Inspection Report

29 July 2024

Edgewater Lodge

Type of service: Nursing
Address: Copeland, Orlock and Lighthouse Suites, 4 Sunnydale Avenue, Donaghadee BT21 0LE
Telephone number: 028 9188 8044

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: Electus Healthcare 1 Limited **Responsible Individual:** Mr Ed Coyle	**Registered Manager:** Mr Paul Williamson - not registered
Person in charge at the time of inspection: Mr Paul Williamson - Manager	**Number of registered places:** 58 A maximum of 17 patients in categories NH-I, NH-PH/PH(E), NH-TI accommodated in the Copeland Suite, a maximum of 41 patients in category NH-DE; 21 accommodated in the Orlock Suite and 20 accommodated in the Lighthouse Suite.
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 patients accommodated in the nursing home on the day of this inspection:** 58
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 58 persons. The home is divided into three units. Copeland Suite which provides general nursing care; Orlock Suite and Lighthouse Suite which provides care for people with dementia. There is also a registered Residential Care Home under the same roof. The manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 29 July 2024 from 9.10 am to 7.30 pm by two care inspectors. The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Patients were happy to engage with the inspectors and share their experiences of living in the home. Patients expressed positive opinions about the home and the care provided. Patients said that staff members were helpful and pleasant in their interactions with them.

Patients who could not verbally communicate were well presented in their appearance and appeared to be comfortable and settled in their surroundings.

Concerns were identified regarding the lack of robust managerial oversight of systems to reduce unnecessary risks to patients. Shortfalls were identified in regard to manual handling practices; supervision of patients at mealtimes; falls management, management of complaints, infection prevention and control (IPC) practices; management of risk; staff training in relation to Deprivation of Liberty Safeguards (DoLs), Control of Substances Hazardous to Health (COSHH) and fire safety, and the quality of record keeping.

The shortfalls identified raised concern that the quality of care provided to patients was below the standard expected. A serious concerns meeting resulted from this inspection.

The Responsible Individual (RI) and the Operations Manager attended a serious concerns meeting with RQIA on 6 August 2024 to discuss the inspection findings and their plans to address the serious concerns identified.

During the meeting the RI discussed the actions they had taken since the inspection to address the concerns raised and provided the necessary assurances to confirm they would address the remaining actions needed to bring the home back into compliance with the regulations and standards. RQIA accepted these assurances and will carry out a further inspection to assess compliance.

Areas requiring improvement were identified during this inspection and are discussed within the main body of the report and Section 6.0.

The findings of this report will provide the manager 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 patients, relatives and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in Edgewater Lodge. 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.

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 findings of the inspection were provided to the registered manager at the conclusion of the inspection.

4.0 What people told us about the service

Patients spoke positively about the care that they received and about their interactions with staff. Patients confirmed that staff treated them with dignity and respect and that they would have no issues in raising any concerns with staff. One patient said, “They (the staff) take very good care of me and the food is very good”, while another patient said, “I am comfortable here and enjoy the company.” A third patient said, “The food is good and I am quite happy here.”

Relatives spoken with were complimentary of the care provided in the home. One relative said, “I have no concerns and I am happy with the care. They (the staff) keep us informed and I go to the relative’s meetings.” Comments received from another relatives during and following the inspection were discussed with the manager and operations manager for follow up as required.

Staff spoken with said that Edgewater Lodge was a good place to work. Staff commented positively about the teamwork. One staff member said that, “The teamwork is very good and we get on very well. The communication is good.” The manager said that there were good working relationships between staff and management.

One response was received to the online staff survey. The respondent was dissatisfied when asked if service users were treated with compassion and if the service was well managed and were satisfied when asked to comment if care delivered was effective and compassionate. The respondent’s comments relating to the manager were shared with the operations manager for follow up.

5.0 The inspection

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

Areas for improvement from the last inspection on 20 April 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 14 (2) (a) **Stated:** First time	The registered person shall ensure that all parts of the home to which patients have access are free from hazards to their safety.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement is not met and is stated for a second time. This is discussed further in section 5.2.3.	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure that a daily menu is on display in a suitable format and in an appropriate location, showing patients what is available each mealtime.	**Partially met**
	Action taken as confirmed during the inspection: This area for improvement is partially met and is stated for a second time. This is discussed further in section 5.2.2.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

A review of a selection of recruitment records confirmed that all pre-employment checks had been completed prior to each staff member commencing in post. Staff were also provided with a comprehensive induction programme to prepare them for providing care to patients.

Checks were made to ensure that staff maintained their registration with the Nursing and Midwifery Council (NMC) or with the Northern Ireland Social Care Council (NISCC).

The staff duty rota accurately reflected the staff working in the home on a daily basis. This rota did not consistently identify the person in charge when the manager was not on duty or the capacity in which staff were working. This was discussed with the manager who arranged for this to be rectified. An area for improvement was identified.

Review of records confirmed all of the staff who take charge of the home in the absence of the manager had completed a competency and capability assessment to be able to do so.

Staff consulted with confirmed that they received regular training in a range of topics such as manual handling, IPC practices and fire safety. However, review of staff training records confirmed that all staff were not up to date with mandatory training. This was discussed with the manager who agreed to arrange for outstanding training to be completed. An area for improvement was identified.

Staff said they felt well supported in their role and were satisfied with the level of communication between staff and management. Staff reported good teamwork although some staff raised concerns regarding the staffing levels. The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met and that the home was well staffed.

Review of staff meeting minutes confirmed that staff meetings were not held on at least a quarterly basis. There were no separate records for the nursing home as joint staff meetings were held with the residential care home. This was discussed with the manager and an area for improvement was identified.

Patients spoke positively about the care that they received and confirmed that staff attended to them in a timely manner; relatives said that they would have no issue with raising any concerns to staff. It was observed that staff responded to patients' requests for assistance in a prompt, caring and compassionate manner.

5.2.2 Care Delivery and Record Keeping

Staff told us they met at the beginning of each shift to discuss any changes in the needs of the patients. Staff members spoken with were knowledgeable of patients' daily routine, wishes and preferences. Staff confirmed the importance of keeping one another up to date with any changing needs in patients' care throughout the day.

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. Staff members were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

Patients who were less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly. However, examination of the recording of repositioning evidenced patients were not consistently repositioned and did not have their skin checked in keeping with their assessed needs. This was discussed with the manager and an area for improvement was identified.

A number of patients nursed in their bedroom were unable to use the nurse call system due to their cognitive impairment. This was discussed with the manager who agreed to ensure those patients who cannot use the system are appropriately supervised.

Management of wound care was examined. Review of a selection of care records confirmed that wound care was provided in keeping with care plan directions.

Significant concerns regarding the health and welfare of patients were identified following observation of staff manual handling practices. The manager had told us that staff had recently completed moving and handling training. Based on the observation of staff practice detailed below, it was evident that this training had not been embedded into practice and that the poor practice observed was custom and practice.

Two staff were observed using an under arm drag lift to transfer a patient from a wheelchair to an armchair. When asked why they used this type of lift, one staff member said they would normally transfer patients this way. A second incident of poor manual handling technique was observed when staff attempted to transfer a patient from a wheelchair to the armchair using the same under arm drag lift. Both the manager and inspector had to intervene to ensure the patient's safety. A third incident was observed where a staff member, using the under arm lift, lifted a patient from the floor following an unwitnessed fall. The staff when asked why they had assisted the patient off the floor in this way said that they were not aware of any other way how this could have been done safely.

RQIA were concerned that there was a lack of leadership and proactive management in relation to safe moving and handling practices; this placed patients at unnecessary risk of harm. As a result of these observations RQIA made referrals to the Adult Protection Gateway team in South Eastern Trust. These events were discussed with the manager and areas for improvement were identified.

At the serious concerns meeting with RQIA the RI outlined the actions they had taken since the inspection to ensure the safe moving and handling of patients and to eliminate poor practice.

Concerns were identified in relation to the management of falls. Review of two care plans in relation to falls, identified that risk assessments and care plans were not consistently updated post fall. Records evidenced that there was an inconsistent approach by registered nursing staff to the recording of clinical and neurological observations and the records reviewed did not note the patient's status post fall.

In addition, RQIA were concerned that a fall which occurred, during the inspection, was not appropriately managed by the registered nursing staff. This was discussed with the manager who provided assurances these shortfalls would be addressed without delay. An area for improvement was identified.

At the serious concerns meeting with RQIA the RI outlined the actions they had taken since the inspection to ensure registered nursing staff, including agency nurses, were aware of their role and responsibility in the management of falls and that clinical observations had to be recorded in keeping with the home's procedures.

Review of a number of patient care records evidenced that patients residing in Copeland Suite had a care plan in place describing that they lived in a “locked unit”. These care plans placed restrictions on patients leaving the general nursing unit unless accompanied by a family or staff member. This could be considered a restrictive practice if a patient is not free to leave. Copeland Suite does have a digital key pad lock in place at the entrance to the unit but measures were not in place to enable patients with capacity to leave if they so wished. This was discussed at length with management and assurances were given that the key code would be displayed and care plans for all patients would be reviewed to ensure they were reflective of their assessed need. An area for improvement was identified.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Lunch was observed to be a pleasant and unhurried experience for the patients. The food served was attractively presented; smelled appetising and portions were generous. A variety of drinks were served with the meal. Patients spoke positively in relation to the quality of the meals provided. However, a number of concerns were identified in relation to the supervision of patients requiring a modified diet due to their risk of choking, that patients were not offered napkins or protectors to help maintain their dignity; that plastic glasses and cups provided to patients were visibly stained and worn and that one staff member referred to patients who require assistance with eating and drinking as “feeders”. RQIA were concerned that management and staff did not place any value on the patients’ dignity or lived experience in the home.

In addition, the previous area for improvement relating to the daily menu had not been met. RQIA provided the manager with details but also referred these matter to the Adult Protection Gateway team in South Eastern Trust. A number of areas for improvement were identified.

At the serious concerns meeting with RQIA the RI outlined the actions they had taken since the inspection to ensure patients’ mealtime experience was improved and their dignity maintained; and that any patient requiring supervision with their meal due to their risk of choking had the required supervision in place.

Patients’ needs were assessed at the time of their admission to the home. Following this initial assessment, care plans should be developed to direct staff on how to meet patients’ needs and included any advice or recommendations made by other healthcare professionals. Review of a selection of care records evidenced that care plans had been developed within a timely manner to accurately reflect their assessed needs.

Concerns were identified regarding the management of one patient’s reduced fluid intake over a number of days with care records not clear as to what actions were taken by registered nurses to monitor and address this. In addition, staff were not consistently recording the 24-hour fluid intake for patients who were having their fluid intake monitored. This was discussed with the manager who agreed to meet with nursing staff and monitor through ongoing care record audits. Areas for improvement was identified.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was also recorded.

Shortfalls were identified in the completion of daily evaluation records. Some entries were made at midnight with no further entries made to comment on how the patient slept. In addition, some evaluations of care were not person centred and contained repetitive statements.

Assurances were provided by the manager that this would be addressed with staff and monitored through their audit systems. This will be reviewed at a future care inspection.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. The home was warm and comfortable. Patients' bedrooms were tidy and personalised with items of importance to each patient, such as family photos and sentimental items from home.

Some patient equipment such as bed ends, bedside tables and laundry trollies required to be repaired or replaced while some armchairs and crash mats appeared to be stained and in need of cleaning. This was discussed with management who provided assurances that many of these issues had been identified and were being addressed through daily monitoring and an environmental action plan. These will be reviewed at a future care inspection.

Concerns were identified regarding the management of risks to the health and safety of patients within the home's environment. For example, cleaning chemicals were not appropriately supervised on a domestic's cleaning trolley and food and fluid thickening agent was accessible to patients in the Copeland Suite dining room. These matters were discussed with staff who took immediate action. An area for improvement identified at the previous care inspection was stated for a second time.

Fire safety measures were in place to ensure that patients, staff and visitors to the home were safe. Staff members were aware of their training in these areas and how to respond to any concerns or risks. A fire risk assessment had been completed on 12 March 2024 and there was evidence that the areas of concern identified by the fire risk assessor had been signed off as fully addressed by the manager.

There were laminated posters displayed at hand washing points to remind staff of good hand washing procedures. Hand sanitisers were available throughout the home.

Observation of staff and their practices evidenced that basic IPC practices were not consistently adhered to. Staff were not bare below the elbow and were wearing jewellery and nail varnish; staff did not take appropriate opportunities to apply and remove personal protective equipment (PPE) correctly or to wash their hands as frequently as they should, particularly after contact with patients and the patient's environment. Full PPE was not available to laundry staff and concerns were identified regarding the management of contaminated laundry.

It was also evidenced that vinyl gloves were being used to deliver personal care and available in PPE dispensing units; and vinyl gloves were also being used by domestic staff. This type of glove is not suitable for use in personal care or cleaning within healthcare setting as indicated by the Regional IPC Guidance. The completed infection prevention and control audits reviewed did not identify the shortfalls identified by RQIA and it was not clear if the person completing the audits had sufficient competence and skill to conduct them effectively. The above shortfalls were discussed with the manager and areas for improvement were identified.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, some patients told us they liked the privacy of their bedrooms whilst others preferred to sit in the lounge or foyer area. Patients were observed listening to music, reading newspapers and watching TV while others enjoyed a visit from relatives.

The atmosphere throughout the home was warm, welcoming and friendly. Music was playing or TV's were on in the communal areas and patients were seen to be relaxed and content in their surroundings. Patients said they enjoyed the activities in the home.

An activity planner displayed in the home confirmed varied activities were delivered by an activity co-ordinator which included one to one activities, music, pampering, garden time and hand and nail care.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mr Paul Williamson has been the manager since 3 October 2022. However, after the inspection RQIA were notified by the RI that the deputy manager had been appointed as acting manager until further notice.

Concerns were identified regarding the management of complaints as the manager did not have a good understanding of what constituted a complaint nor were records satisfactorily maintained in accordance with the regulations. There was evidence that not all complaints were recorded in keeping with best practice guidance. An area for improvement was identified.

A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly. However, there was evidence that at least one incident that had occurred had not been notified to RQIA accordingly. The manager agreed to audit the accidents and incidents and notify RQIA retrospectively.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. The manager or delegated staff members completed regular audits to quality assure care delivery and service provision within the home.

However, based on the inspection findings and a review of a sample of audits it was evident that improvements were required regarding the audit process to ensure it was effective and proactive in identifying shortfalls and driving improvements through clear action planning. An area for improvement was identified.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail. These are available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where 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	11*	6*

*The total number of areas for improvement includes two that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Paul Williamson, manager, as part of the inspection process and with the RI during the serious concerns meeting. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

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

Area for improvement 1 **Ref:** Regulation 14 (2) (a) **Stated:** Second time **To be completed by:** 29 July 2024	The registered person shall ensure that all parts of the home to which patients have access are free from hazards to their safety. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: Thickening agents are now locked in a cupboard in the dining room following usage. This is monitoed daily by the person supervising the mealtime service, and also on the daily walk round by the Acting Manager for compliance. The domestic staff have received supervison and is is dicussed daily at the flash meetings about domestic staff not leaving trollies unattened and asuring that when they are cleaning that their trolley is in sight at all times.
Area for improvement 2 **Ref**: Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by** 29 August 2024	The registered person shall ensure that mandatory training requirements are met to enable staff to meet the needs of patients safely and effectively. Ref: 5.2.1
	Response by registered person detailing the actions taken: Mandatory training is kept under review to ensure compliance. A training schedule is in place along with a schedule of planned trainning. Compliance is monitored by the acting Manager and by the senior team to ensure all staff complete their mandatroy training within a specified timescale.
Area for improvement 3 **Ref:** Regulation 14 (4) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall make arrangements, by training staff or by other measures, to prevent patients from being harmed or suffering abuse or being placed at risk of harm or abuse. This area for improvement is made with specific reference to ensuring that staff training in manual handling practices is embedded into practice. Ref: 5.2.2

	Response by registered person detailing the actions taken: All staff have completed a supervison in relation to moving and handling practices. During staff meetings manual handling practices have been discussed at length. Face to face moving and handling training has been refreshed and the Trust ergonomics team and OT have provided guidance and face to face training to staff, with further dates to be planned.
Area for improvement 4 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure that staff manage falls in keeping with best practice and the homes' own policies and procedures. Ref: 5.2.2
	Response by registered person detailing the actions taken: All nurses have received supervision on the management of falls. All nurses have been given an SOP in relation to 5h3 management of falls based on the new regional guidleines. A post falls tracker is in place to ensure all paper work and actions have been completed. This is reviewed each month by the Acting Manager to ensure the protocol has been followed for each fall.
Area for improvement 5 **Ref:** Regulation 16 (2) (b) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure that the patients in the Copeland Suite with care plans regarding the locked unit have their care plan reviewed in line with deprivation of liberty safeguards. Ref: 5.2.2
	Response by registered person detailing the actions taken: The exit code is now displayed above the keypad. Residents with capacity have had their care plans removed regarding the locked unit. DOLS reviews by the Trust continue and care plans are being updated accordingly following the reviews.
Area for improvement 6 **Ref:** Regulation 13 (1) (b) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure that patients who are identified as being at risk of choking are appropriately supervised at mealtimes in keeping with their assessed needs and plan of care. Ref: 5.2.2
	Response by registered person detailing the actions taken: A designated person is assigned to the dining room and they sign off each meal time to confirm that they have been in the dining room the enitre meal service and have not left the room

	unspervisied. Review of those residents who have been deemed as requiring 1:1 mealtime supervison has been requested and the SALT team are continuing to review those resdients.Care plans have been reviewed and updated to reflect any changes in the SALT advice.
Area for improvement 7 **Ref:** Regulation 13 (8) (a) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall make suitable arrangement to ensure that the home is conducted in a manner which does not potentially impact on the well-being and dignity of patients. This area for improvement is made with specific reference to the following: • the provision of suitable cups, glassware and crockery • the availability of appropriate clothing protectors • staff adopting a person centred care approach and speaking about patients in a manner that is sensitive and understanding of their needs. Ref: 5.2.2
	Response by registered person detailing the actions taken: New cups, jugs, glasses, additional crockery and cuttlery have been purchased. Additional clothing protectors are ordered each week and are freely availabe for use. Supervison has been held with staff around language used and speaking with residents in an appropiate manner.
Area for improvement 8 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure staff have access to appropriate personal protective equipment and are trained in how and when to use it. Ref: 5.2.3
	Response by registered person detailing the actions taken: Additional PPE stations have been added to the dining rooms. IPC competencies and donning and doffing competencies have been completed with all staff. All staff have also had supervision for donning and doffing and IPC. Sustainabily is monitored by the Acting Manager on her daily walk rounds and by the senior team during visits and reg visits to ensure compliance.
Area for improvement 9 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person shall ensure staff adhere to regional infection prevention control guidelines regarding being bare below the elbow. A system should be implemented to monitor staff compliance with this best practice guidance. Ref: 5.2.3

To be completed by: 29 July 2024	**Response by registered person detailing the actions taken**: At each morning flash meeting Nurses are reminded to ensure that their staff are compliant with IPC, in that staff are bare below elbows. This is monitored on daily walk rounds by the accting Manager and also by the senior team duirng visits and Reg 29 visits. Monthly IPC audits are also completed to review compliance.
Area for improvement 10 **Ref**: Regulation 24 (3) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure that all complaints are managed in keeping with this standard and appropriate records are retained. Retrospective records should be completed for any identified complaints. Ref: 5.2.5
	Response by registered person detailing the actions taken: A complaints log is now in place. All complaints are recorded on the log, the original complaint will be logged along with the holding letter and investigation notes and outcome letter, this will all be availbe for review and auditing for patterns and trends.
Area for improvement 11 **Ref**: Regulation 10 (1) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure that there is a robust system of governance in place, that it is effective and proactive in identifying shortfalls and driving improvements through clear action planning**.** Ref 5.2.5
	Response by registered person detailing the actions taken: Audits have been reviewed and a solid governance system is in place. Going forward audits that have been completed will be ratified for accuracy to ensure that improvements that are required are action planned and completed in a timely manner to ensure continuous quality improvement.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 12 **Stated:** Second time	The registered person shall ensure that a daily menu is on display in a suitable format and in an appropriate location, showing patients what is available each mealtime. Ref: 5.1 and 5.2.2

To be completed by: 29 July 2024	**Response by registered person detailing the actions taken:** Pictorial menus are in the process of being developed to show the new seasonal menu. The daily menu is displayed in the dinning rooms for all resdients to see. A choice sheet is also availabe for residents to assist them in menu choices.
Area for improvement 2 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure records are kept of all staff working in the home over a 24-hour period. The capacity in which they are working and the name of the nurse in charge of each shift should be clearly identified. Ref: 5.2.1
	Response by registered person detailing the actions taken: Rotas have been reviewed, full names and designation are recorded. Rotas are signed off by the Acting Manager and the person in charge of the home on each shift is clearly identified.
Area for improvement 3 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 29 October 2024	The registered person shall ensure that staff meetings take place on a regular basis, at a minimum quarterly. Separate staff meeting minutes should be retained for the nursing home. Ref: 5.2.1
	Response by registered person detailing the actions taken: A staff meeting schedule has been put in place and is on display in each unit to inform staff of the dates. The nursing home and residential home going forward will have separate meetings. A sign in sheet is used and minutes are recorded. Any actions required will be shared and a copy of the minutes will be made availabe for staff.
Area for improvement 4 **Ref**: Standard 4 **Stated:** First time **To be completed by** 29 July 2024	The registered person shall ensure that repositioning records evidence the delivery of pressure area care and skin checks as prescribed in the patients care plan. These records should be accurately completed. Ref: 5.2.2
	Response by registered person detailing the actions taken: A review of the care plans of those residents who are repositioned has taken place. Repositioning booklet directions match the care plan directions. The booklets are checked randomly by the Acting Manager on daily walk rounds for compliance and also by the person completing the reg 29 visit.

	Nurses also sign off the repositioning booklets at the end of their shift.
Area for improvement 5 **Ref**: Standard 4.9 **Stated:** First time **To be completed by** 29 July 2024	The registered person shall ensure that a contemporaneous record is maintained of actions taken and discussion held regarding patients care and treatment. This area for improvement is mad with specific reference to management of patients with reduced fluid intake. Ref: 5.2.2
	Response by registered person detailing the actions taken: Supervisions have been completed on the recording of fluids. Fluid intake is disucssed at flash meetings. Resdients who fail to meet their fluid totals for three or more consecutive days are reffered to the G.P. for advice on the next steps. All advice is recorded clearly in the residents care notes.
Area for improvement 6 **Ref**: Standard 37.4 **Stated:** First time **To be completed by** 29 July 2024	The registered person shall ensure that patients' fluid intake over a 24-hour period is reviewed by a registered nurse where appropriate and accurate records are maintained. Ref: 5.2.2
	Response by registered person detailing the actions taken: Supervision and staff metting held with the nurses to discuss fuild intake monitoring. Fulid totals are calculated by night staff and carried forward to the residents progress notes at the end of night shift for the review by day staff.

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