents on whom a particular type of restraint was used had been completed, risk assessments on residents who availed of the use of bedrails as an enabler were not up to date.

There were arrangements in place for investigating and learning from serious incidents/adverse events involving residents. The PIC stated that incidents were discussed at staff meetings, handover reports and management meetings and clinical review meetings. Documented audits reviewed by an inspector supported this. The centre had an up-to-date policy with regard to these arrangements.

The inspector viewed the emergency plan and noted that there were arrangements in place for responding to emergencies and a location identified for safe placement of residents, in the event of an evacuation.

The inspector noted that reasonable measures were in place to prevent accidents (hand-rails, grab rails, safe floor covering). A functioning call-bell was in operation.

The centre had an in-house trainer/facilitator on the principles of safe hoisting, the potential risks involved and on how to use each specific piece of hoisting equipment. There was evidence that staff had attended this training. The inspectors observed staff applying correct manual handling techniques while attending to residents who availed of the use of a standing hoist. There was evidence that manual handling equipment was serviced by a suitably qualified external contractor and regularly cleaned.

Records reviewed by the inspector indicated that the fire alarm was serviced on a quarterly basis, fire safety equipment was serviced on an annual basis and fire drills took

place on a six monthly basis. There was evidence of arrangements in place for reviewing fire precautions which included the alarm panel, the fire exits and the testing of fire equipment. Fire records were kept which included details of fire drills/ fire alarm tests/ number, type and maintenance of fire-fighting equipment.

Inspectors noted that one exit was partially impeded by exercise equipment. This was immediately addressed by the provider. All other fire exits were unobstructed. A procedure for the safe evacuation of residents and staff in the event of fire was prominently displayed throughout the centre. Staff spoken to by the inspector were aware of what to do in the event of a fire and were aware of the identified fire exits.

An external smoking conservatory had been constructed since the last inspection of 20 November and 21 November 2013. It was suitably furnished with flame retardant seating, a stainless steel cigarette bin, a fire extinguisher, a fire apron and blanket. Another seated uncovered smoking area, circumvented by a glazed windbreaker, was adjacent the smoking conservatory. A wall mounted cigarette lighter was located in this area. The centre currently had three residents who smoked and there was evidence of robust risk assessments being carried out. The centre is aspiring to being smoking free by March 2014. Three staff had attended a seminar of interventions for smoking cessation on 6 November 2013. A smoking group, whose membership included a resident, had been established. An active smoking cessation programme was currently in place for residents and staff. This programme included:
• the use of nicotine free cigarettes
• the availability of alternative therapies to residents and staff
• promotion of physical activity.

A visitor's sign in/out book was readily accessible at the front door. There was evidence that persons entering and leaving the centre signed the book.

**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 - Minor

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

**Findings:**
The inspector noted that there were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Staff wore red tabards indicating that they were not to be disturbed while administering medications. Staff were observed adhering to appropriate medication management practices.

A comprehensive system of ongoing audit and analysis was in place for reviewing and monitoring safe medication management practices. A clinical nurse manager was assigned this role.

The inspector reviewed a number of medication prescription charts and noted that all included the resident's photo, date of birth, general practitioner (GP) and details of any allergy. Medications administered crushed to residents were signed off by the resident's GP. The use of a medication communication sheet provided staff with up to date information with regard to recent changes to residents' medication.

Some residents were prescribed a medication that necessitated the measurement of a resident's pulse prior to the administration of the medication. It was evident that staff were recording the observation prior to administration of the medication.

There was documentary evidence on residents' medical notes that indicated that residents' medication was reviewed by the GP on a three-monthly basis and as required.

There was evidence of ongoing review of residents prescribed psychotropic medications and of how the combined approach of the GP and the nursing staff resulted in residents' medications being decreased or discontinued.

The processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation. There was a facility in place for the safe storage of scheduled controlled drugs. The inspector reviewed the controlled drug register and carried out a spot check on the controlled drugs (MDAs) and found that the totals matched.

The controlled drugs were stored in a designated locked cabinet. The centre engaged the services of an external pharmacy to dispense a pre-packaged monitored dosage system for administration of medications to residents.

There were appropriate procedures for the handling and disposal for unused and out of date medicines and the documenting of same. While an inspector saw evidence of secure storage of unused medication, records of unused/discontinued medications that were returned to the external pharmacy supplied were not maintained on one floor. This practice did not concur with the centre's policy. The PIC stated, and the inspector noted, that the in-house audit of November 2013 highlighted this non compliance. A pharmacy returns book was now being located on each floor.

Fridges containing medications were located in secure clinical rooms. There was evidence that the temperature of the fridge was monitored daily and that the fridges contained medication only.

The medication administration trolleys were securely locked via the security chains provided.

No resident currently self administered medication. Residents could be responsible for their own medication following an appropriate assessment.

The policy included protocols to guide staff in the transcription of medications. All transcribed entries reviewed were co-signed and dated. However, on one floor only, it was not clear as to which chart nurses were transcribing from as previously dated charts were not archived. This was immediately addressed by the PIC.

**Outcome 09: Notification of Incidents**
*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**
Safe 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:**
A record of all incidents occurring in the designated centre was maintained. The inspector noted that while all notifiable incidents were forwarded to the Chief Inspector, some relating to staff issues, were not forwarded within the time stipulated by the Chief Inspector. The PIC gave an undertaking to address this and subsequent to the inspection forwarded the required notifications to the Authority.

A quarterly report was provided on two occasions to date in 2013 to the Authority to notify the Chief Inspector of any incident which did not involve personal injury to a resident and where there had been no such incidents, a 'nil' return was made under Section 65 of the Health Act 2007.

The inspector reviewed the accident/incident book and noted that the records concurred with the notifications forwarded to the Authority. There was evidence of rigorous audit and follow up of incidents, medical review where appropriate, review of medications and analysis of falls.

**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:**
Compliant

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

**Findings:**
There was an across-the-board system of audit in place, capturing all departments, to review and monitor the quality and safety of care and the quality of life of residents. There was evidence that resources were allocated to activities that promoted quality and safety. For example; the in-house nutritionist, supernumerary for three months, was tasked to research, review and implement a nutritional management plan for all residents and guidance/education for staff.

Satisfaction surveys were carried out on a regular basis with the most recent survey carried out in November 2013. Thirty responses were returned indicating that 93% of respondents were either satisfied or very satisfied with care. Relatives' questionnaires reflected a high satisfaction with care their relatives received in the centre. There was evidence that residents' meetings were convened on a regular basis. Minutes reflected that a broad range of topics were tabled and discussed.

Other reviews of clinical quality indicators included pressure ulcers, falls, the use of psychotropic medications, bed rails, medication management and administration, the assessment of risk and health and safety. There was evidence that audit findings were communicated to staff in the staff meetings.

An audit of infection control practices included a review of the environment, the use of personal protective equipment (PPE), hand-washing, waste management and equipment. There was evidence of the generation of a report, inclusive of findings and an action plan. There were records and findings of random checks of staffs' hands post hand washing by means of an ultra violet lamp.

On foot of the previous inspection of 20 November 2013 and 21 November 2013, a comprehensive review of the Armada unit was referred to an external consultant. The final report outlined recommendations on the environment, activities, staff training, routines and expectations. Inspectors noted that recommendations were actioned resulting in positive changes. The actioned recommendations included:
• increasing staff hours allocated to the unit
• the unit is staffed by the same cohort of staff
• the use of softer colour schemes
• local shop fronts recreated on corridor walls
• residents' bedroom doors painted the same colour as their door at home
• installation of windows, reducing the height of the external walls by three metres, resulting in increased natural light
• the development of the 'old shop' with familiar branded goods, sweet jars and tins reminiscent of a particular era.

An audit on person centred care in relation to dementia care in the Armada suite was undertaken in July 2013.

Residents spoken to by the inspector stated that they could ask any staff member for

anything they may need and there was evidence of consultation with residents and their representatives.

**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 - Minor

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

**Findings:**
Inspectors reviewed a sample of residents' care plans and found that residents had timely access to GP services and appropriate treatment and therapies. There was evidence that residents had access to allied health care services which reflected their diverse needs. Records were maintained of all referrals and follow-up appointments. Of the care plans reviewed by the inspectors it was evident that the assessment/care planning processes and clinical care accorded with evidence based practice. While there was evidence that the care delivered encouraged the prevention and early detection of ill health and enabled residents to make healthy living choices, there was evidence that care and/or treatments recommended by the dentist or the in-house nutritionist were not always captured in the resident's care plan. Clinical risk assessments, using recognised tools, were carried out on residents. The PIC and staff informed the inspector that oral care was routinely attended to but accepted that this information was not always captured in the residents' care plan or in the computerised nurses' record.

It was evident that the residents' care plans were reviewed three monthly and it was apparent that this review was done in consultation with residents and/or their relatives.

Care planning was in a period of transition. The PIC informed inspectors that an audit review of the centre's care planning resulted in the undertaking of a quality improvement project to introduce a new care planning system and reduce duplication of information. To advance this project, external advice and education had been sought. Care plans were available to residents. Each resident had a care plan detailing their individual needs and choices. There was evidence that consent to treatment was obtained from residents and the residents' right to refuse treatment respected and documented. This concurred with the centre's policy.

There was evidence that processes were in place to ensure that when residents were admitted, transferred or discharged, relevant and appropriate information about their care and treatment was shared between providers and services. A pre-admission assessment is carried out on each prospective resident.

An inspector attended the mid morning handover attended by two staff nurses and four health care assistants (HCAs). The staff nurse chairing the report was establishing with the HCAs, the nutritional and fluid intake of residents and the status of the delivery of personal care. Clear guidance, including a focus of priorities, was given to the HCAs by the staff nurses. All staff were observed actively engaging and participating in the meeting. The CNM informed the inspector that each staff nurse was allocated a number of residents. There was documented evidence of a daily nursing record capturing up to date clinical care and medical review and of a daily flow sheet capturing the activities of daily living, completed for all residents.

While assessments for residents on whom a particular type of restraint was used had been completed, risk assessments on residents who availed of the use of bedrails as an enabler were not up to date. This was captured under outcome 7. The PIC stated that a restraint free environment was being actively promoted in the centre and that the use of bedrail was considerably reduced to 9% (7 residents). The PIC had provided residents with a variety of alternatives such as low-low beds, crash mats, sensor mats and falls sensor beams. A falls management programme was evident. The inspector reviewed the care plans of residents on whom restraint was used. There was documented evidence to reflect that consent was sought for the use of restraint and evidence of checks of residents on whom restraint was used.

There was evidence that clinical observations were recorded and that residents were weighed monthly.

It was evident that residents had opportunities to participate in activities that were meaningful and purposeful to them and that suited their needs, interests, and capacities. A range of activities were facilitated, for example, newspapers, prayers/mass, live music sessions, exercises, Sonas activities, hairdressing, movies, crosswords, outings, arts and crafts, cookery. An activities coordinator organised concurrent activities on all floors over the seven days of the week. Residents informed the inspector that they enjoyed the music. A computer was available for residents' use. On day one of inspection, some local musicians hosted an impromptu session for the residents. A bread baking session was facilitated for the residents on the Armada suite. This bread was served at evening tea.

Staff spoken with by the inspector were very knowledgeable about residents' health and social care needs. A number of residents spoken to by the inspector related that they had lived in the centre for a length of time and stated that they were very happy with the care they received.

The centre promoted continence programmes and staff had received training on the assessment of incontinence wear to ensure that residents benefited from the correct incontinence wear.

The centre had a policy on challenging behaviour. It comprehensively guided and informed staff on evidence-based best practice and guidelines. While staff training records indicated that staff had attended regular training in how to manage episodes of challenging behaviour, there was evidence that one staff member did not comply with the centre's policy in this matter. Further training was organised for this staff member.

The inspector reviewed the incident book and the residents' care plans and noted that residents who sustained a fall (witnessed or unwitnessed) were observed and reviewed and neurological observations were carried out. There was evidence that residents who sustained falls were medically reviewed in a timely manner.

It was evident that residents who experienced dysphagia (difficulty in swallowing) had care plans tailored to their particular needs and had been assessed by the speech and language therapist (SALT) and the in-house nutritionist.

The inspector reviewed the care plans of residents who smoked and there was evidence that the care plan was done in consultation with the resident and/or their relative. The residents were assessed as to whether or not they required supervision while smoking. Residents who smoked, did so in a designated external covered conservatory or in the uncovered designated area. Staff were able to view the smoking area and were aware if residents were availing of the smoking areas. Residents had access to a call bell in this area and appropriate fire equipment was conveniently located.

The privacy, dignity and confidentiality of all residents were safeguarded in that information and documentation pertinent to residents was stored in a safe manner.

**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:**
Compliant

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

**Findings:**
The provider, in his submission for re registration of the centre had included an application to increase the bed complement from 72 to 79 beds. Refurbishment within the current building included reorganising the layout by relocating some rooms, the conversion of other rooms and reducing the open space in the reception. This would

result in changes outlined below.

Ground floor:
• a single room (room 62) with full en suite facilities
• converting an unused lounge (room 64) to a two bedded room with full en suite facilities
• converting another room (room 63) to a two bedded room with full en suite facilities

Armada suite:
• converting a single bedroom with full en suite facilities in the Armada suite to a two bedded room with a wash hand basin
• converting a single bedroom with full en suite facilities to a two bedded room with full en suite facilities.
This proposal was discussed with the provider at the feedback meeting held at the end of day two of the re registration inspection.

The premises and grounds were well-maintained. Appropriate lighting and ventilation were provided. Inspectors noted that the premises and grounds were free from significant hazards.

The centre was warm and comfortable and suitably decorated. An under-floor heating system was in operation. Housekeeping was of a high standard. The size and layout of the current bedrooms occupied by the residents were suitable to meet the needs of residents. A sufficient number of toilets, bathrooms and showers and an assisted bathroom were provided. Notwithstanding the provider's application to increase occupancy, the floor space available in each bedroom currently accommodating residents, met the requirements of the Authority's Standards.

Residents had access to appropriate equipment which promoted their independence and comfort. Specialised assistive equipment or furniture that residents may require, were provided. For example, assisted hoists with designated slings, wheelchairs, alarm mats and cushions, specialist beds and mattresses, respiratory equipment and a computer.

Residents had access to a number of gardens inclusive of walkways, water features, raised gardens and seating/tables.

A functioning call bell system was in place and call bells were appropriately located throughout the centre.

The centre had a separate main kitchen complete with cooking facilities, equipment, dry stores, cold rooms and shelving. Catering staff had designated changing and toilet facilities. Appropriate personal protective equipment (PPE) was available to staff in the annex prior to entering the main kitchen. Catering staff distributed meals by means of a serving hatch from the main kitchen to the main dining room on the ground floor. Staff served the meals to residents. Meals for the Armada suite and the first floor were transported via hot trolleys. Kitchenette facilities were available on the other two floors.

Aside from the provider's application to increase the bedroom capacity and reorganise other bedrooms, the current design and layout of the premises is suitable for the 72

residents accommodated in the centre.

**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 - Minor

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

**Findings:**
There was evidence that a comprehensive record of complaints (from residents and staff) was maintained, including the details of the complaint, the results of any investigations, any actions taken. However, it was not always apparent if the complainant was satisfied with the outcome of the complaint. The centre had an up-to-date policy and procedure for the management of complaints. The complaints procedure was displayed in a prominent place and a copy was included in the Resident's Guide and the resident's contract of care. There was a nominated person to deal with complaints and the PIC was the nominated person to ensure that all complaints were appropriately responded to. The advocate was the named independent appeals person. Residents and relatives spoken with by inspectors stated that they could raise any issue or concern with the PIC or staff member.

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

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

**Judgement:**
Compliant

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

**Findings:**
The inspector reviewed the centre's up-to-date policy on end-of-life care. Information to guide staff through the different stages in end-of-life care was laid out in an orderly manner.

The PIC stated that the implementation of advanced care directives for residents' care at this time was in progress with 24 plans completed to date. The inspector reviewed a sample residents care plans with regard to end-of-life care and noted that they comprehensively captured residents' preferences at this time. All information was accessible to staff.

Residents who spoke to the inspector spoke in a positive manner with regard to their care. Most residents stated that in the event they became very unwell, they would prefer to be cared for in the centre. This information was reflected in the residents' end-of-life care plans.

Staff training records indicated that staff had attended training on palliative care issues inclusive of spiritual care, psychological issues, pain management, communication and comforting the bereaved with dignity at end of life. Training was facilitated internally and externally. Staff, when required, received training from the staff of the local hospice team, on the use of a syringe driver (a mechanical pump used to administer medications) in symptom management. The PIC stated that the centre was well supported by the specialist team from the local hospice. Records reviewed evidenced this and it was evident that relatives were appropriately involved and informed.

Religious and cultural practices were facilitated. Residents had the opportunity to attend religious services held in the centre and had access to Ministers from a range of religious denominations.

There was evidence in residents' care plans that residents had choice as to the place of death. The majority of bedroom accommodation in the centre comprised single bedrooms.

Sitting rooms were available for family and friends to use as an overnight facility at this time. Facilities were provided for relatives to have refreshments and snacks. Open visiting was facilitated.

The inspector reviewed a sample of care plans of deceased residents and noted that the residents were regularly reviewed by the general practitioner (GP), the out-of-hours service and specialist services. There was evidence that medication management was regularly reviewed and closely monitored by the GP. It was evident that residents received care at the end of his/her life which met his/her physical, emotional, social and spiritual needs.

The centre used the Hospice friendly Hospitals (HfH) practice of the end-of-life symbol. A remembrance service was held annually.

The PIC stated that upon the death of a resident, his/her family or representatives were offered practical information (verbally) and on what to do following the death of their relative. An information booklet on how to access bereavement and counselling services was planned.

There was a protocol for the return of personal possessions. Samples of residents'

inventories of personal property were reviewed. All inventories were up to date and signed by the resident, where possible.

**Outcome 15: Food and Nutrition**
*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*

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

**Judgement:**
Compliant

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

**Findings:**
The centre had up-to-date policies on food and nutrition. A record of staff training submitted to the Authority indicated that staff had attended a broad range of training and that in-house education sessions were ongoing.

Inspectors observed mealtimes including breakfast, mid morning refreshments and lunch. Residents had the option of having their breakfast served in bed, in the dining rooms or at their bedside and at a time of their choosing. Snacks and hot and cold drinks including juices and fresh drinking water were readily available throughout the day. The inspector noted that staff levels were adequate to meet the needs of the residents during mealtimes. Residents having their meals were appropriately assisted and received their meal in a timely manner. A trolley offering light snacks was available throughout the day. This menu included snacks, yogurts, fruits, crackers, biscuits, juices, puddings, sandwiches. Smoothies were served daily.

Assistive cutlery or crockery required for a resident with reduced dexterity was available. There was evidence that residents were reviewed by an occupational therapist.

The inspector reviewed records of resident meetings and the residents were very complementary of the food on offer in the centre.

The inspector met with the head chef who confirmed that he met with the in-house nutritionist, also a senior staff nurse, and received an update of the current status of the residents pertinent to their nutrition. This was aided by the discreet use of colour coded plates for meals to alert staff to a concern pertinent to a resident's nutritional status. An up to date folder of diets, dietary requirements to guide staff, was available to staff. The chef met with all residents new to the centre. The dining experience was currently being audited. Food safety training for staff was in progress. A seasonal menu was on offer.

There was evidence that menus, food choices and preferences, residents experiencing

weight loss/gain were discussed and that this information informed residents' care plans. Staff had in-depth knowledge of residents' likes and dislikes and particular dietary requirements. Residents had input into the menu of offer. There was evidence that ample choice was available to residents for breakfast, lunch and evening tea. The breakfast choice included a variety of hot and cold cereals, hot breakfast option, breads, juices and fruits. Residents confirmed that a staff member came around daily informing them what was on the menu and confirmed that they had a choice. There was evidence that the chef sought feedback from the residents with regard to the meals served. Staff also had the option of putting up on a computer shared drive comments/suggestions from residents regarding the menu. The chef checked this on a daily basis.

A sample of medication administration charts reviewed evidenced that nutritional supplements prescribed by the GP for residents were administered accordingly.

Breakfast was served to residents from 7.30am onwards or at a time of the resident's choosing. Dining tables were attractively presented and inclusive of good quality delph and cutlery. The dining tables were adorned with centrepieces with a marine theme, glassware and serviettes. The breakfast club was located on the first floor and residents from all floors had the option of joining.

Lunch was served from 12.30pm onwards. The inspector noted that lunch, in sufficient portions, was served on hot plates and presented in an appetising manner. Gravies/sauces were served separately. Staff informed the inspector that residents could choose to have their meal in the dining room or in their room. On the day of the inspection, most residents dined in the dining rooms. Residents voiced how they enjoyed the lunch. Choices of desserts were served from a dessert trolley. Staff were observed assisting residents, particularly residents with a cognitive impairment, in a sensitive and discreet manner. Meal times were unhurried social occasions and staff were observed using the mealtimes as an opportunity to communicate and interact with residents. The inspector noted staff describing the meal to residents and asking residents if they wished to wear protective attire.

All residents' dining rooms were bright, spacious, appropriately decorated and had quiet sitting areas furnished with comfortable furniture, lamps and bookshelves. Inspectors noted that the residents' dining experience in each of the dining rooms, while different, was a relaxed and social occasion, with background music playing in one of the dining rooms.

Evening tea was served from approximately 4.30pm.

The inspector was informed by staff that the residents had access to speech and language therapy services and occupational therapy and there was evidence of this in residents' care plans.

There was evidence that residents had a MUST assessment on admission and monthly thereafter. Staff, spoken to by the inspector, were familiar with how to assess and use the tool. There was evidence that staff completed a daily record of residents' nutritional and fluid intake/output in the care planning system.

Residents' weights were recorded monthly or more often and it was evident that the documentation of a weight loss/gain prompted an intervention once a concern was identified including the commencement of food and fluid charts.

Residents with diabetes had a care plan guiding their care. The inspector noted information in residents' care plans regarding the recording of blood sugars and corresponding documentation of this information in residents' progress nursing notes.

Care planning, with regard to residents who experienced a weight loss/gain was comprehensive. There was evidence that residents' clinical risk assessments informed residents' care planning.

The inspector spoke with the in-house nutritionist/senior staff nurse, who described how the nutritional management progress evolved to date. It was now planned that a representative from each floor would lead on the dining experience and be part of a wider review group. The nutritionist regularly reviewed the menu on offer and checked that residents received a nutritious and varied diet and ensured that alternative options were available on request. There was evidence that specific diets, incorporating therapeutic and modified consistency diets, were facilitated and there was evidence of this information in residents' care plans. The inspector noted that a HCA ensured that residents were served what they ordered and that residents with particular dietary requirements received the appropriate meal.

There was evidence that suggestions arising from the residents' meetings regarding food were addressed. This is described in more detail under Outcome 16.

**Outcome 16: Residents Rights, Dignity and Consultation**
*Residents are consulted with and participate in the organisation of the centre. Each residents privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.*

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

**Judgement:**
Compliant

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

**Findings:**
There was evidence that residents were consulted about how the centre was run. Residents meetings, chaired by an independent person, were held monthly with an average of 20 attendees at each meeting. On reviewing the minutes it was clear that a variety of topics were tabled, discussed and actioned. The PIC stated that she met with residents and relatives on a daily basis. The inspector observed the PIC and staff

interacting with residents and relatives. It was evident that residents received care in a dignified way that respected their privacy at all times. Residents had access to a telephone facility and a computer. Televisions were located in all bedrooms, sitting rooms and reception areas. A quiet sitting room/library areas, an oratory were available to residents. Information on local events was evident. The inspector noted a notice informing residents and visitors that there were no restrictions on visits except when requested by the resident or when the visit or timing of the visit was deemed to pose a risk.

**Outcome 17: Residents clothing and personal property and possessions**
*Adequate space is provided for residents personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*

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

**Judgement:**
Compliant

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

**Findings:**
The centre had a policy on residents' personal property and possessions; it included a reference that inventories of residents' personal belongings were regularly recorded. Evidence indicated that this was the practice in the centre.

Residents could retain control over their own possessions and clothing.

There were adequate laundry facilities with systems in place to ensure that residents' own clothes were returned to them.

**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 - Minor

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

**Findings:**
The action from the previous inspection related to staff files. The inspector reviewed a sample of staff files and observed that the regulatory requirements had been met.

There were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times. Staffing levels took into account the statement of purpose and size and layout of the building.

There was an actual and planned staff rota which indicated that staff nurses were on duty at all times. Staff nurse and care assistant hours had been increased since the most recent inspection of 20 November and 21 November 2012.

Staff had access to a comprehensive range of education and training which enabled them to provide care that reflected contemporary evidence based practice. Education and training provided reflected the statement of purpose. The inspector noted evidence of opportunities for further training advertised in the centre.

Staff stated that they felt competent to deliver care and support to residents because of the learning from attending education days and the in-house training.

Staff were aware of policies and procedures related to the general welfare and protection of residents and there was evidence that staff had read the centre's policies and procedures. They were also aware of the Regulations and the Authority's Standards and were supervised appropriate to their role.

There was evidence of effective recruitment procedures that included checking and recording all required information. However, some gaps were noted in the employment records of two staff.

All relevant members of staff had an up-to-date registration with a relevant professional body.

## 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:*

Geraldine Ryan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | Haven Bay Care Centre |
| **Centre ID:** | ORG-0000235 |
| **Date of inspection:** | 03/12/2013 |
| **Date of response:** | 09/01/2014 |

## 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 06: Safeguarding and Safety

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
More attention is required to ensure that the follow up meetings in regard to disciplinary issues and the conclusions of such issues are formally documented.

**Action Required:**
Under Regulation 6 (1) (a) you are required to: Put in place all reasonable measures to protect each resident from all forms of abuse.

**Please state the actions you have taken or are planning to take:**
These issues are now formally documented at management meetings.

**Proposed Timescale:** 09/01/2014

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

| Outcome 07: Health and Safety and Risk Management |
| --- |
| **Theme:** Safe Care and Support<br><br>**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**<br>While the centre had a comprehensive assessment of clinical risks, risk assessments on some residents who availed of the use of bedrails as an enabler, were not up to date.<br><br>**Action Required:**<br>Under Regulation 31 (2) (a) and (b) you are required to: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.<br><br>**Please state the actions you have taken or are planning to take:**<br>The existing care plan committee will also review clinical risks assessments. Residents who have requested the use of bedrails as an enabler will be reviewed every 3 months. |
| **Proposed Timescale:** 28/02/2014 |

| Outcome 08: Medication Management |
| --- |
| **Theme:** Safe Care and Support<br><br>**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**<br>Records of unused/discontinued medications that were returned to the external pharmacy supplied were not maintained on one floor.<br><br>**Action Required:**<br>Under Regulation 33 (2) you are required to: Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.<br><br>**Please state the actions you have taken or are planning to take:**<br>Medications from all floors being returned to pharmacy will be documented. |
| **Proposed Timescale:** 28/02/2014 |

## Outcome 09: Notification of Incidents

**Theme:** Safe Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some notifications relating to staff issues were not forwarded to the Authority, within the time stipulated by the Chief Inspector.

**Action Required:**
Under Regulation 36 (2) (f) you are required to: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation of misconduct by the registered provider or any person who works in the designated centre.

**Please state the actions you have taken or are planning to take:**
Administration to ensure that Notifications will be forwarded to HIQA within the stipulated timeframe.

**Proposed Timescale:** 09/01/2014

## Outcome 11: Health and Social Care Needs

**Theme:** Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Care and/or treatments recommended by the dentist or the in-house nutritionist were not always captured in the resident's care plan.

**Action Required:**
Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

**Please state the actions you have taken or are planning to take:**
The care plan committee are currently revising care plans. This will incorporate multi disciplinary recommendations. Revised personal care plans are being trialled.

**Proposed Timescale:** 09/01/2014

| Outcome 13: Complaints procedures |
| --- |
| **Theme:** Person-centred care and support<br><br>**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**<br>It was not always apparent if the complainant was satisfied with the outcome of the complaint.<br><br>**Action Required:**<br>Under Regulation 39 (8) you are required to: Inform complainants promptly of the outcome of their complaints and details of the appeals process.<br><br>**Please state the actions you have taken or are planning to take:**<br>Complainant's satisfaction will be recorded. |
| **Proposed Timescale:** 09/01/2014 |

| Outcome 18: Suitable Staffing |
| --- |
| **Theme:** Workforce<br><br>**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**<br>Staff records were reviewed and some gaps were noted in the employment records of two staff.<br><br>**Action Required:**<br>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.<br><br>**Please state the actions you have taken or are planning to take:**<br>There are now no gaps in the two staff members' employment records. |
| **Proposed Timescale:** 09/01/2014 |