The Regulation and Quality Improvement Authority

Inspection Report

11 & 14 March 2024

Cherryvalley Care Home

Type of service: Nursing
Address: 14-24 Kensington Drive, Belfast, BT5 6NU
Telephone number: 028 9040 1560

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Beaumont Care Homes Limited **Responsible Individual:** Mrs Ruth Burrows	**Registered Manager:** Ms Roxanna Mitrea - not registered
Person in charge at the time of inspection: Ms Roxanna Mitrea, Manager	**Number of registered places:** 46
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 27
Brief description of the accommodation/how the service operates: This is a registered Nursing Home which provides care for up to 46 patients. Patient bedrooms are located over the ground and first floors. There are communal lounges, a dining room, and garden space.	

2.0 Inspection summary

An unannounced inspection took place on 11 March 2024 from 10.00 am to 5.40 pm by two care inspectors, and on 14 March 2024 from 10.15 am to 2.15 pm by two pharmacist inspectors.

The home was clean and warm. Staff were seen to respond to patients' needs in a timely manner and were warm and compassionate during interventions with patients. It was evident from observing interactions between patients and staff that they knew each other well and patients were comfortable in the company of staff.

Patients spoke positively about how they were treated by staff but expressed ambivalence about living in Cherryvalley Care Home. For example, one patient described occasions of going along with the home's routine rather than doing what they wished to do, such as spending time in the garden instead of in their bedroom.

The inspection assessed progress with all areas for improvement identified in the home since the last inspection and focused on care delivery, provision of activities, patient experience, record keeping, medicines management, and governance arrangements.

Five areas for improvement identified at previous inspections were assessed as met. An area for improvement relating to auditing was not met and stated for a second time. An area for improvement relating to the provision of activities was not met and stated for a third time.

New areas for improvement were identified in relation to patient choices around what meals they had and where they dined, menu displays, communications about patients' do not attempt cardiopulmonary resuscitation (DNACPR) status, wound care, oral care, time management of medication rounds, the management of warfarin, and the environment. The inspection findings highlighted an issue relating to how patients spent their day and how they exercised choice throughout the day.

At the time of the inspection the home was under interim management arrangements and RQIA were aware that a new manager was due to commence post imminently following the inspection. In the interest of continuity, a meeting was held on 3 April 2024 to discuss the findings of the inspection with the senior management team and the newly appointed manager. At this meeting the management team gave assurances in relation to the identified areas for improvement and submitted an action plan to RQIA.

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

The findings of this report will provide the management team with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Roxanna Mitrea, Manager, at the conclusion of the inspection, and with Ruth Burrows, Responsible Individual (RI), following the inspection.

4.0 What people told us about the service

Patients said they had mixed experiences living in Cherryvalley Care Home. Patients described staff as “very nice”, “friendly”, and “okay”, but also said that “some things could be better.” For example, some patients said that while staff were good, they only saw them during tasks, “they are in and out.”

Patients told us that they did not always have the opportunity to make decisions about their daily life. For example, some patients did not recall seeing a menu or making meal choices, and one patient said that if they did not like the main meal that was presented, they often did not get an alternative choice. Furthermore, some patients described going along with the home’s routine and practices rather than their own wishes or preferences. For example, one patient accepted the offer of having their nails painted by staff as an activity despite not liking nail varnish, and another patient told us that they went along with spending time in their bedroom rather than in other areas of the home because they would require assistance from staff with mobilising.

Patients said that they were satisfied with the level of cleanliness in the home and that visiting arrangements were working well.

Staff told us that they were satisfied with the staffing levels and management arrangements. Staff described the manager as “very good”, and said that they felt confident that any issues or concerns raised would be well managed. Staff said that they were provided with the necessary training to carry out their roles and that they were happy working in Cherryvalley Care Home.

No staff survey responses were received within the allocated timeframe for this report.

One relative response was received following the inspection. The relative said that they were very satisfied that the care and services provided in the home were safe and that they were satisfied that the treatment provided to patients was effective, delivered with compassion, and that the service was well led.

The relative suggested that the home could provide better communication to relatives in relation to patient care plans. This comment was shared with the management team for their consideration and action where appropriate.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 11 May 2023</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Regulation 13 (4)

Stated: First time</td><td>The registered person shall review the management of thickening agents to ensure that care plans are in place and records of prescribing and administration are accurately maintained.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was evidence that this area for improvement was met.

Please refer to section 5.2.6 of this report for more detail.</td></tr>
<tr><td rowspan="2">Area for Improvement 2

Ref: Regulation 17 (1)

Stated: First time</td><td>The registered person shall ensure that deficits identified during the process of auditing are addressed through an action plan stating the actions required, who is responsible, and expected timeframe for completion.

There should be evidence that plans have been reviewed and signed off once the required actions have been taken.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
An auditing system was in place, however, this process fell short of demonstrating clear action plans and the audits had not been reviewed to ensure deficits had been addressed.

This area for improvement was not met and was stated for a second time.

Please refer to section 5.2.5 of this report for more detail.</td></tr>
</table>

Area for Improvement 3 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure as far as reasonably practical that all parts of the home to which patients have access are free from hazards to their safety. This was in relation to securing of rooms where medications and/or chemicals are stored. Storage rooms should be organised in such a fashion as to reduce the risk of heavy equipment such as televisions falling from high shelving. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met.	**Met**
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 18 **Stated:** First time	The registered person shall review the management of distressed reactions to ensure that care plans are in place and the reason for and outcome of administration are recorded on all occasions. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met. Please refer to section 5.2.6 of this report for more detail.	**Met**
Area for Improvement 2 **Ref:** Standard 12.1 and 12.6 **Stated:** Second time	The registered person shall ensure that patients' dietary preferences are recorded accurately on dietary notification records and shared with relevant departments such as catering in a timely manner. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met as stated. However, a new area for improvement in relation to meal choices was identified and is detailed in this report and in the home's quality improvement plan (QIP).	**Met**

Area for Improvement 3 **Ref:** Standard 11.1 **Stated:** Second time	The registered person shall review the provision of activities within the home and ensure that person centred activities are provided to patients in a consistent manner.	**Not met**
	Action taken as confirmed during the inspection: The inspection findings evidenced that the activities programme was not being delivered in a consistent or equitable manner. This area for improvement was not met and was stated for a third time. Please refer to section 5.2.4 for further detail.	
Area for improvement 4 **Ref:** Standard 4 and 6 **Stated:** First time	The registered person shall ensure that care plans relating to the personal hygiene needs of patients are reflective of each patient's current preferences in relation to bathing and showering. Reasons for veering from patients' stated preferences should be documented. Care plans should be developed for those patients who cannot avail of a bath or shower and required bed-bathing.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Staff confirmed that they were satisfied with the staffing levels in the home and that they were able to meet the patients' needs in a timely manner. Patients were seen to have access to the nurse call bell system and confirmed that staff responded when they called for assistance. One patient's call bell cord was found to be too short to be safely tracked from the wall to where the patient was sitting. This was brought to the attention of the manager and replaced immediately with a longer length lead. Some patients commented that staff would attend promptly but would leave as soon as a task was completed, "they are in and out…I don't see them much."

Patients told us that they found staff to be "very nice" and "friendly" during interactions.

Staff told us that they met at the beginning of each shift to discuss any changes in patients' needs and to prioritise the tasks for that shift. In addition to a verbal handover of information, the nurses used a handover sheet which provided information on each patients' primary needs in relation to, but not limited to, mobility, eating and drinking, continence, cognition, and emergency arrangements. Care staff received an allocation sheet which directed them on particular duties for that day, such as, meal time coordinator and break arrangements.

Staff said that they felt supported in their roles through regular training. Staff confirmed that the majority of training was delivered on an eLearning system and that face to face sessions were provided for some topics such as moving and handling and first aid. Records showed that there was good overall compliance with all mandatory topics and that nurses had received recent face to face training on basic life support, end of life care, catheter management, and accountability, responsibility, and delegation.

5.2.2 Care Delivery and Record Keeping

Patients looked well cared for, in that, attention had been paid by staff to address patients' personal care and dressing needs. One patient was noted to require nail care and their bedrail bumper needed cleaned. This was brought to the attention of the manager who took immediate action to address.

Patients' main care records were held securely, although it was observed that some supplementary records which contained patient information were stored along the corridors. This was brought to the attention of the manager who took immediate action to secure all patient records and gave assurances that this practice would be addressed with all staff and would cease. This will be reviewed at the next inspection.

Personal care, wound care, oral care, dining arrangements, and DNACPR arrangements were reviewed as part of the inspection focus. It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly.

Care plans were in place to direct staff on patients' preferences with personal care needs and staff maintained a record of any support or interventions provided to patients on supplementary care records.

A review of supplementary records evidenced that oral care was not being offered as per patient care plans. For example, care plans directed staff to provide oral care twice daily, however, records evidenced that oral care was offered only once in the morning. In addition, records showed that if a patient declined oral care in the morning, staff did not make any further attempts during the day or night to encourage patient oral hygiene. An area for improvement was identified.

Wound care was reviewed. For one patient, care records indicated discrepancies between the recommendations made by podiatry and nursing interventions. The patient's wound care plan did not clearly state the care required to address the wound. Only one wound care plan was in place despite the patient having two separate wounds. In addition, the nurses' handover sheet incorrectly stated that this patient's skin was intact. An area for improvement was identified.

The home had a resuscitation policy which reflected best practice guidelines. There was a system in place to document patients' expressed wishes in relation to resuscitation and best interest decisions involving the patients' general practitioner (GP) and, where appropriate, next of kin. Review of records showed that patients with a DNACPR were well documented in the care records. Quick reference systems were also in place to communicate patients' DNACPR status to nursing staff. For example, on the nurses' handover sheet.

Discussion with staff evidenced that despite care staff having been trained to deliver CPR and willing to implement this training if required, the DNACPR status of patients was not communicated to care staff. An area for improvement was identified.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Observations and discussions with patients and staff evidenced that patients were not routinely offered a choice of where they had their meals. All patients had breakfast in their bedrooms and at lunch time eight patients went to the dining room while the remaining patients had lunch in their bedrooms. Staff were not seen to offer choice to patients in relation to where they had their meals. An area for improvement was identified and patient choice about where they spend their time is addressed further in section 5.2.4 of this report.

The dining room tables were set in preparation for lunch and patients were seen to enjoy streaming music through the smart television. A three-week menu planner was on display on the dining room wall and a copy of this was available on each table. The menu format was difficult for patients to read. An area for improvement was identified.

Staff told us that they obtained patients' meal choices each evening during the evening drinks trolley round and that the meal choice records were delivered to the kitchen in preparation for the next day's meals. Discussion with patients evidenced that they often didn't recall what they had ordered the previous day. It was observed during the serving of lunch that patients were not reminded of their previous choices or offered the opportunity to confirm their choices. Drinks were provided with meals but staff were not observed to offer a choice of drinks. An area for improvement was identified.

The menu planner evidenced a wide variety of nutritious meals and it was positive to note that the home had liaised with dietetics and speech and language therapy specialists when developing the menus. There was evidence of at least two main meal options for breakfast, lunch, and dinner. It was noted that on some days there was only one meal option for those patients who required a modified diet. An area for improvement was identified.

There was evidence that patients' weights were checked at least monthly to monitor for changes. There was a system in place for manager oversight of weight management which highlighted patterns and patients who required additional focus to support with their weight.

Relative questionnaire response indicated that they were very satisfied with the care provided in the home. A relative suggested that there could be better communication with next of kin in relation to patients' care plans. This comment was shared with the management team following the inspection for their consideration and action where appropriate.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was clean and warm. Corridors were maintained free from clutter and fire doors and exits were free from obstruction.

Storage areas were seen to be organised, however, two store rooms required cleaning. The manager provided confirmation following the inspection that both store rooms had been deep cleaned.

Communal bathrooms and toilets were clean and accessible. One sluice room was found to have shampoo and liquid soap inappropriately stored. This was brought to the attention of the manager and the items were removed.

Patients bedrooms were clean and there was evidence of personalisation of bedrooms with items of importance or interest to each patient. Décor in the home was maintained to a good standard, although, there was a lack of homely touches such as, but not limited to, flowers, plants, and pictures.

Communal lounges were available on each floor and it was noted that no patients were using these rooms. This is discussed further in section 5.2.4. The communal lounges were clean and decorated to a good standard, however, there was a lack of signage to show what these rooms were for. In addition, it was observed that the lounges were not suitably furnished. An area for improvement was identified.

There was evidence that systems and processes were in place to ensure the management of risks associated with infections. For example, hand sanitiser was available for everyone entering the building, personal protective equipment (PPE) was strategically located around the home, and the home liaised with the Public Health Authority (PHA) when required.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of PPE had been provided.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

5.2.4 Quality of Life for Patients

Patients described mixed experiences and showed some ambivalence about living in Cherryvalley Care Home. For example, patients spoke positively about staff, describing staff as “friendly”, and interactions between staff and patients were seen to be warm, compassionate, reassuring, and at times fun. But patients also described not spending time with staff outside treatment or care interventions, “they are in and out.”

While patients did not directly raise any concerns in relation to how they spent their time in the home, patients described occasions of going along with the home’s routine instead of truly exercising their own wishes and preferences. For example, patients talked about not spending time outside of their bedrooms because of mobility or care needs and felt that these were

reasonable explanations; “I’d like to go to the garden but sure my legs don’t work”, or “I come back to bed after lunch because that’s just what they do.” Other patients expressed apathy, “I never leave my room, what’s the point.” An area for improvement was identified.

An activities programme was on display which advertised organised activities from Monday to Friday. However, review of records and discussions with staff and patients evidenced that this programme was not being delivered as expected. The manager informed RQIA that the activities leader worked part time hours and that there were no arrangements in place to provide activities outside of those hours. The manager confirmed that they had a recruitment drive ongoing to employ into this role. An area for improvement that was previously identified was stated for a third time.

Visiting arrangements were in place and patients told us that these arrangements worked well and that friends and family could visit at any time of the day.

5.2.5 Management and Governance Arrangements

There had been a change in the management arrangements of the home since the last inspection and these arrangements were temporary. Ms Roxanna Mitrea was appointed acting manager on 5 February 2024 until a permanent manager could be appointed.

Staff were aware of who was in charge of the home at any given time and told us that the management arrangements were working well and that they could approach anyone in the management team for support. Staff said that they felt that any concerns or issues raised would be dealt with appropriately.

It was positive to note that the manager had proactively contacted each patient’s next of kin to update them on recent developments in the home and records of any communications with relatives were well maintained.

During the meeting on 3 April 2024, the management team confirmed that Ms Tanya Brannigan had been appointed manager for the home and would be supported during her induction to the role by a peripatetic manager and members of the senior management team. RQIA were satisfied with these arrangements.

An auditing system to monitor the quality of care and services provided in the home was in place. Review of a sample of audits evidenced that deficits were being identified. However, these audits fell short of having clear actions plan and the manager informed us that they had not yet reviewed the audits to ensure the corrective actions had been taken. A previously identified area for improvement was stated for a second time.

5.2.6 Medicines Management

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to state that they were accurate.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines prescribed on a "when required" basis for distressed reactions was reviewed. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain or infection. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were in place.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans and pain assessments were in place.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

The management of thickening agents was reviewed. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

The management of warfarin was reviewed. Warfarin is a high risk medicine and therefore safe systems must be in place to ensure patients are administered the prescribed dose and arrangements are in place for regular blood monitoring. The latest warfarin dose communicated by the GP had not been verified by two members of staff when transcribed onto supplementary administration records to ensure the correct dose was recorded. Obsolete warfarin records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer an incorrect dose to the patient. An area for improvement was identified.

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error. The records inspected showed that medicines were available for administration when patients required them.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately.

Satisfactory arrangements were in place for the safe disposal of medicines.

Nurses must follow safe medication administration processes to ensure that medicines are administered to the right patient at the right time. Medicine doses must not be unduly delayed as this may cause harm to the patient. The time of administration must be accurately recorded to ensure that correct dosage intervals are achieved.

The morning medicines round on the first floor was not completed until 12.45pm; the medication administration records indicated that the medicines had been administered at 10.00am. Medicines must be administered at the prescribed time and medication administration records must be accurately maintained. Measures should be implemented to ensure nurses are afforded protected time to complete the medication round in a timely manner. An area for improvement was identified.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. Satisfactory arrangements were in place for the management of controlled drugs.

Several patients have their medicines administered in food/drinks to assist administration. Care plans detailing how the patients like to take their medicines were in place. Some of the practices followed by staff to assist administration mean that medicines are being administered outside the terms of their product licence. This means that the way the medicine is given has been changed to meet the need to the patient. While this is appropriate for most patients, this practice should be checked to ensure that the patient's GP agrees. Written authorisation was in place when this practice occurred.

The audit process for medicines management was reviewed. Daily running stock balances were in place to monitor the administration of medicines. A monthly managerial audit was also completed which encompassed all aspects of medicines management. Recent training and competency assessments had been completed for all staff with responsibility for medicines management.

The audits completed at the inspection identified the medicines were being administered as prescribed.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	4*	9*

*The total number of areas for improvement includes one under regulations that has been stated for a second time and one under standards that has been stated for a third time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Roxanna Mitrea, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 17 (1)

Stated: Second time

To be completed by:
28 March 2024</td><td>The registered person shall ensure that deficits identified during the process of auditing are addressed through an action plan stating the actions required, who is responsible, and expected timeframe for completion.

There should be evidence that plans have been reviewed and signed off once the required actions have been taken.

Ref: 5.1 and 5.2.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
All Home audits will be delegated between the Home Manager and Deputy Manager for completion and an action plan will be created accordingly, if required. Action plans will include time frame for completion and person responsible for addressing each action. The Home Manager will diarise time frames to review to ensure actions have been addressed. All action plans will be signed off on completion by Home Manager. Compliance will be monitored by Operations Manager during Reg 29 visits.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Regulation 13 (1) (b)

Stated: First time

To be completed by:
11 March 2024</td><td>The registered person shall ensure that there is a system in place to communicate the DNACPR status of patients to all staff trained to deliver CPR.

Ref: 5.2.2</td></tr>
<tr><td>Response by registered person detailing the actions taken:
All Registered Nurses have completed face to face Basic Life Support training. There is a Handover Summary used at each shift handover which is available for all care staff which includes the DNACPR status of all residents. All care files have also been marked with a red dot on the binder for ease of reference to indicate individual DNACPR status.</td></tr>
</table>

<table>
<tr><td rowspan="2">Area for improvement 3

Ref: Regulation 18 (2) (c)

Stated: First time

To be completed by:
6 May 2024</td><td>The registered person shall ensure that all communal rooms are suitably furnished and that signage is displayed to help orientate patients and visitors to the use of these rooms.

Ref: 5.2.3</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Signage has been ordered to ensure all communal areas are clearly signposted to support the orientation of residents. Additional armchairs have been ordered for lounge areas.</td></tr>
<tr><td rowspan="2">Area for improvement 4

Ref: Regulation 13 (4)

Stated: First time

To be completed by:
11 March 2024</td><td>The registered person shall ensure that medicines are administered at their prescribed time and medication administration records accurately maintained.

Ref: 5.2.6</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Disposable red “Do not Disturb” tabards have been purchased for the Registered Nurses to wear during medication rounds, to minimise disturbance whilst administering medications.
The time taken to complete medication rounds has been monitored since the inspection took place and the length of time taken has been reduced significantly. This will continue to be monitored and discussed during flash meetings if required.</td></tr>
<tr><td colspan="2">Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 11.1

Stated: Third time

To be completed by:
15 April 2024</td><td>The registered person shall review the provision of activities within the home and ensure that person centred activities are provided to patients in a consistent manner.

Ref: 5.1 and 5.2.4</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Recruitment continues for the part time Activity Leader. An Activity Forum has been established by the Company and the first meeting will be held in May 2024. This forum is in place to support and develop the activity provision in each Home and will be attended by the current part time Activity Leader. Whilst recruitment is ongoing as an interim measure there will be an identified member of staff allocated to carry out activities on weekdays when the current Activity Leader is off, this will be identified on the roster.</td></tr>
</table>

Area for improvement 2 **Ref:** Standard 21 **Stated:** First time **To be completed by:** 11 March 2024	The registered person shall ensure that wound care is provided in line with best practice guidelines. That wound care plans clearly evidence recommendations made by specialists such as podiatry and /or tissue viability, and that records are maintained accurate and up to date. Ref: 5.2.2
	Response by registered person detailing the actions taken: All Registered Nurse wound competencies are currently being renewed as part of annual updates. Daily flash meetings include discussions around skin integrity, wounds and actions to be taken if required. All wounds are recorded on the new Incident Reporting System which will alert the Home Manager of the event. The Home Manager reviews all wound documentation to ensure all appropriate records are being completed. All wounds are currently being updated on Home Managers Monthly Report and compliance will be spot checked during Operations Manager during Reg 29 visits.
Area for improvement 3 **Ref:** Standard 21.5 **Stated:** First time **To be completed by:** 11 March 2024	The registered person shall ensure that oral care is provided in line with best practice and that the rationale for any variation from best practice is clearly documented. Ref: 5.2.2
	Response by registered person detailing the actions taken: The recording of Oral Care Charts has been discussed at flash meetings with care staff to ensure oral care is offered as per plan of care. A spot check of the Oral Care Charts is taking place as part of the walkabout audit. Supplementary Charts will be spot checked during Reg 29 visits carried out by the Operations Manager.
Area for improvement 4 **Ref:** Standard 12.20 **Stated:** First time **To be completed by:** 11 March 2024	The registered person shall ensure that patients are made aware of dining locations available to them and ensure that patients are routinely offered a choice of where they wish to have their meals. Ref: 5.2.2
	Response by registered person detailing the actions taken: Signage has been ordered to ensure all communal areas, including dining rooms, are clearly signposted to support the orientation of residents. A review of communal areas on the first floor is currently being undertaken. The Walkabout Audit has been reviewed to include sampling residents' preferences where they wish to stay during the day and whether they raised

	any concerns. Staff in the Home are to continue to encourage residents to use dining room for meals and this has been discussed at Daily Flash Meetings. The Operations Manager will also speak to residents during the Reg 29 visits to ensure their wishes are documented and that these are being met.
Area for improvement 5 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 18 March 2024	The registered person shall ensure that daily menus are displayed in a format that is user friendly and accessible to patients. Ref: 5.2.2
	Response by registered person detailing the actions taken: A new menu display has been put in place in the dining room. This will be updated on a daily basis and will be reflective of menu choices. Compliance will be monitored as part of the Walkabout Audit and during the Reg 29 visit carried out by the Operations Manager.
Area for improvement 6 **Ref:** Standard 12.6 **Stated:** First time **To be completed by:** 11 March 2024	The registered person shall ensure that patients are supported at every available and appropriate opportunity to make choices about food and drinks in a manner that is accessible to the patients. Ref: 5.2.2
	Response by registered person detailing the actions taken: Staff have completed the “Meal Time Matters” training which was facilitated by the Belfast Trust Speech and Language team on 24.04.24 and 01.05.24. Ensuring residents choices are confirmed at each meal time has been discussed during Daily Flash meetings and further discussions will take place during staff meeting scheduled for 15.05.24. The monitoring of the choice of fluids/meals offered to residents are included in the Dining Audit which is currently being completed by a senior member of the team. Feedback on the outcome of the audit is provided to staff on completion of each audit. Compliance will be monitored by Home Manager and quality checked by Operations Manager during Reg 29 visits.

<table>
<tr><td rowspan="2">Area for improvement 7

Ref: Standard 12.13

Stated: First time

To be completed by:
11 March 2024</td><td>The registered person shall ensure that patients requiring a modified diet have a choice of two main options at meal times.

Ref: 5.2.2</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Two choices of modified diets are available for each main meal which is clearly identified on the menu display with the letter 'm'. Choices of modified diets are included in the Dining Audit which is completed by a senior member of the team and feedback is provided to staff on completion of each audit. Compliance will be monitored by Home Manager and quality checked by Operations Manager during Reg 29 visits.</td></tr>
<tr><td rowspan="2">Area for improvement 8

Ref: Standard 9

Stated: First time

To be completed by:
14 May 2024</td><td>The registered person shall undertake a consultation exercise to seek the views and preferences of patients about daily life in the home.

The daily routine of the home should be varied and flexible to the individual preferences of patients; including, but not limited to, where and how they spend their time.

Ref: 5.2.4</td></tr>
<tr><td>Response by registered person detailing the actions taken:
A consultation exercise is currently being undertaken where residents’ choices/preferences will be recorded in their individual activity care plan. The outcome of the consultation will be discussed at the staff meeting to be held on 15.05.24. Staff will continue to encourage residents to use communal areas to socialise with other residents. The Walkabout Audit has been reviewed to include sampling residents’ preferences where they wish to stay during the day and whether they raised any concerns. The Operations Manager will also speak to residents during Reg 29 visits regarding their wishes.</td></tr>
</table>

Area for improvement 9 **Ref:** Standard 28 **Stated:** First time **To be completed by:** From the date of inspection (11 March 2024)	The registered person shall ensure safe systems are in place for the management of warfarin. Ref: 5.2.6
	Response by registered person detailing the actions taken: The outcome of Pharmacy Inspection was discussed with the Registered Nurses during the trained staff meeting held on 27.04.24. Warfarin Management is audited on a quarterly basis which includes checking that 2 registered nurses have transcribed any instructions required and that these have been signed by both staff, this is in addition to the Monthly Medication Audit. All Warfarin records that are no longer applicable have been archived from the resident's file. Compliance will be spot checked by Operations Manager during the Reg 29 visits.

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

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