Unannounced Care Inspection Report
23 January 2018

Shaftesbury Mews

Type of Service: Nursing Home (NH)
Address: 646 Shore Road, Newtownabbey, BT37 0PR
Tel No: 028 9085 5888
Inspector: Michael Lavelle

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care for up to 18 persons.

3.0 Service details

Organisation/Registered Provider: Parkcare Homes No2 Ltd **Responsible Individual:** Nicola Cooper	**Registered Manager:** No manager currently registered
Person in charge at the time of inspection: Anne McLellan, deputy manager	**Date manager registered** Michelle Montgomery, no application received
Categories of care: Nursing Home (NH) LD – Learning disability LD(E) – Learning disability – over 65 years	**Number of registered places:** 18 comprising: A maximum of 6 patients to be accommodated in each of the 3 bungalows

4.0 Inspection summary

An unannounced inspection took place on 23 January 2018 from 09.20 to 18.25 hours.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staffing, staff recruitment, the home's environment, communication between residents, staff and other key stakeholders, dignity and privacy and activities.

Areas requiring improvement were identified in relation to competency and capability assessment, training, infection prevention and control, supplementary care records, medicines management, post fall management, duty rotas and governance arrangements.

Patients described living in the home in positive terms. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

As a consequence of the issues identified during the inspection, the registered person was invited to attend a meeting at RQIA to discuss the concerns identified. At this meeting on 30 January 2018 the registered person provided RQIA with an action plan and assurances that Shaftesbury Mews is operating in accordance with RQIA requirements.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	5	*4

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Michelle Montgomery, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Concerns were raised in relation to the areas for improvement identified. The findings were discussed with senior management in RQIA, following which a decision was taken to hold a concerns meeting in RQIA on 30 January 2018. At this meeting the registered person acknowledged the failings and provided an action plan as to how the concerns, raised at the inspection, would be addressed by management. RQIA were provided with the appropriate assurances and the decision was made to take no enforcement action at this time.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent inspection dated 1 August 2017

The most recent inspection of the home was an announced medicines management inspection undertaken on 1 August 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection the inspector met with three patients and 13 staff. Questionnaires were left in the home to obtain feedback from patients and patients' relatives. A poster was also displayed for staff inviting them to provide online feedback to RQIA.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- duty rota for all staff from week commencing 15 January 2018 to 28 January 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- three patient care records
- a selection of patient care charts including food and fluid intake charts and elimination charts
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

The area for improvement identified at the last care inspection was reviewed and assessment of compliance recorded as partially met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 1 August 2017

The most recent inspection of the home was an announced medicines management inspection. One area for improvement was identified.

This QIP will be validated by the medicine management inspector at the next medicines management inspection.

6.2 Review of areas for improvement from the last care inspection dated 6 June 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 22 **Stated:** First time	The registered person shall ensure that falls prevention is managed in accordance with the DHSSPS, Care Standards for Nursing Homes, 2015.	**Partially met**
	Discussion with the manager evidenced a new falls risk assessment pathway is due to be introduced to the home. Review of a selection of completed risk assessments demonstrated these were well completed. However, review of the most recent fall in the home evidenced a post falls risk assessment was not completed within 24 hours. This was not in keeping with best practice guidance and the care standards. This area for improvement is now stated for a second time.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The acting manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from week commencing 15 January 2018 to 28 January 2018 evidenced that the planned staffing levels were adhered to. Discussion with staff evidenced that they had no concerns regarding staffing levels. Discussion with the manager and review of records evidenced that dependency levels were kept under review to determine staffing requirements. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The deputy manager confirmed they were in charge of the home at the time of the inspection. Review of induction records and further discussion with the deputy manager evidenced they had not completed their induction or a satisfactory competency and capability assessment to be in charge of the home in the absence of the manager. On the manager's return this was discussed and arrangements were made to ensure the home was appropriately managed in the manager's absence. This has been identified as an area for improvement under the regulations.

Staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. An agency staff induction file was reviewed; examination of this evidenced a robust system of oversight and orientation to the home.

The manager has recently reviewed staff supervision and appraisal records. Review of these records and discussion with the manager evidenced that monthly supervisions are planned.

Review of the training matrix/schedule for 2017/18 indicated that training was partially completed. However, review of recent correspondence with the manager evidenced training was planned to ensure that mandatory training requirements were met. Staff spoken with expressed difficulty in accessing online training. Discussion with the manager and review of training records evidenced that a system had been introduced to ensure staff complete mandatory training; provision has been made to purchase additional computers for the home to assist staff to meet their training needs online.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. However, discussion with a one support worker evidenced they were preparing meals for patients and lacked knowledge and training in food hygiene. This was discussed with the deputy manager and identified as an area for improvement under the regulations.

Discussion with the manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The manager and staff spoken with, clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns.

Discussion with the manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last care inspection confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Staff spoken with were complimentary in respect of the home's environment.

Infection prevention and control measures were generally well adhered to and equipment was appropriately stored. However, areas for improvement relating to infection prevention and control measures and practices were identified as follows:

- a lack of readily available personal protective equipment (PPE) throughout the home
- no soap dispenser available at an identified sink
- an overflowing waste bin in an identified room & a rusted waste bin in an identified toilet
- faecal staining observed under an identified shower chair
- sharps boxes in the clinical rooms were not signed and dated and did not have the aperture closed
- inappropriate use of PPE and PPE not used appropriately at all times

Details were discussed with the manager and an area for improvement under the regulations was made.

Fire exits and corridors were observed to be clear of clutter and obstruction. Discussion with the manager evidenced that fire points were checked throughout the home weekly and that a fire drill took place every six months. Fire marshal training is planned to ensure each registered nurse is aware of their role in the event of an evacuation.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction and the home's environment.

Areas for improvement

The following areas were identified for improvement in relation to competency and capability assessment, training and infection prevention and control.

	Regulations	Standards
Total number of areas for improvement	3	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Supplementary care charts such as food and fluid intake records, personal activity plan, elimination records and hourly checks evidenced that records were generally well maintained in accordance with best practice guidance, care standards and legislation. However, a number of deficits were noted. For example, one patient had no food intake recorded from 15.45 hours on the 21 January 2018 until 09.45 hours on the 22 January 2018. An elimination record noted a ten day gap from 31 December 2017 until 10 January 2018 where nothing was recorded. A further elimination record had nothing recorded from 4 January 2018 up until the day of inspection. Review of patients care records evidenced that totals of fluid intake were not recorded in the daily progress notes. This was discussed with the manager and identified as an area for improvement under the care standards.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. However, patients' records were not maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005. Deficits were noted in relation to the administration of topical medicines. Two care records were reviewed. Review of the first record evidenced support staff were not completing topical medication records. For example, medication was prescribed to be administered twice daily; from 1 January 2018 until 23 January 2018 records were not signed for on ten occasions. No record was completed to evidence the second prescribed application was given. This was cross referenced with the medicines administration record. Review of this record from 15 January 2018 evidenced this was not completed on any date up to and including the day of inspection. Review of the second record evidenced that medication was prescribed as once daily. Examination of the topical medication record evidenced that from 18 January 2018 until 23 January 2018 evidenced that it had been administered on two days but not on another four days. This was cross referenced with the medicines administration record. Review of this record from 15 January 2018 until 22 January 2018 evidenced that registered nurses had documented this medicine was given at 0800 hours and 2200 hours each day. This record was also signed for 0800 hours on the day of inspection. Review of medicine administration records evidenced these were not consistently dated on receipt of medicines. This was discussed with the manager and identified as an area for improvement under the regulations. This matter is also referred to the medicine management inspector for information purposes.

Review of three patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. Review of one care record however evidenced that on an occasion where a patient had sustained a head injury, a post fall risk assessment was not completed within 24 hours. This was discussed with the manager and had been identified as an area for improvement at the inspection of 6 June 2017. This area for improvement has been stated for a second time in the quality improvement plan (QIP) of this report.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), SALT, dietician, and TVN. Discussion with staff and a review of care records evidenced that recommendations made by healthcare professionals in relation to specific care and treatment were clearly and effectively communicated to staff and reflected in the patient's record.

Discussion with the manager confirmed that company policy is that staff meetings are held on a three monthly basis although they are currently being held on a monthly basis; records were maintained. Staff confirmed that staff meeting were held every month at present and that the minutes were made available.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the manager.

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Discussion with the manager and review of records evidenced that patient and relatives meetings were held on a three monthly basis. The manager confirmed no one attended the meeting held in October 2017. A further meeting is planned for January 2018.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication between residents, staff and other key stakeholders.

Areas for improvement

The following areas were identified for improvement in relation to supplementary care charts and medicines management. An area for improvement in relation to post fall management is stated for a second time.

	Regulations	Standards
Total number of areas for improvement	1	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Observations evidenced that patients were afforded choice, privacy, dignity and respect. Staff interactions with patients were observed to be compassionate, caring and timely. For example staff were observed to knock on patients doors before entering and kept them closed when providing personal care. Staff were also observed playing games with patients. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Inspection of patient's bedrooms evidenced that they were personalised in keeping with the patient's wishes.

Discussion with the manager confirmed there was a social and leisure officer (SLO) in the home responsible for the provision of activities. The activity room within the home evidenced a wide range of activities patients had been involved in, particularly arts and crafts. Discussion with the SLO evidenced a very varied programme planned to meet the individual needs of the patient's. Patients were actively involved in the RSPB bird count and had made bird cakes. In addition to the previously mentioned activities, patient's enjoyed baking cakes and buns, crazy golf, bowling and pet therapy. Seasonal activities have also been planned for spring time. The deputy manager confirmed there are plans for a multi-sensory room within home.

The serving of the midday meal was observed. The dining room was bright and spacious. A range of drinks were readily available. No menu was displayed or available in a suitable format. Discussion with the cook evidenced that the planned menus were being revised and were not currently being adhered to. No record of patients likes and dislikes were retained and there was no evidence that patients had been consulted prior to the menu change. The manager must ensure that the planned rotational menu is adhered to unless in exceptional circumstances. The rotational menu should be reviewed and updated if it is no longer reflective of the meals provided. This was identified as an area for improvement under the care standards.

The meals were nicely presented, were of good quality and smelt appetising. Staff confirmed that patients who required a modified diet were afforded a choice at mealtimes. The support workers were observed supervising and assisting patients with their meal and monitoring patients' nutritional intake. However, PPE was not worn by any staff involved with the serving or assisting patients with their meals. This has been previously referenced in section 6.4 and was discussed with the manager; an area for improvement has been identified under the regulations.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Discussion with the manager confirmed that there were systems in place to obtain the views of patients on the running of the home. This was done on a monthly basis by the SLO.

Thirteen staff members were consulted to determine their views on the quality of care within Shaftesbury Mews. Discussions with staff were fed back to the manager and responsible individual. Some staff comments to the inspector during inspection were as follows:

"The staff are good to the patients here."
"The patients are well fed and are looked after."
"I have seen nothing but goodness and kindness from the staff."
"So much dedication and commitment from the staff here."
"The staff all care about the patients."

A poster was given to the acting manager to be displayed in the staff room inviting staff to respond to an on-line questionnaire. Ten of the staff responded within the timeframe for inclusion in this report. Staff commented positively with regard to care delivery and management of the home.

Three patients consulted were complimentary and some commented as follows:

“It’s ok. I like it here.”
“The staff are nice but I want to go home.”
“It’s a lovely place. They take good care of me.”

Ten patient questionnaires were left in the home for completion. None of the patient questionnaires were returned within the timeframe for inclusion in this report.

No patient representatives were available for consultation during the inspection. Ten patient representative questionnaires were left in the home for completion. None were returned within the timeframe for inclusion in the report.

Any comments from patients, patient representatives and staff in returned questionnaires or online surveys, received after the return date will be shared with the manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to dignity and privacy and activities.

Areas for improvement

The following areas were identified for improvement in relation to infection prevention and control and review of the rotational menu reflecting patient’s views.

	Regulations	Standards
Total number of areas for improvement	0	1

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Discussion with the manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

The manager has been in post since October 2017 and the home have recently appointed a new deputy manager. No application has yet been received by RQIA in relation to the registration of the manager.

A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were not clearly recorded. The duty rota suggested the manager was working on the day of the inspection although the deputy manager confirmed they were not on duty. The duty rota further reflected the manager was working in two different roles. For example, one duty rota identified the manager as home manager and another duty rota stated they were a site manager. This was discussed with the manager on their return to the home and an area for improvement under the care standards was made.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the manager and review of records evidenced that the home was operating within its registered categories of care.

The manager confirmed that the policies and procedures for the home were systematically reviewed on a three yearly basis. Staff confirmed that they had access to the home's policies and procedures.

Discussion with the manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Staff were knowledgeable of the complaints process.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately. Discussion with the manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with the manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. Audits had been recent completed for accidents and incidents, housekeeping and the environment. However, not all audits were completed in accordance with best practice guidance. For example care records had not been audited since October 2017, monthly safety checks were not completed since September 2017, monthly medication audits were last completed in November 2017 and infection prevention and control audits had not been completed since July 2017. This has been identified as an area for improvement under the regulations.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Discussion with the manager and review of records evidenced that Regulation 29 (or monthly quality) monitoring visits were completed in accordance with the regulations and care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and trust representatives.

As a consequence of the issues identified during the inspection, the registered person was invited to attend a meeting at RQIA to discuss the concerns identified. At this meeting on 30 January 2018 the registered person provided RQIA with an action plan and assurances that Shaftesbury Mews is operating in accordance with RQIA requirements.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, and the home's environment.

Areas for improvement

The following areas were identified for improvement in relation to duty rotas and governance arrangements.

	Regulations	Standards
Total number of areas for improvement	1	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Michelle Montgomery, acting manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref**: Regulation 20 (3) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the registered manager carries out a competency and capability assessment with any nurse who is given the responsibility of being in charge of the home for any period in their absence. Ref: Section 6.4
	Response by registered person detailing the actions taken: Competency and capability assessments have been completed for those Nurses who take charge of the Home in absence of the Registered Manager.
Area for improvement 2 **Ref**: Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by:** 23 April 2018	The registered person shall ensure all employees receive training appropriate to the work they are to perform. 1. Staff involved in the preparation of food should be trained in Food Hygiene 2. Staff involved in the application of topical medicines should be appropriately trained. Ref: Section 6.4
	Response by registered person detailing the actions taken: Food Hygiene training and topical medication training has been completed and will be on-going for employees as appropriate.
Area for improvement 3 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure suitable arrangements are in place to minimise the risk of infection and spread of infection between patients and staff. This area for improvement is made with particular focus to the following: • availability of PPE throughout the home • ensuring a soap dispenser is available at an identified sink • ensuring waste bins are emptied regularly • replacing rusted waste bin in an identified toilet • effective decontamination of an identified shower chair • sharps boxes to be signed and dated and have the aperture closed when not in use • ensuring appropriate use of PPE during meal service and cleaning. Ref: Section 6.4

	Response by registered person detailing the actions taken: New stations for PPE are now in place,auditing of infection control practices, environment and domestic practices ensure that the above findings have been actioned and sustained. Ongoing auditing and daily monitoring will ensure practices are embedded.
Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure suitable arrangements for recording and safe administration of medicines. This is made with specific reference to administration of topical medicines. Ref: 6.5
	Response by registered person detailing the actions taken: Appropriate staff have completed training relating to safe administration of topical administration of medication. Medication audits are completed monthly by management and additional more frequant audits by the Reg Nurse.
Area for improvement 5 **Ref:** Regulation 17 (1) **Stated:** First time **To be completed by:** 1 March 2018	The registered person shall ensure monthly audits should be completed in accordance with best practice guidance. Any shortfalls identified should generate and action plan to ensure the necessary improvements can be embedded into practice. Ref: Section 6.7
	Response by registered person detailing the actions taken: Evidence of audits with generated action plan and outcomes achieved are in place.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref**: Standard 22 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that falls prevention is managed in accordance with the DHSSPS, Care Standards for Nursing Homes, 2015. Ref: Section 6.5
	Response by registered person detailing the actions taken: Falls management has been reviewed and practice improved to meet standard required.

Area for improvement 2 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that supplementary care records; for example, elimination and food & fluid intake records, reflect a full 24 hours and that the total intake/output are collated into the patient's daily progress records. Ref: Section 6.5
	Response by registered person detailing the actions taken: Supplimentary records are reviewed daily by nurse in charge and audited by management team. Any shortfalls are communicated to the Nurse in Charge and spot checks are in place to ensure good record keeping of 24hr calculation within daily progress notes.
Area for improvement 3 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 1 March 2018	The registered person shall ensure the planned rotational menu is adhered to unless in exceptional circumstances. The rotational menu should be reviewed, updated and records retained reflecting patient's views. The menu should also be displayed in a suitable format. Ref: Section 6.6
	Response by registered person detailing the actions taken: Since the Inspection, the Home has recruited a new Cook with experience in Nursing Home setting. This area of improvement is being addressed and is currently in progress due to staff change.
Area for improvement 4 **Ref**: Standard 41 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure the duty rota accurately reflects the name of the nurse in charge of the home on each shift; hours worked and signed by the nurse manager or designated representative. Ref: Section 6.7
	Response by registered person detailing the actions taken: The name of nurse in charge is present on each duty rota, and , each rota is signed as required.

Please ensure this document is completed in full and returned via Web Portal

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