The Regulation and Quality Improvement Authority

Inspection Report

23, 24 and 30 September 2021

Carlingford Lodge Care Home

Type of Service: Nursing Home
Address: 76 Upper Dromore Road, Warrenpoint, BT34 3PN
Tel no: 028 4175 9200

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: Amore (Warrenpoint) Limited **Responsible Individual:** Mrs Nicola Cooper	**Registered Manager:** Mrs Sara Main **Date registered:** 27 March 2018
Person in charge at the time of inspection: Mrs Sara Main	**Number of registered places:** 58 A maximum of 25 persons in category NH-I and 33 persons in category NH-DE.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 50
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 50 persons. Patients are accommodated over two floors. Patients with a dementia are cared for on the lower floor and patients requiring general nursing care are cared for on the floor above. Patients have access to communal lounges and dining areas.	

2.0 Inspection summary

An unannounced inspection took place on 23 September 2021 from 9.40am to 5.15pm and on 24 September 2021 from 9.30am to 3.00pm by a care inspector. A pharmacist inspector conducted an unannounced inspection on 30 September 2021 from 9.30am to 2.15pm. All inspection findings are combined into this report.

The inspection assessed progress with all areas for improvement identified in the home 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.

Patients were well presented in their appearance and spoke positively on living in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and the staff are included in the main body of this report.

Areas for improvement were identified in relation to the environment, compliance with best practice on infection prevention and control, staffing arrangements, provision of activities, management of hydration, falls management, medicines management and pressure management.

RQIA was assured that the delivery of care and service provided in Carlingford Lodge was compassionate and that the home was well led. Staff were knowledgeable about the patients in their care and care was delivered in a caring and compassionate manner. Addressing the areas for improvement will enhance the safe and effective care provided in the home.

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.

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

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

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

The findings of the inspection were discussed with the manager and the deputy manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we spoke with 12 patients and eight staff. We received no feedback from the staff online survey and no contact was received from patients or relatives following the inspection. Patients spoke highly on the care that they received and on their interactions with staff. Patients confirmed that staff treated them with respect and that they would have no issues in raising any concerns with staff. Staff acknowledged the difficulties of working through

the COVID – 19 pandemic and shared concerns regarding the staffing arrangements in the home but all staff agreed that Carlingford Lodge was a good place to work.

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 25 March 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the infection control issues identified during the inspection are managed to prevent the risk and spread of infection.	**Partially met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has not been fully met and this will be discussed in Section 5.2.3. This area for improvement has not been fully met and will be stated for a second time.	
Area for improvement 2 **Ref:** Regulation 18 (2) (n) **Stated:** First time	The registered person shall review the provision of activities in the home to ensure that all patients, who wish to engage, are included in regular meaningful activity.	**Partially met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has not been fully met and this will be discussed in Section 5.2.4. This area for improvement has not been fully met and will be stated for a second time.	
Area for improvement 3 **Ref:** Regulation 12 (4) (d) **Stated:** First time	The registered person shall ensure that patients, who require having meals modified, are offered a choice of meal at mealtimes.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met.	

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		Validation of compliance
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time	The registered person shall ensure that supplementary care records, in relation to food and fluid intake, accurately reference the patient's nutritional requirements.	**Met**
	Action taken as confirmed during the inspection: Intake records reviewed made accurate reference to the patients' nutritional requirements.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that the identified patient's care plans are written in a format which specifically directs individualised patient care and avoids the use of general terminology in accordance with professional guidance.	**Partially met**
	Action taken as confirmed during the inspection: A review of the identified patient's care records evidenced that this area for improvement has not been fully met. This area for improvement has not been fully met and will be stated for a second time.	
Area for improvement 3 **Ref**: Standard 29 Criteria (2) **Stated:** First time	The registered person shall ensure that TMARs are completed in full at the time of administration.	**Not met**
	Action taken as confirmed during the inspection: A random review of three TMARs evidenced that this area for improvement has not been met. This area for improvement has not been met and will be stated for a second time.	

Area for improvement 4 **Ref**: Standard 4 Criteria (9) **Stated:** First time	The registered person shall ensure that all personal care delivered to patients is recorded to evidence actual care given.	**Partially met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has not been fully met and this will be discussed in Section 5.2.2. This area for improvement has not been fully met and will be stated for a second time.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Staff were recruited safely ensuring all pre-employment checks had been completed and verified prior to the staff member commencing in post. All staff were provided with an induction programme to prepare them for working with the patients. Checks were made to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics such as infection prevention and control (IPC), patient moving and handling and fire safety. A system was in place to ensure that staff completed their training. Some staff confirmed that they would appreciate additional training on the management of dementia. This information was shared with the manager for their review and action as appropriate.

Staff confirmed that they were very busy in the home and provided examples of how the staffing arrangements could affect the daily running of the home. This included staff missing breaks and patients' breakfasts being given late. This was discussed with the manager and an area for improvement was identified not only to review the staffing levels and skill mix of staff but also to review the deployment of staff and the morning routines in the home.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis. This included the use of agency staff. The duty rota identified the nurse in charge when the manager was not on duty.

Staff confirmed that the teamwork in the home was generally good, however, also identified potential barriers to effective teamwork. These were shared with the manager for their review and action as appropriate.

Patients spoke highly on the care that they received and confirmed that they would have no issues on raising any concerns that they may have to staff. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. It was

clear through these interactions that the staff and patients knew one another well and were comfortable in each other's company.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of patients' needs, their daily routine, wishes and preferences. A diary was maintained to ensure important daily activities were not missed such as blood tests or appointments. 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. This was good practice. Staff were observed to be prompt in recognising patients' needs and any early signs of distress, especially in those patients who had difficulty in making their wishes known.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

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. We reviewed the care records of a patient who required pressure management. The assessment for pressure management damage had not been completed since July 2021. The pressure management care plan did not detail a frequency for repositioning and the repositioning records did not always record the position that the patient had been repositioned too. This was discussed with the manager and identified as an area for improvement.

Where a patient was at risk of falling, a dedicated falls care plan was in place to direct staff in how to manage this area of care. Falls in the home were monitored monthly to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to prevent further falls from occurring. However, gaps were identified within two patients' care/accident records following a fall in the home. The appropriate risk assessments and care plans had not been updated to reflect the falls and one patient's monitoring record had not been completed sufficiently. This was discussed with the manager and identified as an area for improvement.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, alarm mats and/or bed rails. Review of a patient's care records and discussion with the manager confirmed that the correct procedures had been followed when restrictive practices had been used.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this could include simple encouragement through to full assistance from staff. Staff assisted patients throughout the day with food and fluids in an unhurried manner. Records of patients' intake and outputs were recorded where this was required. A review of a patient's fluid intake records evidenced that they did not meet their fluid target over a four day period. Overnight fluid intake had not been

recorded. Daily care evaluation records did not identify the intake deficit and actions were not taken in accordance with the patient's care plan. This was discussed with the manager and identified as an area for improvement. Staff were aware of the actions to take when a patient's intake was low. Nutritional risk assessments were carried out monthly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST).

Gaps were identified in three patients' topical medicines application records (TMAR). Topical medicines can include creams applied to patients' skin. The person who applies the cream is the person responsible for completing the TMAR. Gaps signify that the cream was either not applied or applied but not signed. This was discussed with the manager and an area for improvement identified at the previous inspection in this regard has been stated for the second time. Many of the topical preparations in use in the home had not been dated when they had been opened. This is important when it comes to disposing of them in accordance with manufacturers guidelines. This was discussed with the manager and identified as an area for improvement.

Skin bundles had been incorporated into supplementary care records to include detail of the personal care delivery to patients such as oral, eye and nail care and also used to identify when the patient last had a shower/bath/body wash. Where some had been completed in good detail, others were not completed consistently. For example, when a patient refused personal care in the morning, records reviewed did not evidence when this was offered again until the following day. In some cases the record had not been completed at all. This was discussed with the manager and an area for improvement in this regard has been stated for the second time. Staff consulted were aware of the actions to take when a patient refused personal care assistance in the morning.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. The home was warm, clean and comfortable. There were no malodours detected in the home. However, several areas in the home were in need of redecoration. An area for improvement was identified for management to review the rooms in use in the home and to submit a refurbishment plan with the completed Quality Improvement Plan.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible. A system was in place to ensure that all staff in the home had taken part in a fire drill at least once annually.

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 and staff. Environmental infection prevention and control audits had been conducted monthly. However, we observed some staff practices that were not in keeping with best practice on infection prevention and control. This was discussed with the manager and an area for improvement in this regard identified at the previous inspection has been stated for the second time.

All visitors to the home had a temperature check and symptom checks when they arrived at the home. They were also required to wear personal protective equipment (PPE). Visits were by appointment only.

Five chairs in a communal room in the dementia unit were observed to be in disrepair with foam protruding through the surface rendering them unable to be effectively cleaned. In addition, three patients' wheelchairs/own chairs were observed to be unclean. This was discussed with the manager and identified as an area for improvement.

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, patients could have a lie in or stay up late to watch TV. Patients confirmed that they could remain in their bedroom or go to a communal room when they requested. Patients, who could, could choose what they wore and what they preferred to eat.

There was no programme of activities displayed in the dementia unit. Activities did take place, though, focused on groups of patients. There was no pre-planned engagement evidenced for those patients who remained in their rooms or who did not wish to engage in group activity. Activities included games, music, armchair yoga, massage, doll therapy and reminiscence. An area for improvement in relation to the provision of activities in the home to ensure that all patients, who wish to engage, have an opportunity to engage in regular meaningful activities has been stated for the second time.

Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients. An up to date visiting policy was available and reflective of Department of Health guidelines. A newsletter was published fortnightly and emailed to patients' next of kin.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Sara Main has been the registered manager in this home since 27 March 2018. Staff were aware of who the person in charge of the home was in the manager's absence. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

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 had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

A complaints file was maintained and evidenced detail of any investigations into complaints made and the corresponding actions including correspondence sent to the complainant. Cards and compliments were kept on file and shared with staff.

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; where action plans for improvement were put in place,

these were followed up to ensure that the actions were correctly addressed. Completed reports were available for review by patients, their representatives, the Trust and RQIA.

Review of staff training records confirmed that all staff were required to complete adult safeguarding training on an annual basis. Staff told us they were confident about reporting any concerns about patients' safety. Staff were aware of who to report their concerns to and who to escalate their concern to if they felt that this was required.

5.2.6 Medicines Management

The audits completed at the inspection indicated that the patients had received their medicines as prescribed.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example at medication reviews or hospital appointments. The patients' personal medication records reviewed were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to provide a double check that they were accurate.

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment. A sample of these records was reviewed. The records were found to have been completed to the required standard.

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. The records inspected showed that medicines were available for administration when patients required them.

Medicines must be stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error. The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Records were maintained of the disposal of medicines.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs are recorded in controlled drug record books. Robust arrangements were in place for the management of controlled drugs. The controlled drugs record books had been maintained to the required standard.

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another. The management of medicines was reviewed for two patients who had been admitted to this home. Hospital discharge letters had been received and a copy had been forwarded to the patients' GPs. The medicine records had been accurately

maintained and medicines had been administered in accordance with the most recent directions.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. For the five patients whose records were reviewed, pain management care plans and pain assessment tools were in place.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and its effect. For the two patients whose records were reviewed, directions for use of medicines prescribed on a "when required" basis were clearly recorded on their personal medication records and care plans. Reasons and outcomes for administration were generally recorded.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals to manage weight loss. For the four patients whose records were reviewed, speech and language assessment reports and care plans were in place. Records of prescribing and administration of thickeners by the nursing staff, which included the recommended consistency level, were maintained. However, there were significant gaps in the recording of the administration of thickeners by care staff; an area for improvement was identified.

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that they are supported. Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments. However, the observations made during this inspection indicated that care staff needed additional training in relation to the recording of the administration of topical medicines and thickeners; an area for improvement was identified.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The need to closely monitor the recording of the administrations of topical medicines and thickeners by care staff was discussed with the manager.

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. The audit system in place in this home helps staff to identify medicine related incidents.

6.0 Conclusion

Based on the inspection findings 14 areas for improvement were identified. Seven were in relation to safe care and the remaining seven were in relation to effective care. We are satisfied that care is being provided in a caring and compassionate manner and that the home is well led.

Patients consulted were happy with the care that they were receiving. Those who could not verbally communicate appeared comfortable and settled in their surroundings. Staff confirmed that they were happy working in the home had been trained to perform their role, though, the staffing arrangements including deployment of staff and morning routines required a review. The home was warm, clean and comfortable although attention was required in identified areas. Visiting was in line with DOH guidelines with a positive impact for both patients and visitors.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and/or the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	5*	9*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Sara Main, Registered Manager and Paula Magee, Deputy Manager, as part of the inspection process. 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 13 (7) **Stated:** Second time **To be completed by:** 24 October 2021	The registered person shall ensure that the infection control issues identified during the inspection are managed to prevent the risk and spread of infection. Ref: 5.1 and 5.2.3 **Response by registered person detailing the actions taken:** The infection control issues identified during the inspection have been addressed in relation to PPE. IPC procedures within the home will continue to be monitored through daily manager quality walkarounds and audits. Any actions required will be addressed with staff in real time. Donning and doffing competencies will be reviewed with all staff.
Area for improvement 2 **Ref:** Regulation 18 (2) (n) **Stated:** Second time **To be completed by:** 24 October 2021	The registered person shall review the provision of activities in the home to ensure that all patients, who wish to engage, are included in regular meaningful activity. Ref: 5.1 and 5.2.4 **Response by registered person detailing the actions taken:** The care home has successfully recruited a permanent activity coordinator and she has commenced in her role. The activity programme is reviewed regularly through feedback from the residents. The activity coordinators worked with this feedback to successfully develop a range of clubs designed to our resident needs. For residents who do not wish to engage in group activities, an alternative activity is offered. This will include one to one activities for residents confined to their bedrooms. This is monitored through quality walkarounds and discussed at daily flash meetings.
Area for improvement 3 **Ref:** Regulation 12 (1) (a)(b) **Stated:** First time **To be completed by:** 30 October 2021	The registered person shall review patients' pressure management in the home to include: • Pressure management risk assessments are completed monthly • Where a risk is identified, a pressure management care plan is developed detailing the care required and to include frequency of repositioning where appropriate • Records of repositioning are maintained accurately. Ref: 5.2.2

	Response by registered person detailing the actions taken: Pressure management has been reviewed within the care home and discussed with nursing staff. Supervision will be completed with all nursing staff in regard to wound management. A weekly tissue viability aduit has been implemented to monitor wounds within the home. All risk assessments and care plans will be reviewed monthly or earlier if there are any changes identified as being required. Initial wound charts and ongoing wound assessment charts are recorded. All staff will be reminded of the need for accurate recording of supplementary charts and care staff will complete the recording of supplementary record competency asesssment. This is be monitored through daily manager walkrounds and doucumentation quality walkarounds. The completion of repositioning records are monitored through daily walk rounds and spot checks.
Area for improvement 4 **Ref:** Regulation 12 (1) (a)(b) **Stated:** First time **To be completed by:** 30 October 2021	The registered person shall review the management of falls in the home to ensure that the appropriate actions are taken after any fall in the home to include the appropriate monitoring of the patient, notifying the appropriate persons and ensuring that the appropriate documentation has been updated. Ref: 5.2.2
	Response by registered person detailing the actions taken: The management of falls has been reviewed in the care home. The falls strategy will be shared with all nursing staff and supervision will be carried out with Registered Nurses in regard to falls management and the associated documentation that is required to be completed following a fall. A falls checklist is in place for Registered Nurses to complete following a fall to ensure that all relevent documentation has been completed and that all appropriate stakeholders are informed of a fall. A monthly falls tracker is in place and detailed analysis will be carried out on a monthly basis to establish if there are themes and trends relating to falls. Trust Adverse Incident Forms have also been reviewed and this now includes more details of the fall and outcomes.

Area for improvement 5 **Ref:** Regulation 12 (1) (a)(b) **Stated:** First time **To be completed by:** 30 October 2021	The registered person shall review the management of hydration in the home to ensure that fluid intake records are recorded accurately and that there is evidence within patients' care records of any actions taken when any deficit is identified. Ref: 5.2.2
	Response by registered person detailing the actions taken: Supplementary records for monitoring nutrition and hydration have been reviewed for each resident. Fluid intake is monitored over a 24 hour period. If a deficit in fluid intake is noted, this will be commicated to staff at hadover for further observation and review. Staff will be reminded of the importance of accurate fluid intake recorded and reporting through daily flash meetings.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 30 September 2021	The registered person shall ensure that the identified patient's care plans are written in a format which specifically directs individualised patient care and avoids the use of general terminology in accordance with professional guidance. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: The identified residents care plan has now been reviewed to avoid the use of general terminology and all care plans are person centred. This will be monitored through resident of the day documentation and documentation quality walk rounds.
Area for improvement 2 **Ref**: Standard 29 Criteria (2) **Stated:** Second time **To be completed by:** 24 October 2021	The registered person shall ensure that TMARs are completed in full at the time of administration. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: The use of topical medications have been reviewed for each individual resident. TMARS are now reflective of prescribed creams and completed at time of administration. Topical medication competencies continue to be reviewed annually or as needed with all care staff. The recording of TMARs will be monitored as spot checks during daily manager walk rounds.
Area for improvement 3 **Ref**: Standard 4 Criteria (9)	The registered person shall ensure that all personal care delivered to patients is recorded to evidence actual care given. Ref: 5.1 and 5.2.2

Stated: Second time **To be completed by:** 24 October 2021	**Response by registered person detailing the actions taken:** Supplementary records reviewed for personal care and are now reflective should a resident refuse personal care. Care staff will encourage and record outcome when staff offer personal care during the day. Care staff to report to nurse on duty any difficulties they may be having in carrying out personal care. This will be monitored through daily daily walk rounds.
Area for improvement 4 **Ref:** Standard 41 **Stated:** First time **To be completed by:** 30 October 2021	The registered person shall review the staffing arrangements in the home to include the deployment of staff and morning routines to ensure the needs of patients are met. Ref: 5.2.1
	Response by registered person detailing the actions taken: Staffing levels and arrangements have been reviewed. Daily staff allocation has been reviewed in each unit to ensure that staff are delegated specific duties each day. This will ensure that resident needs are met in a timely manner. Times of staff breaks are also allocated throughout the day. This will be communicated to the team at each handover. The nurse in charge on each unit will monitor this on a daily basis and report any concerns to the manager.
Area for improvement 5 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 30 October 2021	The registered person shall ensure that topical preparations in the home are dated on opening and disposed of in accordance with manufacturer's guidelines. Ref: 5.2.2
	Response by registered person detailing the actions taken: Topical medications will be reviewed monthly along with the monthly drug cycle and creams will be dated on opening. Topical medication competencies continue to be reviewed annually or as needed with care staff. This will be monitored through spot checks on the daily manager quality walk rounds.
Area for improvement 6 **Ref:** Standard 44 Criteria (1) **Stated:** First time **To be completed by:** 30 November 2021	The registered person shall conduct an audit on rooms/areas in the home to ascertain which require redecoration and submit a refurbishment plan with the completed QIP. Ref: 5.2.3
	Response by registered person detailing the actions taken: An audit has been completed of all rooms and areas of the home and a refurbishment plan has been implemented. This has commenced with redecoration identified for priority areas.

Area for improvement 7 **Ref:** Standard 46 Criteria (2) **Stated:** First time **To be completed by:** 30 October 2021	The registered person shall ensure that chairs used by patients are maintained clean at all times. Any chairs in disrepair should be removed and repaired/replaced as soon as possible. Ref: 5.2.3
	Response by registered person detailing the actions taken: Lounge chairs have been reviewed and a capex request will be raised to replace current chairs with non-permeable seating. Lounge chairs in disrepair will be repaired or removed. The frequency of cleaning of personal wheelchairs has been reviewed and the frequency has been increased. This will be monitored as spot checks during daily manager quality walk rounds.
Area for improvement 8 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 30 September 2021	The registered person shall ensure that whenever care staff administer thickeners they routinely record this activity. Ref: 5.2.6
	Response by registered person detailing the actions taken: Dysphagia, modified diets and thickening agent competencies will be reviewed with care staff. Fluid intake charts are now reflective of thickening agents required and completed by care staff. Staff are reminded of the importance of accurate recording of thickening agents. The recording will be monitored through daily manager quality walk rounds.
Area for improvement 9 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 30 October 2021	The registered person shall ensure that care staff are provided with the additional necessary training in relation to the recording of the administration of topical medicines and thickeners Ref: 5.2.6
	Response by registered person detailing the actions taken: Competency frameworks for topical medications and thickening agents will be reviewed and updated annually. This will form part of the induction process for care staff.

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

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