Unannounced Care Inspection Report
14 June 2018

Cairnmartin

Type of Service: Nursing Home (NH)
Address: 250 Ballygomartin Road, Belfast, BT13 3NG
Tel No: 028 9072 2050
Inspector: Sharon McKnight

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 62 persons. There were 35 patients accommodated at the time of this inspection.

3.0 Service details

Organisation/Registered Provider: Amore Elderly Care Limited **Responsible Individual** Mrs Nicola Cooper	**Registered Manager:** See Below
Person in charge at the time of inspection: Mrs Fiona Archer	**Date manager registered:** Mrs Fiona Archer, Registration Pending
Categories of care: NH-PH, NH-DE, NH-I, NH-PH(E)	**Number of registered places:** 62 A maximum of 31 patients in categories NH-I and NH-PH(E) and a maximum of 31 patients in category NH-DE. Category NH-PH for 2 identified patients only.

4.0 Inspection summary

An unannounced inspection took place on 14 June 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 and staff development, adult safeguarding, infection prevention and control, and the home's environment. There were examples of good practice found throughout the inspection in relation to assessment of patient need, the management of nutrition, falls and the delivery of wound care. Good practice was observed in relation to the culture and ethos of the home, mealtimes and the provision of activities.

One area for improvement was identified under regulation with regard to the management of individual patient risk.

Areas for improvement were identified under the standards in relation to maintaining records to evidence that Access NI checks are received and reviewed prior to staff commencing work, care records, completion of body maps, systems for communicating patient risk and the reintroduction of systems to provide management with oversight of wound care.

Patients commented positively regarding their care. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

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	6

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

Details of the Quality Improvement Plan (QIP) were discussed with Fiona Archer, manager and Caron McKay, quality improvement lead, 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 7 February 2018

The most recent inspection of the home was an unannounced care inspection undertaken on 7 February 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

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

- notifiable events since the previous care inspection
- 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 we met with five patients individually and with the majority in small groups, eight staff and two patients' relatives. Questionnaires were also left in the home to obtain feedback from patients' relatives. A poster was provided which directed staff to an online survey.

A poster informing visitors to the home that an inspection was being conducted was displayed on the front door of the home.

The following records were examined during the inspection:

- duty rota for all staff from 6 -17 June 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
- seven patient care records
- two patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- a sample of 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 7 February 2018.

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and was validated during this inspection.

6.2 Review of areas for improvement from the last care inspection dated 7 February 2018

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 12(1) (b) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that patients are monitored for signs of pressure ulcers. Accurate records must be maintained of patients' skin condition when being assisted to reposition.	**Not met**
	Action taken as confirmed during the inspection: A review of two completed repositioning charts evidenced that an accurate record of the patients' skin condition when being assisted to reposition was not being recorded. This area for improvement has not been met and is stated for a second time.	
Area for improvement 2 **Ref:** Regulation 12(1)(a) **Stated: First** time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that care interventions prescribed by the TVN to meet the patients individual needs are implemented.	**Met**
	Action taken as confirmed during the inspection: Wound care records evidenced that interventions prescribed by the TVN, and other professionals, were implemented. This area for improvement has been met.	
Area for improvement 3 **Ref:** Regulation 16(1) **Stated:** First time **To be completed by:** 7 March 2018	The registered person shall ensure that care plans are in place to direct the wound care required.	**Met**
	Action taken as confirmed during the inspection: Wound care records were in place to direct the wound care required. This area for improvement has been met. Wound care records are further discussed in section 6.5 of this report.	

Area for improvement 4 **Ref:** Regulation 19(1)(a) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that records are maintained of wound care delivery.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced that records were maintained of wound care delivery. This area for improvement has been met.	
Area for improvement 5 **Ref:** Regulation 20(1)(a) **Stated:** First time **To be completed by:** 7 March 2018	The registered person must ensure that wound care competency assessments are completed with registered nurses and where deficits in knowledge are identified training is provided.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced that wound competency assessments were completed with the registered nurses. Registered nurses had also attended training in wound care. This area for improvement has been met.	

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. A review of the staffing rota for week commencing 4 and 11 June 2018 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients.

We spoke with the relatives of two patients during the inspection; all were complimentary regarding staff. One completed questionnaire was received during the inspection and seven were received from relatives following the inspection. Although all of the respondents replied that they were either very satisfied or satisfied with the provision of staff two commented that more staff were required at night. All of the comments provided were shared with the manager.

Review of two staff recruitment files evidenced that these were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought and received as part of the recruitment process. Whilst records evidenced that the checks had been completed the dates that the outcome of the checks were received was not recorded and therefore did not evidence that the checks had been reviewed prior to the staff commencing employment. This was identified as an area for improvement under the standards. A review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

The home continues to use agency nurses due to vacancies; assurances were provided that recruitment was ongoing and in the interim the manager was attempting to block book staff to ensure consistency and continuity of care. A profile containing confirmation of the Access NI check, registration with the Nursing and Midwifery council (NMC) and training was held in the home for each agency nurse. A review of records evidenced that agency staff received a structured orientation and induction to the home at the commencement of their first shift in the home.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC.

We discussed the provision of mandatory training with staff and reviewed staff training records. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Training was delivered through face to face interactive sessions and via an electronic learning programme. Records evidenced good compliance with mandatory training. The manager confirmed that systems were in place to ensure staff received annual appraisal and regular supervision.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

Review of seven patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process. A review of one patient's care records evidenced that a risk assessment and care plan had not been developed following a near miss incident. The registered nurses were knowledgeable of the risk and of the actions taken to minimise the risk; care staff on duty were not aware of the near miss or the identified risks. This was identified as an area for improvement under the regulations.

We reviewed accidents/incidents records for the period February - April 2018 in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation. Discussion with the manager and review of records confirmed that on a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. Records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices, for example; bed rails and alarm mats.

Observation of practices, discussion with staff and review of records evidenced that infection prevention and control measures were adhered to. We observed that personal protective equipment, for example gloves and aprons, were available throughout the home.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges and dining rooms. The home was found to be warm and clean throughout.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, and the home's environment.

Areas for improvement

One area for improvement was identified under regulation with regard to the management of individual patient risk.

An area for improvement was identified under the standards in relation to maintaining records to evidence that Access NI checks are received and reviewed prior to staff commencing work.

	Regulations	Standards
Total number of areas for improvement	**1**	**1**

6.5 Is care effective?

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

Review of seven patient care records evidenced that generally care plans were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of nutrition, patients' weight, management of falls and wound care. Care records generally contained details of the care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

We discussed the monitoring of patients' weights and were informed that all patients were weighed a minimum of monthly. We reviewed the management of nutrition for one patient. A nutritional risk assessment was completed monthly; a care plan for nutritional management was in place. Food and fluid intake charts were maintained with fluid intake reconciled on a 24 hour basis. We requested to review the food and fluid charts for the seven day period prior to the inspection; of the seven charts provided only three were dated. This was identified as an area for improvement under the standards.

We reviewed the management of falls for three patients. Falls risk assessments were completed and reviewed regularly. Care plans for falls management were in place and were reviewed for each patient following a fall.

We reviewed the management of wound care for three patients. Care plans contained a description of the wound, location and the dressing regime. Wound care records evidenced that dressing regimes were adhered to. However in one care record the care plan had not been reviewed and updated to reflect improvements to the wound and changes to the dressing regimes. Another care plan did not specific how often the dressing was due to be renewed; records did evidence that dressing was renewed regularly. An area for improvement under the standards was identified with the records for wound care. The registered nurses spoken with were knowledgeable of the wounds in the home, the treatment regimes and when dressings were due to be renewed.

A new body map was completed to reflect when patients sustained injuries or skin damage. However there was no evidence of re-evaluation of previous injuries to identify if they remained or were healed; this risked confusing the reader. This was identified as an area for improvement under the standards.

Records evidenced that patients were assisted to change their position for pressure relief in accordance with their care plans. As previously discussed in section 6.2 an area for improvement was identified during the previous care inspection with regard to ensuring that records are maintained of patients' skin condition when being assisted to reposition. This area for improvement has not been met and is stated for a second time.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), SALT and dieticians. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), the speech and language therapist (SALT) or the dietician changed.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted. As previously discussed in section 6.4 of this report an area for improvement was made to ensure that identified risks following near misses and accidents/incidents are communicated to staff. A further area for improvement has been made to review the systems for communicating patient need to ensure they are effective.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the manager or the nurse in charge. All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to assessment of patient need, the management of nutrition, falls and the delivery of wound care.

Areas for improvement

Areas for improvement were identified in relation to care records, the completion of body maps and reviewing the systems for communicating patient risk.

	Regulations	Standards
Total number of areas for improvement	**0**	**4**

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.

We arrived in the home at 09:30 hours. Patients were enjoying their breakfast in the dining rooms or in their bedrooms as was their personal preference; some patients remained in bed, again in keeping with their personal preference. There was a calm atmosphere throughout the home.

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with five patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. Staff were observed to knock on patients' bedroom doors before entering and kept them closed when providing personal care.

Patients said that they were generally happy living in the home. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings. We spoke with the relatives of two patients. Both commented positively regarding the care their loved ones were receiving.

Discussion with patients and staff and review of the activity programme evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. The activity co-ordinator was engaged with one patient arranging activities around the football world cup. They explained that they divided their time between one to one activities and group activities. A selection of games/equipment was available in the lounges and we observed in the dementia unit care staff were engaging with patients using the activity equipment throughout the morning. Whilst the games and equipment have been available during previous inspections we had not observed care staff engaging with patient; this improvement was good to note.

We observed the serving of the lunchtime meal. Patients were assisted to the dining room or had trays delivered to them as required. Staff were observed assisting patients with their meal appropriately. Patients able to communicate indicated that they enjoyed their meal. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks.

Cards and letters of compliment and thanks were displayed in the home. Some of the comments recorded included:

"During her stay in the home she lived in a very clean and comfortable environment and enjoyed good food." (January 2018)

"…All of the staff in a different job made an important contribution to her care." (January 2018)

"Thank you for your kindness and support."

We spoke with the relatives of two patients. Both of the relatives commented positively regarding the care their loved ones were receiving.

Relative questionnaires were also provided. As previously discussed, one was returned prior to the end of the inspection and seven were received from relatives following the inspection. All of the relatives responded that they were very satisfied or satisfied with the care provided across the four domains. Comments regarding staffing have been discussed in section 6.4. These are examples of the additional comments provided:

"Our mum and grandmother is cared for by the best people."
"It is good, we are very happy."
"Everything is excellent."
"….Medication has also been known to be given out later – not all the time."
"At times cleanliness in the ensuite area could be improved."

All of the comments received where shared with the manager who agreed to review those comments which indicated improvements may be required.

Staff were asked to complete an online survey; we received no responses within the timescale specified.

Any comments from relatives and staff in returned questionnaires or online responses 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, mealtimes and the provision of activities.

Areas for improvement
No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	**0**	**0**

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 certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been changes in the management arrangements; RQIA were notified appropriately. An application for registration with RQIA has been received by the current manager and is being processed. A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded. Relatives spoken with were

aware of who the new manager was. Staff commented positively on the support and leadership provided to date by the new manager. Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The manager explained that diversity and equality of opportunity for patients was supported by staff; any training required by staff to support patients, would be provided as required.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents and wound care. Systems previously in place to provide management with an overview of all of the wounds in the home, and compliance with care, were not in place at the time of the inspection. This was identified as an area for improvement.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005. An action plan was generated to address any areas for improvement and the progress on compliance with the areas for improvement commented on in the next report.

Areas of good practice

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

Areas for improvement

An area for improvement under the standards was identified with regard to systems to provide management with oversight of wound care.

	Regulations	Standards
Total number of areas for improvement	**0**	**1**

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Fiona Archer, manager and Caron McKay, quality improvement lead, 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 12(1) (b) **Stated:** Second time **To be completed by:** 12 July 2018	The registered person shall ensure that patients are monitored for signs of pressure ulcers. Accurate records must be maintained of patients' skin condition when being assisted to reposition. Ref: section 6.2
	Response by registered person detailing the actions taken: Guidance is being provided for all Nursing and Care staff on how to complete the re positioning charts asa concise and true indication of skin condition at the time of repositioning activities. Example documentationis readily available to support in recording accurate information that is informative and reflective of residents needs. Senior Nursing and Management will embed this in practice through supervision,monitoring and auditing processes.
Area for improvement 2 **Ref**: Regulation 14(2((c) **Stated:** First time **To be completed by:** Immediate from the day of the inspection.	The registered person shall ensure that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated. Following near misses, accident and/or incidents individual risk assessments and care plans must be completed. The identified risk and actions taken to minimise the risk of a reoccurrence must communicated to staff. Ref: section 6.4
	Response by registered person detailing the actions taken: Risk registers are in use as per Priory systems and policy. Daily risk is identified by Senior Nursing staff. Resident specifically identified at risk are highlighted in a warning system using 'Traffic lights'. This is on display in each unit and is ammended as needed and no less than each morning. These risks are discussed as part of the shift handover process and are updated and reflected on through out the day.This is exampled by Nursing and senior staff conducting flash meeting post mid morning/early afternoon. Unit shift reports , incharge reports and flash meetings documentation are presented to the Senior Staff and Management following completion of the 24 hours period. Incident reporting processes are in place.

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 38 **Stated:** First time **To be completed by:** 12 July 2018	The registered person shall ensure that records are maintained to evidence that Access NI checks are received and reviewed prior to staff commencing work. Ref: section 6.4
	Response by registered person detailing the actions taken: Comprehensive recruitment records of all new starts will be keep in the employee file. This will require printing of files from Priory main on line recruitment file and maintaining a hard copy in the personnel file. A log of Employee Access NI numbers will be kept on site as per advisement from RQIA Inspector
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that all care records contain the date they are completed. Ref: section 6.5
	Response by registered person detailing the actions taken: Stamps have been provided for each unit to faciliate ease of date recording. Night duty Care staff will stamp/date each new documentation put into place for the beginning of the 24 hours period. Senior and all Care staff will check documentation following the handover to ensure that dates are in use for the documentation to be completeded through the day. Designated staff will review care shart following the morning care round and again prior to completion of the day/evening shift.
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 12 July 2018	The registered person shall ensure that care plans are updated when dressing regimes change. Care plans should include the frequency with which wounds are required to be redressed. Ref: section 6.5
	Response by registered person detailing the actions taken: Homemanager has held discussion with RN's: Rn's will keep dressing regimes updated to reflect the needs of the resident. RN have reviewed the care file and have archived information that is no longer in use or currently reflects residents wound care needs. Compliance with monitoring, reporting and recording wound care activities is being done none less than weekly, Home Management also supports this process with a monthly wound care anlaysis, which is keep then kept on file as evidence of these activities

Area for improvement 4 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 12 July 2018	The registered person shall ensure that body maps accurately reflect the patients' skin condition. When new body maps are completed previous documents should be discontinued. Ref: section 6.5
	Response by registered person detailing the actions taken: Care files have been audited and reviewed. All non current non, essential body maps have been archived and files now currently reflect the condion and siutation of the resident. RN have been provide a guidance on how to maintain accurate record keeping and archiving when using and updating of body maps
Area for improvement 5 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 12 July 2018	The registered person shall review the systems for communicating patient need to ensure they are effective. Ref: section 6.5
	Response by registered person detailing the actions taken: Unit reports and handovershifts are in use. Registered nurse will use these documents as a both a process of recording activities, but to use as an informativetool to communcate residents, needs and risks and changes. The handover tools are keep in the unit for no less then one week, to act asa guide and remind staff of previous days activities and events. These are then presented the home manager for safe keeping/staorage. The handover tools will be keep updated by the Nurses and used at handover, flash meeting, staff huddles(impromptu meetings). Further the unit reports, incident report, in charge reports will be used to report daily events to the senior staff and management
Area for improvement 6 **Ref**: Standard 35.6 **Stated:** First time **To be completed by:** 12 July 2018	The registered person shall ensure that systems previously in place to provide management with an overview of all of the wounds in the home, and compliance with care are reinstated. Ref: section 6.7
	Response by registered person detailing the actions taken: Compliance with monitoring, reporting and recording wound care activities is being done none less than weekly, Home Management also supports this process with a monthly wound care anlaysis, which is keep then kept on file as evidence of these activities. This a priory group tool that has now been identified by the new Home Manager in post and has has been implemented/reestablished to further support the auditing and anaylsis and quality improvement process.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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

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