Unannounced Care Inspection Report
21 February 2018

Edgewater Lodge

Type of Service: Nursing Home (NH)
Address: Copeland, Lighthouse and Orlock Suites, 4 Sunnydale Avenue, Donaghadee, BT21 0LE
Tel No: 028 9188 8044
Inspector: Heather Sleator

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 58 persons.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** Vera Ribeiro
Person in charge at the time of inspection: Michelle Macmillan (acting manager)	**Date manager registered:** Acting position, application of registration not submitted.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of registered places:** 58 20 patients in categories NH-I, NH-PH/PH(E), NH-TI accommodated in the Copeland Suite 38 patients in category NH-DE; 21 accommodated in the Orlock Suite and 17 accommodated in the Lighthouse Suite.

4.0 Inspection summary

An unannounced inspection took place on 21 February 2018 from 09.30 to 17.00 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 arrangements, activities and maintaining good relationships in the home.

Areas requiring improvement were identified under regulation in relation to ensuring patients who require a specialised diet are provided with snacks, suitable to their needs, throughout the twenty four hour period. An area for improvement previously identified at the inspection of 8 November 2017 has been stated for a second time regarding staff recruitment and selection procedures.

Areas identified for improvement were identified under the care standards in relation to ensuring patients are suitably positioned prior to commencing meal service, ensuring dementia practice is patient focused, care records clearly define and report on the individual care needs of patients and listening to and valuing patients and their representatives and taking account

of the views of patients. Areas for improvement previously identified at the inspection of 8 November 2017 have been stated for a second time and include the registration of care staff with the appropriate professional body, the displaying of the day's menu in a suitable format and having a systematic planner in place for staffs annual appraisal and supervision.

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. Comments included "I think they're (staff) very kind and caring and go out of their way to help everybody." Refer to section 6.6 for further comments.

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	*2	*7

*The total number of areas for improvement includes one regulation and three standards which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Elaine McShane, regional manager Four Seasons Health Care, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent inspection dated 12 January 2018

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 12 January 2018.

There were no further actions required to be taken following the most recent 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
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing.
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with seven patients individually and four staff. There were no patients' representatives who wished to meet with us during the inspection. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives. Ten questionnaires for relatives and ten for patients were left for distribution. A poster was given to the manager to display in the staff room inviting staff to respond to an on-line questionnaire.

A lay assessor was present during the inspection and their comments are included within this report.

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 12 to 18 February 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
- three patient care charts including food and fluid intake charts and reposition charts
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not 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 12 January 2018

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 8 November 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 21 (1) (b) **Stated:** First time	The registered person shall ensure that all persons are recruited in accordance with best practice and legislation and that the efficacy of this is present in staff recruitment and selection files.	**Partially met**
	Action taken as confirmed during the inspection: The review of two staff recruitment and selection files evidenced that shortfalls were present in the information. For example; the pre-employment health statement had not been validated by the registered manager and the information on the application was not fulsome and there was no evidence that potential issues had been followed up or discussed at interview.	
Area for improvement 2 **Ref:** Regulation 14 (2) (c) **Stated:** First time	The registered person shall ensure that risks to health and safety of patients are identified and so far as possible eliminated by making sure the clinical room is locked at all times.	**Met**
	Action taken as confirmed during the inspection: The clinical room doors of Orlock, Lighthouse and Copeland units were locked and a key code is required to gain entrance to the rooms.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref:** Standard 35 (13) **Stated:** First time	The registered person shall have robust arrangements in place to ensure care staff are registered with the Northern Ireland Social Care Council (NISCC).	**Partially met**
	Action taken as confirmed during the inspection: The review of the monitoring records in respect of staff registered with NISCC did not evidence that a system was in place to ensure that either all staff were registered or that their registration was being processed.	
Area for improvement 2 **Ref:** Standard 46 **Stated:** First time	The registered person shall ensure access to the sluice is not inhibited by inappropriate storage of equipment.	**Met**
	Action taken as confirmed during the inspection: The sluice that had previously been identified was viewed and there was no evidence of inappropriate storage.	
Area for improvement 3 **Ref:** Standard 48.7 **Stated:** First time	The registered person shall ensure the personal emergency evacuation plans (PEEP's) are maintained in an up to date manner and reflect the current needs of patients' at any given time.	**Met**
	Action taken as confirmed during the inspection: The review of the personal emergency evacuation plans (PEEP's) evidenced that these had been maintained in an up to date manner.	
Area for improvement 4 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure that the daily menu is displayed in a suitable format and in an appropriate location, showing what is available at each mealtime.	**Not met**
	Action taken as confirmed during the inspection: The day's menus in the three units were observed to be written on blackboards and were difficult to read. The menu also did not give sufficient information for patients to be informed of the meal service.	

Area for improvement 5 **Ref:** Standard 35.6 **Stated:** First time	The registered person shall ensure that effective quality monitoring and governance systems are implemented regarding the supervision and annual appraisal of staff and the competency and capability assessments for any nurse in charge of the home.	**Partially met**
	Action taken as confirmed during the inspection: The review of the staff supervision and appraisal planner for 2018 evidenced that appraisals completed in January for staff were recorded. However, there was no evidence that a systematic plan was in place for the rest of the year to ensure that all staff are in receipt of an annual appraisal and supervision.	

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 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. During discussion with patients and staff there were no concerns were raised regarding staffing levels with the exception of one patient who commented “I have to wait at times for assistance to the toilet”. However, a review of records, including the staff duty from 12 to 18 February 2018 evidenced that the dependency levels of patients were kept under review and that planned staffing levels were adhered to. In addition observation of the care delivered during this inspection, evidenced that patients’ needs were met by the levels and skill mix of staff on duty.

Staff selection and recruitment information was available for inspection however records were not fully maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. The staff personnel files of two staff employed from the date of the previous inspection of 8 November 2017 were reviewed. The first file did not evidence that the pre-employment screening had been signed and validated by the registered manager and the information on the application form was not detailed. Similarly the second file did not evidence that the application form had been completed in detail and there was no evidence that employment gaps had been discussed at the time of interview. Recruitment and selection procedures were identified as an area for improvement under regulation and the previous inspection of 8 November 2017 and have been stated for a second time. 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.

A review of the supervision and appraisal planner for 2018 evidenced that a registered nurse and three care assistants had completed their staff appraisal in January 2018. However, the planner did not evidence that a systematic approach for staff appraisal had been planned as no further appraisals were scheduled throughout the year. It would be more beneficial to identify appraisals on a monthly basis so as to ensure all staff were in receipt of same. There was no evidence of a supervision planner in place. The governance arrangements regarding ensuring and evidencing staff are supported via supervision and annual appraisal and competency assessments are current and validated by the registered manager should be robust. This had been identified as an area for improvement under the care standards at the previous inspection of 8 November 2017 and is stated for a second time.

Discussion with the manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training. The majority of staff were compliant with mandatory training requirements. The manager stated a letter was sent to staff who still required to complete some of their training modules. Staff training compliance is monitored by the regional manager for the home when completing the monthly quality monitoring visit. The manager stated a number of face to face training events have been planned for February and March 2018 and include; adult safeguarding procedures, dementia awareness, communication and activity and distressed reactions.

Discussion with the manager and review of records evidenced that the shortfalls identified at the previous inspection of 8 November 2017 regarding the arrangements for monitoring the registration status of care staff in accordance with Northern Ireland Social Care Council (NISCC) had not been fully addressed. There was evidence that whilst the registration status of care staff with NISCC had been printed off from NISCC's website, there was no system in place to verify that all care staff were registered or that the registration was in process. This has been stated as an area for improvement under the care standards for a second time.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since November 2017 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 and generally clean throughout. Patients spoken with were complimentary in respect of the home's environment. Two patients' representative did however comment that "cleaning is adequate" and the home "could be cleaner".

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were generally adhered to and equipment was appropriately stored. There was evidenced of rust on a shower chair and toilet frame, these were identified to the regional manager. There was a strong malodour in an identified area of Copeland and Orlock units, the regional manager agreed to address these issues.

Areas of good practice

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

Areas for improvement

No new areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	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 generally informed the care planning process.

The review of two patient care records evidenced that the management of a patient's behaviour was not adequately defined in the care record and the interventions for the behaviour were not supportive. The second care record evidenced that the pre admission assessment made no reference to the patient having a wound. This was discussed with the regional manager who stated that regarding wound care management the home had not been informed that the patient had a wound prior to admission. Regarding behaviour management the regional manager agreed to discuss with staff how best to support the patient and ensure the care record clearly defined how this was to be achieved and the patient's response to planned care. This has been identified as an area for improvement under the care standards. There was evidence that registered nurses were aware of the local arrangements and referral process to access other relevant professionals including General Practitioner's (GP), Speech and Language Therapist (SALT), dietician and the Tissue Viability Nurse Specialist (TVN).

Supplementary care charts, for example repositioning records and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislation.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. Patients' records were maintained in accordance with Schedule 3 of the Nursing Homes Regulations (Northern Ireland) 2005.

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.

The serving of the midday meal was observed. The dining room in one unit was observed to be locked following the setting of the dining tables at 11:00 hours. This was stated to be so as patients did not go into the dining room once the tables were set. This would not be considered good dementia care and the routines of the home should not be staff focused, rather patient focused. This has been identified as an area for improvement under the care standards. The dining tables were poorly set as knives and forks were placed incorrectly and there was evidence of 'dishwasher' staining on the cutlery. As previously stated the day's menu was displayed on a blackboard. Consideration must be given as to whether this is a

suitable visual medium for patients to clearly see. This was identified as an area for improvement at the previous inspection of November 2017 and is stated for a second time. The menu stated the two main meal choices and gave no further information, for example; chicken pie or Vienna steak, again this did not provide patients with sufficient information regarding the upcoming meal service. The meals were nicely presented, were of good quality and smelt appetising. Patients who required a modified diet were afforded a choice at mealtimes; this was verified when reviewing the patients' meal choice record. Registered nurses were observed supervising and assisting patients with their meals and monitoring patients' nutritional intake in the dining room. A number of patients had their meal in their bedrooms and this was taken to them via tray service. Meals were covered when being transported. However, a patient who was having their meal in their bedroom was observed to be trying to sit up from a semi recumbent position to have their meal. Staff should have assisted the patient to a more suitable position for eating their meal before they left the patient's bedroom. This has been identified as an area for improvement under the care standards.

The mid-morning tea trolley was observed in one of the units. Staff were asked what patients who required a specialised diet were having as a mid-morning snack. Staff stated that generally nothing was provided for patients who require a specialised diet. This is not satisfactory and has been identified as an area for improvement under regulation.

Areas of good practice

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

Areas for improvement

The following areas were identified for improvement under the care standards; patient care records should clearly define how a patient is to be supported and the patients response to planned care; care practice in the dementia care units should be patient focused as opposed to staff focused and staff should ensure patients are in a comfortable position for the eating of their meals.

The following area was identified for improvement under regulation; patients who require a specialised diet must be offered a mid-morning and mid afternoon snack suitable to their individual needs.

	Regulations	Standards
Total number of areas for improvement	1	3

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.

Staff interactions with patients were observed to be caring and timely. Consultation with patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Staff were observed chatting with patients when assisting them with everyday tasks. 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.

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.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. Staff supported patients to maintain friendships and socialise within the home. There were two personal activities leader (PALs) responsible for the provision of activities in the home. There was evidence of a variety of activities in the home and discussion with staff confirmed that patients were given a choice with regards to what they wanted to participate in. On the day of the inspection a number of patients were attending a 'lunch club' held weekly in the local community centre. The manager stated the lunch club was greatly enjoyed and patients were enabled to maintain links with the wider community. There were various photographs displayed around the home of patients' participation in recent activities. Social care plans were in place to provide information to staff to ensure that patients' social care needs were met individually.

Four staff members were consulted to determine their views on the quality of care within Edgewater Lodge Care Home. A poster was given to the registered manager to be displayed in the staff room inviting staff to respond to an on-line questionnaire. No staff responded within the timeframe for inclusion in the report.

Some staff comments were as follows:

"Everything is good here."
"I enjoy working here."
"Staffing is fine."
"Plenty of training opportunities."

We consulted with seven patients individually during the inspection; the following comments were made:

"I have to wait for assistance to the toilet."
"The staff couldn't be nicer."
"No complaints at all."
"I think they're (staff) very kind and caring and go out of their way to help everybody."

Eight patient questionnaires were left in the home for completion. Six of the patient questionnaires were completed in discussion with the Lay Assessor. Five patients expressed that they were either satisfied or very satisfied that the delivery of care was safe, effective and compassionate and that the service was well led. One patient was undecided across the four domains.

Ten relative questionnaires were left in the home for completion. Four of the relative questionnaires were returned within the timeframe for inclusion in the report. Three respondents indicated that they were either very satisfied or satisfied with the care provided in the home. One of the respondents was neutral in respect of safe, effective and compassionate care and if the service was well led. Additional comments included:

"Could be cleaner."
"Whilst I've circled 4's mostly the care is adequate and the cleaning is adequate".
"Staff in Copeland are very good and friendly, also approachable."
"Kind and caring (staff) to my relative, really feel my relative has settled so well thanks to this."

One patient's representative made reference to the management of continence; this has been discussed with the manager by telephone.

An area for improvement under the care standards has been identified in relation to comments made by patients and patients' representatives regarding the home's environment and responding to patients request for assistance promptly.

Lay Assessor's comments:

The lay assessor spoke to six patients individually and the six patients completed questionnaires. Feedback was positive and no concerns were raised except for on occasions there was a delay in staff responding to requests for assistance. It was felt that whilst the home was generally clean the building was starting to show it's age and was 'tired' and there was an odour in the home which was hard to define. This was discussed with the regional manager who accepted the observations.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered 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 the culture and ethos of the home.

Areas for improvement

The following areas were identified for improvement in relation to comments made by patients and patients' representatives regarding the home's environment and responding to patients request for assistance promptly.

	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.

The registered manager was not available at the time of the inspection. An acting manager, who will be referred to as the manager throughout the report, had been appointed in the interim. The manager was unable to stay for the completion of the inspection and the regional manager, Elaine McShane facilitated the inspection.

A review of the duty rota evidenced that the hours worked by the manager in either a management and/or clinical role were not clearly recorded. This was discussed with the manager who agreed to ensure this was stated from now on. Staff were able to identify the person in charge of the home.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was not displayed. A certificate for employers liability insurance was displayed however this expired in December 2017. This was discussed with the regional manager who stated that the certificate for public liability insurance was held centrally at head office. RQIA have written to the managing director of Four Seasons Health Care to clarify the situation and gain assurances that there is a current certificate for public liability. Discussion with the manager, regional manager and review of records evidenced that the home was operating within its registered categories of care.

Discussion with the regional 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 Care Standards for Nursing Homes 2015.

Patients spoken with in Copeland unit confirmed that they were aware of the home's complaints procedure. Patients confirmed that they were confident that staff/management would manage any concern raised by them appropriately.

A review of notifications of incidents to RQIA since the last care inspection of 8 November 2017 confirmed that these were managed appropriately. Discussion with the regional 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 regional manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation restraint, the use of bed rails, wound management, infection prevention and control, complaints and incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvement had been embedded into practice. However, as discussed in section 6.4 shortfalls were identified in some aspects of the governance arrangements in the home, for example; the monitoring of the registration of staff with the appropriate professional body and the recruitment and selection documentation. These were identified as areas for improvement at the previous inspection of November 2017 and have been stated for a second time.

As a further element of its Quality of Life Programme, Four Seasons Health Care operates a Thematic Resident Care Audit ("TRaCA") which home managers can complete electronically. Information such as home governance, information governance, housekeeping, resident care and health and safety checks are recorded on various TRaCAs on a regular basis. This information was subject to checks by the regional manager once a month.

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 regional manager and review of records evidenced that Regulation 29 or monthly quality monitoring visits were completed in accordance with the regulations and/or 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.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to management of complaints and incidents and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Elaine McShane, Regional 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 (1) (b) **Stated:** Second time **To be completed by:** 1 April 2018	The registered person shall ensure that all persons are recruited in accordance with best practice and legislation and that the efficacy of this is present in staff recruitment and selection files. Ref: Sections 6.2 and 6.4
	Response by registered person detailing the actions taken: FSHC Human Resource assistants have visited the home and assisted the Administrator with auditing the personnel files and organising them in a new filing system following an index. All gaps identified during inspection have now been rectified. Going forward the home will follow the index system during the recruitment and selection process. Completion will be monitored through the auditing process.
Area for improvement 2 **Ref:** Regulation 12 (4) (a), (b) and (c) **Stated:** First time **To be completed by:** 1 April 2018	The registered person shall ensure that patients who require a specialised diet are provided with a snack at regular intervals throughout the twenty four hour period. Ref: Section 6.5
	Response by registered person detailing the actions taken: FSHC Resident Experience Facilitator has visited the home on 13/3/18 and given Catering staff snack ideas of what to serve residents who require a modified diet. Snacks such as custard, yoghurts, milkshakes and pureed fruit and cream are now readily available at snack times throughout the 24 hour period.This will be monitored through the auditing process.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref**: Standard 35 (13) **Stated:** Second time **To be completed by:** 1 April 2018	The registered person shall have robust arrangements in place to ensure care staff are registered with the Northern Ireland Social Care Council (NISCC). Ref: Sections 6.2 and 6.4
	Response by registered person detailing the actions taken: A new matrix is now in place which clearly identifies staff registered, those who are in the process and those who are due to renew their annual fee. An alert is also sent from FSHC Regional Office if a staff member is due to renew their registration. This will be monitored via the Monthly reg 29 audit.

Area for improvement 2 **Ref**: Standard 12 **Stated:** Second time **To be completed by:** 1 April 2018	The registered person shall ensure that the daily menu is displayed in a suitable format and in an appropriate location, showing what is available at each mealtime. Ref: Sections 6.2 and 6.5
	Response by registered person detailing the actions taken: FSHC Dementia Project Facilitator has visited the home and gave advice of what menus boards should be in place. New boards are being ordered on a rolling programme. Catering staff are in the process of taking photographs of dishes actually served in the home which will be changed and displayed on a daily basis. These photographs will also be displayed in a menu folder to facilitate those residents who are not able to view the menu board. Compliance will be monitored through the Monthly visit of the Regional Manager.
Area for improvement 3 **Ref**: Standard 35.6 **Stated:** Second time **To be completed by:** 1 April 2018	The registered person shall ensure that effective quality monitoring and governance systems are implemented regarding the supervision and annual appraisal of staff. Ref: Sections 6.2 and 6.4
	Response by registered person detailing the actions taken: A new matrix is now in place which clearly identifies the month that staff are due an appraisal or supervision. Once the appraisal or supervision has been held, then this matrix is updated with the actual date held. Compliance will be monitored via the monthly visit by the RM.
Area for improvement 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 1 April 2018	The registered person shall ensure that patient care is planned to reflect patient needs and care interventions clearly define the level of support required and patients' response to planned care. Ref: Section 6.5
	Response by registered person detailing the actions taken: The care record of the identified resident has been reviewed so that it clearly defines the level of support required. Staff have been advised to ensure that this is regularly reviewed to reflect if the plan of care is appropriate to the resident's current needs. Compliance will be monitored through the auditing process.

Area for improvement 5 **Ref**: Standard 25 **Stated:** First time **To be completed by:** 1 April 2018	The registered person shall ensure that the ethos of the dementia units is patient focused, for example; a risk based approach should be in evidence and patients should be able to access communal areas including the dining rooms. Ref: Section 6.5
	Response by registered person detailing the actions taken: The identified dining room has had the lock removed from the door, however there is one identified resident who frequently enters this dining room and removes cutlery and furniture. Staff have been advised to monitor this resident and to regularly review this situation.
Area for improvement 6 **Ref**: Standard 12.24 **Stated:** First time **To be completed by:** 1 April 2018	The registered person shall ensure staff have the knowledge and skills to suitably position patients when eating and drinking to facilitate maximum nutritional intake. Ref: Section 6.5
	Response by registered person detailing the actions taken: Speech and Language recommendations in relation to position have been photocopied and placed in individual files for all care staff to view. A supervision session has been held with staff in relation to this.
Area for improvement 7 **Ref**: Standard 7.1 and 7.5 **Stated:** First time **To be completed by:** 1 April 2018	The registered person shall ensure that the comments of patients and patients' representatives are acted upon, as far as possible, regarding the cleanliness of the home and staffs response to patients' calls for assistance. Ref: Section 6.6
	Response by registered person detailing the actions taken: FSHC operates a daily walkabout TRaCA which will identify any areas of the home that require attention. This is carried out by a different member of the team each day to ensure there is a neutral view. Staff have been advised about the prompt responding to residents request for assistance via the call bells - this is being monitored by the nurse in charge of each unit and by the Home Manager.

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The Regulation and Quality Improvement Authority

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