The Regulation and Quality Improvement Authority

Inspection Report

3 March 2022

Rush Hall

Type of service: Nursing Home
Address: 51 Broighter Road, Limavady, BT49 9DY
Telephone number: 028 7776 9326

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

1.0 Service information

Organisation: Ann's Care Homes Limited **Responsible Individual:** Mrs Charmaine Hamilton	**Registered Manager:** Mrs Carol Craig **Date registered:** 15 May 2018
Person in charge at the time of inspection: Emma McNeill, Deputy Manager	**Number of registered places:** 66 Maximum of 32 patients within category of care NH-DE and located within the Dementia Unit.
Categories of care: Nursing Home (NH) DE – Dementia. I – Old age not falling within any other category.	**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 66 patients. The home is divided into four units. The Hunter and Broighter suites are situated on the ground floor and provide care for people with dementia; the Binevenagh and Roe suites are situated on the first floor and provide general nursing care. Patients have access to communal lounges, dining rooms and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 3 March 2022 from 09.35 am to 6.30 pm by a care inspector.

The purpose of the inspection was to assess progress with all areas for improvement identified in the home since the last care inspection on 18 May 2021 and to determine if the home was delivering safe, effective and compassionate care and if the service was well led. Prior to the inspection concerns were received in relation to the provision of personal care, patient dignity, instances of unexplained bruising and ineffective communication between staff.

The inspection identified similar concerns along with other areas for improvement in relation to the health and welfare of patients, infection prevention and control (IPC), risk management and the environment which are detailed throughout this report and quality improvement plan (QIP) in

Section 7.0. Details of the areas requiring improvement were discussed with the Responsible Individual and management team.

In addition, the areas for improvement from the previous care inspection on 18 May 2021 had not been fully addressed and have been stated for a second or third time. One area for improvement in relation to medicines management has been carried forward for review at a future inspection.

Patients said that they were well looked after and were happy living in Rush Hall. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

A meeting was held between RQIA, the registered persons and the regional manager via teleconference on 14 March 2022. In advance of the meeting a detailed action plan was provided to RQIA outlining the steps that had been taken immediately following the inspection and plans for all other areas identified for improvement to be addressed. During this meeting additional assurances were provided by the management team. The outcome from the inspection and the meeting that followed was shared with the Western Health and Social Care Trust (WHSCT).

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.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in this home. 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 and 'Tell Us' cards 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 Deputy Manager at the conclusion of the inspection.

4.0 What people told us about the service

Fifteen staff, 11 patients individually and others in groups were spoken with during the inspection. Patients told us that they felt well cared for, enjoyed the food and that staff were helpful and friendly. There were no questionnaires returned from patients or relatives.

Staff said that the manager was very approachable, there was great teamwork and that they felt supported in their role. One staff member said: “Really enjoy working here” and another staff member said: “Feel very supported by management.” There were no responses received from the staff online survey.

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 22 September 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 27 (2) (b) (d) (g) **Stated:** First time	The registered person must ensure that all areas of the home are kept in good state of repair, is reasonably decorated and has adequate seating.	**Not met**
	Action taken as confirmed during the inspection: Observation of the environment evidenced that this area for improvement had not been met and has been stated for a second time. This is discussed further in section 5.2.3.	
Area for Improvement 2 **Ref**: Regulation 29 **Stated:** First time	The registered person shall ensure that the monthly quality monitoring report is robust, provides sufficient information on the conduct of the home and includes the person responsible for completing any actions generated from the visit.	**Partially met**
	Action taken as confirmed during the inspection: Review of monthly monitoring reports evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.5.	

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		Validation of compliance
Area for Improvement 1 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that the current prescribed dose is recorded on medicine records and that obsolete doses are discontinued to ensure a clear audit trail.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Area for improvement 2 **Ref:** Standard 46 **Stated:** Second time	The registered person shall ensure, in accordance with regional infection prevention and control guidelines that: • clean and unclean linen are stored separately.	**Not met**
	Action taken as confirmed during the inspection: Observation of the environment evidenced that this area for improvement had not been met and has been stated for a third time. This is discussed further in section 5.2.3.	
Area for improvement 3 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that where a patient requires pressure area care a care plan is implemented detailing the recommended frequency of repositioning which is recorded within the chart and reflective of the care plan.	**Partially met**
	Action taken as confirmed during the inspection: Review of care records and supplementary recording charts evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.2.	
Area for improvement 4 **Ref:** Standard 37 **Stated:** First time	The registered person shall ensure that any record retained in the home which details patient information is stored safely in accordance with the General Data Protection Regulation and best practice standards.	**Not met**

	Action taken as confirmed during the inspection: Observation of the environment evidenced that this area for improvement had not been met and has been stated for a second time. This is discussed further in section 5.2.2.	
Area for improvement 5 **Ref:** Standard 35 **Stated:** First time	The registered person shall ensure that a robust system of audits is implemented and maintained to promote and make proper provision for the nursing, health and welfare of patients. With specific reference to: • environment • IPC • care records.	**Partially met**
	Action taken as confirmed during the inspection: Review of audits evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.5.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

On review of two weeks staff duty rotas there were adequate staffing levels within the home to meet the needs of the patients. There were some inconsistencies noted with the maintenance of the duty rota but RQIA were assured at the meeting that these had been addressed.

Staff said they felt supported in their roles and that there was good team work with effective communication between staff and management. Staff also said that, whilst they were kept busy, the number of staff on duty was generally satisfactory to meet the needs of the patients but that staffing levels can be affected with occasional short notice absenteeism. Staff said that they were aware of the homes recruitment drive and welcomed the addition of new employees to enhance the availability of cover during short notice absence.

Review of a sample of agency staff recruitment profile records evidenced that robust systems were in place to ensure that staff were trained and competent. Inductions were also completed for agency staff and available during inspection. Two agency staff said that management were very supportive and they felt very much part of the team.

The Deputy Manager advised that a new eLearning system for staff mandatory training had recently been introduced to the home and was in the process of being disseminated to all staff. The training included a range of topics such as moving and handling, IPC, fire safety and adult safeguarding.

Records on the overall compliance for staff mandatory training were not fully available during the inspection. Following the inspection the Manager provided written confirmation of the overall staff training statistics indicating good compliance with mandatory training.

Appropriate checks had been made to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC) and care workers with the Northern Ireland Social Care Council (NISCC) with a record maintained by the Manager of any registrations pending.

Patients said that they felt well looked after by the staff and were very happy in Rush Hall. One patient commented “This is a fantastic home”, “The care here is two hundred percent” and another patient referred to the staff as being “Very friendly”.

5.2.2 Care Delivery and Record Keeping

Patients were generally well presented but it was noted that some patients were not wearing socks, shoes or appropriate attire, facial hair had not been attended to and one patient’s spectacles required a thorough clean. Concerns were raised with staff in relation to patients’ dignity but they were unable to offer satisfactory explanations for the appearance of the patients identified. This was discussed with the management team at the meeting and RQIA were assured that patients were dressed according to their personal preferences. The manager was advised to ensure that such preferences were reflected in the patients’ care records and an area for improvement was identified.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The lunchtime dining experience was observed within the Binevenagh suite which was seen to be a pleasant opportunity for patients to socialise and the atmosphere was calm and relaxed.

It was noted that food protectors used by patients throughout the home during meal times were observed to be worn out and in need of replacement. It was further identified that two patients within one of the dementia units did not have appropriate cutlery during an evening meal. This was discussed with the management team during the meeting who confirmed that new food protectors had been ordered and that supervision had been carried out with relevant staff regarding the provision of cutlery during meals.

Patients who were less able to mobilise require special attention to their skin care. Review of two patients’ care records evidenced ‘gaps’ and inconsistencies regarding the recommended frequency of repositioning within the care plan and supplementary recording charts. This area for improvement has been stated for a second time.

Care records were in place to manage patients’ wounds but some improvements are required to the record keeping. One patient’s care plan did not detail the type of wound care dressing or frequency for renewal but this was recorded within the patient’s evaluation of care records.

In addition, a number of wound assessment charts had not been completed following dressing renewal. Details were discussed with the Deputy Manager and an area for improvement in relation to record keeping was identified.

A patient was observed seated on a type of hoist sling which had the potential to impact on their skin integrity. During the meeting on the 14 March 2022 the management team said that the sling was no longer in use and that an appropriate sling had been ordered. The inspector requested that a review of all patients' slings is carried out to ensure that they were appropriate and an area for improvement was identified.

Bruising was noted to two identified patients. There was no evidence that these had been reported by care staff to the registered nurse/management. Action was taken at the inspection to ensure documentation was up to date and the Trust key workers informed. Details were discussed with the Deputy Manager and an area for improvement was identified. Following the inspection written confirmation was received from the Manager that relevant action had been taken and explanations were provided for the bruising.

It was further identified that the body map template used for recording bruising/skin damage did not have a section to record the date of entry. The Deputy Manager agreed to have the template updated following the inspection. During the meeting on the 14 March 2022 the management team confirmed that this had been addressed. The Manager further said that staff are normally very diligent at reporting bruising to the nurse in charge and believed that this was a 'one off oversight'. The importance of reporting such concerns has been emphasised with relevant staff.

Care records for two recently admitted patients evidenced that not all care plans had been completed within the recommended timeframe and an area for improvement was identified.

It was further identified that confidential patient information was not securely stored within an area of the home. This area for improvement was identified at the previous care inspection and has been stated for a second time.

During the meeting on the 14 March 2022 the Responsible Individual and management team advised that action had been taken following the inspection to address the above issues with staff supervisions and a meeting scheduled to discuss the deficits identified during inspection. The Manager also confirmed the actions taken to improve the quality and accuracy of record keeping and care planning through regular monitoring, daily walk arounds and flash meetings with relevant staff.

5.2.3 Management of the Environment and Infection Prevention and Control

Inspection of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. Patients' bedrooms were found to be personalised with items of memorabilia and special interests. The corridors within the Broighter suite were decorated to promote a dementia friendly environment; however, the corridors within the Hunter suite required improvements. We discussed this with the management team who acknowledged this but cited some challenges with adherence to Trust infection control advice. It was agreed at the meeting that improvements should be considered.

Surface damage was evident to a number of curtains in patients' bedrooms and to multiple walls within communal spaces and bedrooms. Moisture damage was observed to the ceiling of a bathroom in the Broighter suite which had previously been identified at an inspection in May 2021. A section of plaster had come away from a bedroom ceiling situated above a patient's bed requiring immediate review. There was limited availability of furniture/seating within identified lounges and no curtains in one of the lounges. This area for improvement has been stated for a second time.

Observation evidenced that corridors and fire exits were clear of clutter and obstruction. An identified bedroom door was observed held open with a 'door weight' preventing the door from closing in the event of a fire. It was concerning that staff did not recognise this as a potential fire safety risk despite having received fire awareness training. This was discussed with the Deputy Manager who removed the 'door weight' following a discussion with the patient around fire safety.

A number of unnecessary risks were identified which had the potential to impact on the health and safety of patients. For example; medicines were not securely stored within two areas of the home; associated choking risks were discussed with staff specific to the texture of bacon which was provided to a patient; there was access to food/fluids within an unlocked fridge and an unsupervised food trolley which also had a hot tea flask. Denture cleansing tablets, blue tack and razors used for shaving were also easily accessible to patients within the dementia units. The importance of ensuring that all areas of the home are hazard free was discussed with the Deputy Manager and an area for improvement was identified.

The Deputy Manager told us that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for patients, staff and care partners and any outbreak of infection was reported to the Public Health Agency (PHA).

All visitors to the home had a temperature check and a health declaration completed when they arrived at the home. They were also required to wear personal protective equipment (PPE) such as aprons, masks and/or gloves. Visiting and care partner arrangements were managed in line with the Department of Health and IPC guidance.

Despite staff having received training in IPC, they were not all consistently adhering to appropriate IPC measures. For example, a member of staff was wearing nail polish, another member of staff was observed carrying a used incontinence product and PPE along a corridor; a used face mask was observed on a table within a lounge and a registered nurse with overseeing responsibilities was not wearing their face mask correctly while in close contact with patients. The Deputy Manager was prompt at addressing these deficits during the inspection.

Patient equipment and personal clothing were inappropriately stored within a number of communal bathrooms and en-suites; hoist slings were observed over wheelchairs within identified lounges; a patient's chair required a thorough cleaning during the inspection; multiple care folders and bedrail protectors were torn and adhesive tape was evident around the exit keypad within the Broighter suite.

The above details were discussed with the Deputy Manager who acknowledged that these findings were not in keeping with IPC best practice and two areas for improvement were identified in relation to IPC and the environment.

An area for improvement identified at previous care inspections in relation to clean and unclean linen stored within an identified linen cupboard has been stated for a third time.

During the meeting on the 14 March 2022 the Responsible Individual and management team provided assurances that IPC measures and practices, risk management and the environment had been reviewed with action taken to address concerns identified during the inspection. The manager conducts a formal walk around the home daily and the template includes a focus on the areas for improvement identified at the inspection. The Responsible Individual advised that the necessary furniture, curtains and patient equipment had been ordered and a refurbishment plan had been initiated with a schedule for painting and decorating which would be monitored by senior management during monthly monitoring visits. This should enable patients to get the full use of the facilities on offer and improve their environment.

5.2.4 Quality of Life for Patients

Observation of life in the home and discussion with staff and patients established that staff engaged well with patients individually or in groups. One patient said; “We are included in decisions regarding activities” and “This feels like a real community here.”

During the inspection patients were observed engaged in their own activities such as; watching TV, resting or chatting to staff. Patients appeared to be content and settled in their surroundings and in their interactions with staff.

Patients commented positively about the food provided within the home with comments such as; “The food is great with a good choice”, “If you don’t like they will always change it for you” and “The food is very good here.”

Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

The planned improvements to the home’s environment should enhance patients’ quality of life and experience.

5.2.5 Management and Governance Arrangements

Since the last inspection there has been a change of ownership to Ann’s Care Homes Limited and the Responsible Individual Mrs Charmaine Hamilton. Mrs Carol Craig remained as the home Manager. The Responsible Individual said that on purchasing the home they were aware of the refurbishment required and were in the process of completing a schedule of works prior to the inspection.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. Where deficits were identified an action plan had been implemented with the person responsible for completing the action, a time frame for completion and a follow up to ensure the necessary improvements have been made. However, the audits did not capture the deficits identified during the inspection specific to the environment, IPC and care records. Details were discussed with the management team and an area for improvement has been stated for a second time.

The home was visited each month by a representative of the Responsible Individual to consult with patients, their relatives and staff and to examine all areas of the running of the home. Whilst the reports generated an action plan with the person responsible and a timeframe, they did not provide sufficient details regarding the environmental deficits and failed to drive the necessary improvements with the areas identified in the QIP from the previous care inspection on the 18 May 2021. This area for improvement has been stated for a second time.

As stated previously RQIA were provided with a detailed action plan as part of the meeting held on the 14 March 2022 and were satisfied that the appropriate action had been taken to address the immediate issues identified with ongoing review dates to address all of the actions required to bring the home into compliance with the regulations and standards.

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 (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	7*	8*

* The total number of areas for improvement includes two regulations and three standards that have been stated for a second time; one standard that has been stated for a third time and one standard that has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Emma McNeill, Deputy Manager, as part of the inspection process and further with the management team at a meeting on 14 March 2022. 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 27 (2) (b) (d) (g) **Stated:** Second time **To be completed by:** 3 May 2022	The registered person must ensure that all areas of the home are kept in good state of repair, is reasonably decorated and has adequate seating. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: An environmental audit has been completed identifing areas that require improvement. Timeframes for these works to be completed are included on the audit and to date these timeframes are on target. Painting has commenced - the Hunter unit has been fully painted, with the other units starting this week. Chairs have been ordered and scheduled to be delivered week commencing 7th May 2022. Furniture, curtains

	and blinds have been ordered, awaiting delivery.
Area for improvement 2 **Ref:** Regulation 29 **Stated:** Second time **To be completed by:** 3 April 2022	The registered person shall ensure that the monthly quality monitoring report is robust, provides sufficient information on the conduct of the home and includes the person responsible for completing any actions generated from the visit. Ref: 5.1 and 5.2.5
	Response by registered person detailing the actions taken: Alongside the Regulation 29 report there is an environment audit that identifies areas that require improvement. The reg 29 report will make reference to this in future.
Area for improvement 3 **Ref:** Regulation 16 (1) (2) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that care plans are prepared in consultation with the patient or representative as to how the patients' needs are to be met which is kept under review and updated as necessary. This specifically refers to the delivery of personal care and preference regarding clothing/footwear. Ref: 5.2.2
	Response by registered person detailing the actions taken: All care plans have been reviewed to take into account resident's personal preference in relation to personal care and dress. A supervision session was carried out with all staff. This area will be monitored by the DM/HM/RM.
Area for improvement 4 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that where instances of bruising are identified that : • these are reported to the nurse in charge • a body map is completed detailing the location of the bruising and the date is completed • relevant care plans and risk assessments are implemented/updated • next of kin, Trusts or other professionals are informed as required. Ref: 5.2.2
	Response by registered person detailing the actions taken: A supervision session was held with all staff in relation to

	unexplained bruising and skin tears, including reporting,completion of body map, updating care plans and risk assessment and informing next of kin. All incident reports are sent to the HM for review, APP1 forms are sent to Trust by DM/HM.
Area for improvement 5 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** With immediate effect	The registered persons must ensure that all areas of the home to which patients have access are free from hazards to their safety. Ref: 5.2.3
	Response by registered person detailing the actions taken: All areas identified during inspection have been addressed. A supervision session ahs been held with staff. This will be monitored during walkabout audits.
Area for improvement 6 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the infection prevention and control issues identified during this inspection are urgently addressed and a system is initiated to monitor ongoing compliance. Ref: 5.2.3
	Response by registered person detailing the actions taken: All staff have had a supervision session on general infection control and included use of PPE and handwashing. This was re-iterated at a staff meeting on 29th March and will be monitored by the DM/HMRM. All areas identified that needed repair has been addressed.
Area for improvement 7 **Ref:** Regulation 27 (2) (b) (d) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that equipment provided at the nursing home for use by patients and staff is properly maintained to enable effective cleaning. Ref: 5.2.3
	Response by registered person detailing the actions taken: All care files and bed rail bumpers have been replaced, the identified chair was cleaned during the inspection. There is a decontamination folder where staff record cleaning of equipment - this is spot checked by the nurses/DM/HM/RM.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	

Area for improvement 1 **Ref:** Standard 29 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the current prescribed dose is recorded on medicine records and that obsolete doses are discontinued to ensure a clear audit trail. Ref: 5.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref:** Standard 46 **Stated:** Third and final time **To be completed by:** With immediate effect	The registered person shall ensure, in accordance with regional infection prevention and control guidelines that: • clean and unclean linen are stored separately. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: An area for storage of clean linen has been identified i.e a trolley set up with linen covered over with a sheet. the dirty linen is removed to the laundry as necessary.
Area for improvement 3 **Ref:** Standard 23 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that where a patient requires pressure area care a care plan is implemented detailing the recommended frequency of repositioning which is recorded within the chart and reflective of the care plan. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: All care files have been audited, any resident who has been identied as requiring pressure area has a care plan in place detailing the frequency of re-positioning. Each individual resident has a file which holds supplementary documentation. There is a form at the front of this file that details the resident's repositioning frequency and skin checks. This form is completed by the nurse in charge as per the care plan. If any changes are made to the care plan this form is updated and staff informed. Spot checks are carried out during walkabout audits.
Area for improvement 4 **Ref:** Standard 37 **Stated:** Second time **To be completed by:**	The registered person shall ensure that any record retained in the home which details patient information is stored safely in accordance with the General Data Protection Regulation and best practice standards. Ref: 5.1 and 5.2.2

With immediate effect	**Response by registered person detailing the actions taken:** All staff have completed an e-learning module on GDPR - stats are 100%. A supervision session was also held and re-iterated at the staff meetings. This area of improvement is monitored during walkabout audits.
Area for improvement 5 **Ref:** Standard 35 **Stated:** Second time **To be completed by:** 3 April 2022	The registered person shall ensure that a robust system of audits is implemented and maintained to promote and make proper provision for the nursing, health and welfare of patients. With specific reference to: • environment • IPC • Care records Ref: 5.1 and 5.2.5
	Response by registered person detailing the actions taken: All care file audits have been audited since the inspection. This has given a baseline of areas that need addressed within the care files. Staff have been advised to address any areas identified within one week of auditing. The home is moving to electronic records - resident's details are currently being innputted to the system and will be totally transferred over by the end of May 2022. There is an environmental audit which identifies any areas in the home that need improvement - this is updated as areas are addressed The IPC audit is being reviewed to ensure oversight of all aspects of the home in a timely fashion.
Area for improvement 6 **Ref:** Standard 23 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the following action is taken where a wound has been assessed as requiring treatment: • that the care plan includes the recommended dressing type and frequency of dressing renewal • wound assessment charts are completed following each dressing renewal. Ref: 5.2.2
	Response by registered person detailing the actions taken: Each wound is audited after it has been reported using a Wound Care TRaCA. Any areas identified are communicated to the nurse to address. Once the nurse signs that the areas have been addressed then the DM/HM checks for compliance.

Area for improvement 7 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 3 April 2022	The registered person shall ensure that where a patient requires a hoist sling to remain in place whilst seated, that the correct type of sling is utilised in accordance with the manufactures guidance. Ref: 5.2.2
	Response by registered person detailing the actions taken: A review of residents who require insitu slings has been undertaken and residents identified as requiring an insitu sling have been provided with one.
Area for improvement 8 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 3 April 2022	The registered person shall ensure that patient care plans are commenced on the day of admission and completed within five days of admission to the home. Ref: 5.2.2
	Response by registered person detailing the actions taken: There have been no admissions since the inspection. A form, namely 'Assessment Guide for new admissions has been implemented - this enables nurses to check that they have all appropriate documentation completed in a timely manner. All new admissions will have a care file TRaCA completed by the DM/HM on Day 6.

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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