Inspection Report

18 October 2022

Oakmont Lodge Care Home Nursing Unit

Type of service: Nursing Home
Address: 267 - 271 Old Belfast Road, Bangor BT19 1LU
Telephone number: 028 9146 5822

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: Dunluce Healthcare Bangor Ltd **Responsible Individual:** Mr Ryan Smith	**Registered Manager:** Mrs Leigh Patience - not registered
Person in charge at the time of inspection: Miss Gail Laverty - nurse in charge from 9.25am until 10.40am and Mrs Leigh Patience – manager from 10.40am until 6.25pm.	**Number of registered places:** 41 There shall be a maximum of 12 residents in Category NH-DE.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 41
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 41 patients. The home is divided in two units; the McKee unit located on the first floor in which patients receive general nursing care; and a 12 bedded unit which provides care to people living with dementia. There is also a registered Residential Care Home located within the same building.	

2.0 Inspection summary

An unannounced inspection took place on 18 October 2022 from 9.25am to 6.25pm by a care inspector. The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Patients spoke positively about the care that they received and confirmed that staff attended to them in a timely manner. Staff members were knowledgeable of patients' needs, their daily routine, wishes and preferences. An activities programme was in place and patients were observed engaging and enjoyed the events delivered during the inspection.

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

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

Areas requiring improvement were identified during this inspection and are discussed within the main body of the report and Section 6.0. Five areas for improvement identified at the previous inspection were partially met and stated for a second time.

One area for improvement previously stated for a second time has not been fully complied with. Assurances to bring the home into compliance with this regulation were provided by the recently appointed manager during and following the inspection. These assurances were discussed with senior management in RQIA and it was agreed that the area for improvement would be stated for a third and final time.

RQIA were assured that the delivery of care and service provided in Oakmont Lodge Care Home Nursing Unit was provided in a compassionate manner by staff that knew and understood the needs of the patients.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection patients, relatives and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working Oakmont Lodge Care Home Nursing Unit. 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 manager at the conclusion of the inspection.

4.0 What people told us about the service

Patients spoke positively about the care that they received and about their interactions with staff. Patients confirmed that staff treated them with dignity and respect and that they would have no issues in raising any concerns with staff. One patient told us, “I like it here, the staff are very good and nice,” while another patient said, “I like it here and everyone is lovely.”

Relatives were complimentary of the care provided in the home and spoke positively about communication with the home. Comments received from one relative were discussed with the manager for follow up.

Staff spoken with said that Oakmont Lodge Care Home Nursing Unit was a good place to work. Staff spoke about the good teamwork in the home and spoke of how much they enjoyed caring for the patients. No questionnaires were returned by patients or relatives and no responses were 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?

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 6 December 2021</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Regulation 13 (7)

Stated: Second time</td><td>The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection.

A more robust system should be in place to ensure compliance with best practice on infection prevention and control.</td><td rowspan="2">Partially met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Although some improvements were noted in staff practice, discussion with staff and observation of staff practice evidenced continued shortfalls in infection prevention and control knowledge and practice. This is discussed further in section 5.2.3.

This area for improvement is partially met and is stated for a third time.</td></tr>
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Area for Improvement 2 **Ref**: Regulation 21 (1) (b) **Stated:** First time	The registered person shall ensure that a robust system is implemented and maintained in regard to monitoring staff registration with the Nursing and Midwifery Council at all times.	**Partially met**
	Action taken as confirmed during the inspection: Examination of records confirmed an inconsistent approach to oversight of staff registration with the Nursing and Midwifery Council. This is discussed further in section 5.2.1. This area for improvement is partially met and is stated for a second time.	
Area for improvement 3 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure as far as is reasonably practicable that all parts of the home to which the patients have access are free from hazards to their safety, and unnecessary risks to the health and safety of patients are identified and so far as possible eliminated. This area for improvement is made with specific reference to the safe storage and supervision of thickening agents and cleaning chemicals.	**Partially met**
	Action taken as confirmed during the inspection: Observation of staff practice evidenced some improvements in supervision of thickening agents. However, further improvements in supervision of cleaning chemicals are required. This is discussed further in Section 5.2.3. This area for improvement has been partially met and is stated for a second time.	

Area for improvement 4 **Ref:** Regulation 10 (1) **Stated:** First time	The registered person shall ensure that robust governance arrangements are put in place to ensure that the deficits identified in the report are appropriately actioned.	**Partially met**
	Action taken as confirmed during the inspection: Examination of governance records and discussion with the manager confirmed that although some improvements have been made to the oversight arrangements in the home, further improvements are required to achieve compliance. This is discussed further in Section 5.2.5. This area for improvement has been partially met and is stated for a second time.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref**: Standard 39.9 **Stated:** First time	The registered person shall ensure that mandatory training requirements are met.	**Partially met**
	Action taken as confirmed during the inspection: Although some improvements were noted in staff training compliance, further improvements in this area are required. This is discussed further in Section 5.2.1. This area for improvement has been partially met and is stated for a second time.	
Area for improvement 2 **Ref**: Standard 40.2 **Stated:** First time	The registered person shall ensure all staff have a recorded annual appraisal and supervision no less than every six months. A supervision and appraisal schedule shall be in place, showing completion dates and the name of the appraiser/supervisor.	**Partially met**
	Action taken as confirmed during the inspection: There was evidence that some staff had an annual appraisal although there was limited evidence of activity regarding staff supervisions. This area for improvement has been partially met and is stated for a second time.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

A system was in place to ensure staff were recruited safely. Staff selection and recruitment records reviewed did not evidenced that gaps in employment were explained and a pre-employment health assessment had not been obtained before making an offer of employment. This was identified as an area for improvement. This was discussed with the manager and assurances were given that the system for reviewing recruitment files would be reviewed.

Checks were made to ensure that staff maintained their registrations with the Northern Ireland Social Care Council (NISCC). However, examination of records highlighted shortfalls regarding oversight of staff registration with the Nursing and Midwifery Council (NMC).This was identified as an area for improvement during the previous care inspection and is now stated for a second time.

The staff duty rota accurately reflected the staff working in the home on a daily basis. This rota identified the person in charge when the manager was not on duty.

Staff who take charge of the home in the absence of the manager should complete a competency and capability assessment. Discussion with the manager confirmed that these had been completed although no records were available for review on the day of the inspection. Examination of records shared with RQIA following the inspection confirmed that most staff had completed these. The manager confirmed that staff requiring these assessments would have them completed within a two week period. This will be reviewed at a future care inspection.

Staff consulted with confirmed that they received regular training in a range of topics such as moving and handling, infection prevention and control (IPC) and fire safety. A review of training records evidenced that although some improvements were made since the last care inspection, further work was required to ensure compliance with mandatory training. An area for improvement identified at the previous care inspection was stated for a second time.

At the previous care inspection the provision of Deprivation of Liberty Safeguards (DOLS) training was discussed and assurances given that this training would be provided to all staff. On the day of inspection not all staff members were aware of their role with regards to. No records of DoLs training were available for review. This was discussed with the manager and identified as an area for improvement.

Review of staff training records confirmed that all staff members were required to complete adult safeguarding training on an annual basis. Staff members were able to correctly describe their roles and responsibilities regarding adult safeguarding.

Staff said they felt supported in their role and were satisfied with the level of communication between staff and management. Staff reported good team work and said when planned staffing levels were adhered to they had no concerns regarding the staffing levels.

There was no evidence that staff meetings were held on a regular basis. The manager, who has recently been appointed, confirmed a staff meeting would be scheduled following the inspection and further staff meetings would be diarised for the incoming the year.

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

5.2.2 Care Delivery and Record Keeping

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

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner and by offering personal care to patients discreetly. Staff members were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

Patients' 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.

Management of wound care was examined. Review of a patient's care records confirmed that wound was not dressed in accordance with the prescribed frequency, wound assessments were not always completed each time the wound was dressed and evaluations did not consistently comment on the progress or condition of the wound. An area for improvement was identified.

Falls in the home were monitored on a monthly basis 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. There was a system in place to ensure that accidents and incidents were notified to patients' next of kin, their care manager and to RQIA, as required.

Examination of one identified patient's care plan and falls risk assessment evidenced that these records were not reviewed, post fall, to ensure they continued to accurately reflect the needs of the patients. An area for improvement was identified.

Care plans examined detailed how patients should be supported with their food and fluid intake and reflected the international dysphagia diet standardisation initiative (IDDSI) descriptors.

A review of the management of patient's weights identified that these were not always monitored on a monthly basis. To ensure that weight loss or gain is identified in a timely manner, nutritional screening must be completed monthly or more frequently depending on assessed need. This was identified as an area for improvement. Where weight loss was identified referrals were made to the appropriate healthcare professionals.

Records were maintained to evidence the delivery of personal care. Where patients have the potential to resist support with personal care a care plan should be in place detailing their behaviours and interventions required to support the patient. An area for improvement was identified.

Supplementary care records were reviewed. Food and fluid intake records and repositioning charts reviewed evidenced gaps in the records of care delivery. This was identified as an area for improvement.

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

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and the administration of food supplements in addition to meals. Staff told us how they were made aware of patients' nutritional needs to ensure that patients received the right consistency of food and fluids.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Lunch was a pleasant and unhurried experience for the patients. The food served was attractively presented and smelled appetising and portions were generous. A variety of drinks were served with the meal.

Patients may need support with meals; ranging from simple encouragement to full assistance from staff. Staff attended to patients' dining needs in a caring and compassionate manner while maintaining written records of what patients had to eat and drink, as necessary. Patients spoke positively in relation to the quality of the meals provided. One patient said, "The food is great. You get a choice and can pick what you want to eat" while another patient joked and said "The food is great but I get far too much!".

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment evidenced the home was warm, clean and comfortable. Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, clean and tidy.

It was pleasing to note ongoing refurbishment within the home. The Responsible Individual confirmed that the flooring in patient's bedrooms has been replaced and plans were in place to replace carpets in communal lounges along with replacing the units in the kitchenette areas.

We observed trolleys with cleaning chemicals left unattended. This was discussed with identified staff who took immediate action to ensure that the risks were reduced or removed immediately. Assurances were provided by the manager that further action would be taken to reduce risks to patients in the home. An area for improvement identified at the previous care inspection was stated for a second time.

Fire safety measures were reviewed. A fire risk assessment had been completed on 24 September 2022; the manager advised that a number of areas requiring action were identified however the written report had not been received by the home at the time of the inspection. Confirmation was received following the inspection that all of the areas requiring action from the current fire risk assessment, with the exception of one, had been addressed. The responsible individual confirmed that work was ongoing to address the outstanding work.

Review of records identified that that fire detection & alarm tests were not completed on a weekly basis. In addition, from discussion with staff and records examined it was not clear if all staff had taken part in a fire drill. These deficits were discussed with the manager and responsible individual who gave assurances that fire safety measures would be reviewed as a priority. Areas for improvement were identified.

The manager said that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. Any outbreak of infection was reported to the Public Health Authority (PHA).

There were laminated posters displayed throughout the home to remind staff of good hand washing procedures. Posters regarding the correct method for applying and removing of personal protective equipment (PPE) did not appear to be frequently displayed at PPE stations. This was discussed with the manager who agreed to have these put in place.

Discussion with staff confirmed that training on infection prevention and control (IPC) measures and the use of PPE had been provided. Some staff members were observed to carry out hand hygiene at appropriate times and to use PPE correctly; other staff did not. Some staff members were not familiar with the correct procedure for the donning and doffing of PPE, while other staff members were not bare below the elbow. Identified storage areas in the home were cluttered while some PPE was observed to be inappropriately stored in toilet areas. This was discussed with the manager who agreed to address these matters with staff and ensure the nurse in charge monitors compliance on their daily walk about. As discussed in Section 2.0, this area for improvement has previously been stated for a second time. Given that some improvement had been achieved since the previous inspection and assurances provided during and following the inspection, it was agreed that the area for improvement would be stated for a third and final time.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. Some patients told us they liked the privacy of their bedroom, but would enjoy going to the dining room or a lounge for meals.

Patients were observed enjoying listening to music, reading newspapers/magazines and watching TV, while others enjoyed a visit from relatives. One patient said, “We have quite a bit of entertainment, we do bingo and ball games and we are having a Halloween party”. Staff said the activity co-ordinator did a variety of one to one and group activities to ensure all patients had some activity engagement. Staff said there were plans in place to celebrate Halloween; many decorations had been displayed throughout the home.

There was evidence that a planned activities programme was in place. An activity planner displayed in the dementia unit confirmed varied activities were delivered which included arts and crafts, church services, memory games and the music man. However, this activity planner was reflective of the activities planned for the previous week and there was no evidence that activities had been planned in any of the suites for the week of the inspection. Discussion with staff and review of the staffing rota confirmed an activity co-ordinator was on a period of leave and no provision had been made for activity provision in their absence. This was discussed with the manager who agreed to review allocation of activities in the absence of the activity co-ordinator.

5.2.5 Management and Governance Arrangements

Staff members were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

There has been a change in the management of the home since the last inspection. Mrs Leigh Patience has been the manager in this home since 18 July 2022**.** RQIA were notified appropriately.

Staff commented positively about the manager and described them as supportive, approachable and always available for guidance. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

Discussion with the manager confirmed that systems were in place for staff appraisal and supervision, although these were not up to date. The manager confirmed they are developing a planner to assist with the management of any outstanding supervisions and appraisals. An area for improvement identified at the last care inspection has been stated for a second time.

There was a system in place to manage complaints. Examination of one complaint confirmed that although a complaints log was in place to monitor complaints received, there were no records available detailing the nature of the complaint, actions taken and the complainant's level of satisfaction regarding the outcome of the complaint. This was discussed with the manager who agreed to complete the records retrospectively and review current systems to ensure complaints were recorded correctly and that accurate records are maintained. This will be reviewed at a future care inspection.

Review of accidents and incidents records found that these were generally well managed and reported appropriately. However, review of records identified one notifiable event which had not been reported. This was submitted retrospectively.

Review of a sample of quality assurance audits identified that there was an absence of audits, for example around the areas of management of wound care and IPC practices.

RQIA acknowledged that the recent change in management arrangements may have impacted the governance arrangements. Assurances were provided that the manager and the responsible individual had been working to a plan to improve the governance arrangements in the home. RQIA were satisfied that the manager understood their role and responsibilities in terms of governance and needed a period of time to address the areas for improvement identified as a result of this inspection. Additional assurances were provided by the responsible individual regarding high level supports that will be made available to the manager to address the shortfalls highlighted in this report. An area for improvement in relation to governance arrangements was stated for a second time.

Review of records identified that monthly monitoring reports in accordance with Regulation 29 were either inconsistently completed, or were insufficiently robust so as to identify deficits and drive necessary improvements within the home. This was discussed with the responsible individual who gave assurances that the arrangements for the completion of the monthly monitoring reports would be reviewed. An area for improvement was identified.

6.0 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 the Care Standards for Nursing Homes (April 2015).

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

*The total number of areas for improvement includes five that have been stated for a second time and one that has been stated for a third and final time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Leigh Patience, manager, and Mr Ryan Smyth, responsible individual, 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:** Third and final time **To be completed by:** Immediate action required (18 October 2022)	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. A more robust system should be in place to ensure compliance with best practice on infection prevention and control. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: Daily IPC Walk around home which is documented and details actions required/addressed. Staff supervisions carried out as required and all staff have received further IPC training through the trust. This is evidenced on the training matrix
Area for improvement 2 **Ref**: Regulation 21 (1) (b) **Stated:** Second time **To be completed by:** Immediate action required (18 October 2022)	The registered person shall ensure that a robust system is implemented and maintained in regard to monitoring staff registration with the Nursing and Midwifery Council at all times. Ref: 5.1 and 5.2.1
	Response by registered person detailing the actions taken: These are checked monthly and individual copies kept on file - staff due for renewal are written to as a reminder.
Area for improvement 3 **Ref:** Regulation 14 (2) (a) (c) **Stated:** Second time **To be completed by:** Immediate action required (18 October 2022)	The registered person shall ensure as far as is reasonably practicable that all parts of the home to which the patients have access are free from hazards to their safety, and unnecessary risks to the health and safety of patients are identified and so far as possible eliminated. This area for improvement is made with specific reference to the safe storage and supervision of thickening agents and cleaning chemicals. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: Daily walk round to check locked doors and this has also been discussed with staff at recent meetings. New lockable domestic trolleys have also been purchased and are in use throughout the home.

Area for improvement 4 **Ref:** Regulation 10 (1) **Stated:** Second time **To be completed by:** Immediate action required (18 October 2022)	The registered person shall ensure that robust governance arrangements are put in place to ensure that the deficits identified in the report are appropriately actioned. Ref: 5.1 and 5.2.5
	Response by registered person detailing the actions taken: An audit planner is in place to cover all required areas. These are split over a 12 month period. Actions resulting from audits have evidence provided to support outcomes.
Area for improvement 5 **Ref**: Regulation 21 (1) (b) **Stated:** First time **To be completed by:** Immediate action required (18 October 2022)	The registered person shall ensure that before making an offer of employment any gaps in employment are explored and explanations recorded and that a pre-employment heath assessment is obtained. Ref: 5.2.1
	Response by registered person detailing the actions taken: Health questionnaires are sent out with application forms and reviewed in advance of interviews. An employment gap check prompt has been included in interviewer notes.
Area for improvement 6 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** Immediate action required (18 October 2022)	The registered person shall ensure that nursing staff manage falls in keeping with best practice. All actions taken post fall should be appropriately recorded in the patient's care record. Ref: 5.2.2
	Response by registered person detailing the actions taken: Discussed with staff at last group of meetings - these are checked as part of a new monthly falls audit as well as post incident to ensure consistency with incident report forms. Staff supervisions are carried out as required if any gaps are noted in record keeping.
Area for improvement 7 **Ref**: Regulation 27 (4) (d) (v) and (f) **Stated:** First time **To be completed by:** Immediate action required (18 October 2022)	The registered person shall make adequate arrangements for fire detection & alarm test activation on a weekly basis. All staff must participate in a fire evacuation drill at least once per year. Ref: 5.2.3
	Response by registered person detailing the actions taken: Fire test and alarm drills are carried out weekly - all staff respond and a comprehensive record is kept - this also evidences points for discussion/what could have been done differently. All staff have completed annual online training and 6 monthly face to face sessions - evidenced on training matrix. Evacuation drills have been scheduled 6 monthly.

Area for improvement 8 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that the Regulation 29 monitoring visits are completed on a monthly basis. These reports should be robust and clear on the actions required to drive the necessary improvements to ensure compliance with regulations and standards. Ref: 5.2.5
	Response by registered person detailing the actions taken: Alternative arrangements are now in place for person carrying out regulation 29 visits. First visit is due in December 2022. RQIA reg 29 template has been suggested for use by nurse manager.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 39.9 **Stated:** Second time **To be completed by** 18 November 2022	The registered person shall ensure that mandatory training requirements are met. Ref: 5.1 and 5.2.1
	Response by registered person detailing the actions taken: An annual training planner is in place - this also details face to face training required. Previous gaps have been identified and actions have been taken to rectify. All staff are compliant.
Area for improvement 2 **Ref**: Standard 40.2 **Stated:** Second time **To be completed by:** 18 December 2022	The registered person shall ensure all staff have a recorded annual appraisal and supervision no less than every six months. A supervision and appraisal schedule shall be in place, showing completion dates and the name of the appraiser/supervisor. Ref: 5.1 and 5.2.5
	Response by registered person detailing the actions taken: All staff are compliant for 2022. A 2023 planner is also in place. This identifies supervisors/supervisees schedule of when appraisals and supervisions are due.
Area for improvement 3 **Ref:** Standard 39.4 **Stated:** First time **To be completed by:** 18 November 2022	The registered person shall ensure staff complete training in relation to Deprivation of Liberty Safeguards. Ref: 5.2.1
	Response by registered person detailing the actions taken: All staff have completed this training and this is evdienced within the training matrix planner.

Area for improvement 4 **Ref**: Standard 21.1 **Stated:** First time **To be completed by** 18 November 2022	The registered person shall review the provision of wound care to ensure that: • to ensure that wounds are dressed in accordance with the prescribed frequency • Wound assessments must be completed each time wounds are dressed • Wound care evaluations must comment on the progress or condition of the wound. Ref: 5.2.2
	Response by registered person detailing the actions taken: Wound care charts have always been in place as used by the trust - these detail all of the above points. The home has introduced another evaluation form which expands on this information to provide further clarity for any external agencies needing access to the information.
Area for improvement 5 **Ref:** Standard 12.4 **Stated:** First time **To be completed by:** Immediate action required (18 October 2022)	The registered person shall ensure nutritional screening assessments are completed monthly or more frequently depending on assessed need. Ref: 5.2.2
	Response by registered person detailing the actions taken: All MUST and dietary notifications are in place for all residents. A daily review of food/fluid charts is undertaken by the RNs in charge.
Area for improvement 6 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Immediate action required (18 October 2022)	The registered person shall ensure where patients have the potential to resist support with personal care, a care plan is in place detailing their behaviours and interventions required to support the them. Ref: 5.2.2
	Response by registered person detailing the actions taken: These plans have been implemeted and care file audits are in place to identify any areas of non compliance.

Area for improvement 7 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** Immediate action required (18 October 2022)	The registered person shall ensure contemporaneous repositioning and food and fluid intake records are maintained. Ref: 5.2.2
	Response by registered person detailing the actions taken: These have been reviewed with all staff post inspection and a collective decision taken to make changes to current documentation to ensure a more robust system is in place to prevent gaps in records.

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

The Regulation and Quality Improvement Authority

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