Unannounced Care Inspection Report
26 April 2021

Kilwee Care Home

Type of Service: Nursing Home
Address: 42f Cloona Park, Dunmurry, Belfast BT17 0HH
Tel no: 028 9061 8703
Inspector: Nora Curran

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.

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.

1.0 What we look for

2.0 Profile of service

This is a nursing home registered to provide nursing care for up to 32 persons.

3.0 Service details

Organisation/Registered Provider: Merit Retail Ltd **Responsible Individual(s):** Jarlath Conway	**Manager:** Deborah Campbell – Not registered
Person in charge at the time of inspection: Deborah Campbell	**Number of registered places:** 32 A maximum of 20 patients in category NH-DE and 12 patients in categories NH-I, NH-PH and NH-PH (E).
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. MP – Mental disorder excluding learning disability or dementia. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 10 in NH-I, NH-PH, and NH-PH (E) 18 in NH-DE 28 total

4.0 Inspection summary

An unannounced inspection took place on 26 April 2021 from 08.30 to 17.20 hours.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to prioritise inspections to homes on the basis of risk.

This inspection was undertaken to assess the progress with areas for improvement identified at the last inspection; it also sought to determine if patients were provided with safe, effective and compassionate care and if the service was well managed.

The following areas were examined during the inspection:

- staffing
- environment
- infection prevention and control (IPC) and personal protective equipment (PPE)
- care delivery
- governance and management.

Patients said, “We’re looked after the very best”.

The findings of this report will provide Kilwee Care 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	*8

The total areas for improvement include one under standards that has been carried forward to the next inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Deborah Campbell, Manager, 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.

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
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care and medicines management inspection reports.

During the inspection the inspector met with seven patients, one professional visitor and seven staff. Questionnaires were also left in the home to obtain feedback from patients and patients’ representatives. Ten patients’ questionnaires and ten patients’ relatives/representatives questionnaires were left for distribution. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided the registered manager with ‘Tell us’ cards which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

RQIA received one completed relative questionnaire within the allocated timeframe. This relative provided contact details and additional feedback was obtained during a telephone call. Their opinion and comments are included in this report.

No staff surveys were completed and no patient questionnaires were received.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- two weeks duty rotas from 16 April 2021
- records confirming registration of relevant staff with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC)
- staff training records
- staff recruitment records
- complaints and compliments records
- accident and incident records
- correspondences with relatives about visiting and care partner arrangements
- provider monthly monitoring visits
- a selection of quality assurance audits
- fire risk assessment
- four patients' care records, including supplementary records.

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 previous inspection(s)

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 22 October 2020.

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 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals. This is in specific reference to care plans and daily recording charts: • accurately reflect the frequency of repositioning • contain clear information regarding the recommended type of pressure relieving mattress • contain clear information regarding patients' recommended daily fluid intake and action to take if it is below the set target • accurately reflect the level of assistance required with personal care • accurately reflect the patients pain management • contain clear information regarding medical conditions where treatment is being provided • where a patient has a history of weight loss the MUST is accurately reflected within the care records.	**Met**
	Action taken as confirmed during the inspection: Four patients' care records were reviewed and improvement was noted in relation to the areas stated above. In the records reviewed there was evidence that outcomes for patients were good, in that, there were no pressure ulcers and there was evidence of good hydration. Some further improvement is required with record keeping in relation to daily fluid intake management, recording of pressure relieving mattress settings and repositioning records. These have been stated as areas for improvement under the standards in the quality improvement plan.	

Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the environmental and infection prevention and control issues identified during this inspection are urgently addressed and a system is initiated to monitor ongoing compliance.	**Met**
	Action taken as confirmed during the inspection: There was ample supply of PPE and hand sanitiser available in the home. Staff were seen to use PPE correctly and uniform policy was adhered to. All en-suite bathrooms had new pedal bins in place.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. • hand hygiene and PPE compliance audits should be sufficiently robust to ensure that any IPC deficits are appropriately identified and actioned • governance audits in respect of care records to ensure care plans and care records are maintained as required.	**Met**
	Action taken as confirmed during the inspection: Governance audits looking at IPC, hand hygiene, PPE compliance and care records were in place and completed monthly. Audit outcomes and action plans were evidenced to drive improvement.	
Area for improvement 2 **Ref**: Standard 18 **Stated:** First time	The registered person shall review and revise the management of distressed reactions to ensure that: • when more than one medicine is prescribed the personal medication records and care plans provide details of which medicine should be used first line and the timing interval before a second medicine can be administered • the reason for and outcome of administration are recorded.	**Carried forward to the next care inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.	

Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that care plans for adding medicines to food/drink to assist administration contain sufficient detail to direct the required care.	**Met**
	Action taken as confirmed during the inspection: Patient care records for adding medicines to food and/or drink were reviewed and found to contain sufficient detail, including how to administer, level of assistance required, multidisciplinary discussion, next of kin involvement and best interest documents.	

6.2 Inspection findings

6.2.1 Staffing

Safe staffing begins at the point of recruitment. Three staff recruitment records were reviewed as part of the inspection. There was a system in place to verify staff identity, complete enhanced Access NI checks, obtain employment references, review staffs' health status, and where applicable, evidence of relevant qualifications and training. It was also noted that, where required, proof of eligibility to work in the UK was obtained.

Staff were provided with a comprehensive induction to prepare them for working with patients, and of the three individual records reviewed, two inductions were fully completed and one was still ongoing.

Newly recruited care staff, not previously registered with Northern Ireland Social Care Council (NISCC), were supported to start the application process at the start of their employment. All other relevant staff were registered with NISCC or the Nursing and Midwifery Council (NMC) respectively. Both NISCC and NMC registers were checked monthly and any anomalies or actions required were documented and signed off by the manager.

The duty rotas accurately reflected the staff working in the home over the 24 hour period. The person in charge at each shift was highlighted on the rota and staff demonstrated an awareness of who was in charge. Any persons assuming charge of the home in the absence of the manager had a 'nurse in charge' competency completed and reviewed yearly.

The manager explained how safe staffing levels were determined by ongoing monitoring of the number and dependency levels of patients; staffing levels were adjusted when needed and took into account the skill mix of staff. It was noted that there was enough staff in the home to quickly respond to the needs of patients. Staff were seen to be polite and warm in their interactions with patients, and it was positive to note that staff were intuitive to the needs of those patients with communication difficulties, specifically those difficulties relating to dementia.

There was a system in place to ensure that mandatory training was kept up to date. While it was noted that the majority of mandatory training was being provided on an eLearning platform due to the COVID-19 pandemic, some courses requiring a practical element were provided face to face in small groups. Some recent sessions included, fire safety, moving and handling, and first aid.

The manager had oversight of mandatory training compliance and there was evidence of actions taken if staff became overdue in completing a course.

Staff told us that they were satisfied with the planned staffing levels and that any issues such as short notice staff absences were managed appropriately and promptly. Staff acknowledged that improvements had been achieved in the stability of the staff group due to recent recruitments and a reduced need for agency/temporary staff. They described team working in positive terms.

Patients told us that there were enough staff available to them and there were no concerns about staffing expressed by the relative or professional visitor. Patients spoke in positive terms about staff and described feeling comfortable and supported in their needs.

The returned questionnaire indicated that this relative was very satisfied that the service was safe and compassionate. The relative who responded to the questionnaire provided additional comments via a telephone call and said, “I’m very happy with the care…staff are very accommodating, I couldn’t praise them enough”.

The visiting professional said, “I always find here very good…the staff are polite and professional…there is good communication and they are helpful. I have no concerns”.

6.2.2 Environment

A selection of bedrooms, lounges, dining rooms, and storage areas were inspected. Dementia friendly signage was used on doors to orientate patients to their bedrooms, bathrooms/toilets and communal rooms. All areas of the home were free from malodour.

Bedrooms were found to be clean, well-lit, spacious, and decorated to a good standard. There was an absence of personalisation in some bedrooms, with a distinct lack of photos and/or pictures on the walls, or patients’ memorabilia. Personalisation of individual patients’ space would encourage memory connections, stimulate cognition, and provide a more homely feel. An area for improvement was identified.

Some areas containing items with potential to cause harm to patients were not properly secured, specifically; a cleaning store in the dementia unit was found to be unlocked with access to cleaning materials, hot water tap, and an opened access hatch to piping and valves. The majority of en-suite bathroom cabinets in the dementia unit containing toiletries and razors were unlocked when not in use. A wheelchair store which was unsecured contained a bag with painting materials and glue. Several other items such as hairspray, dry shampoo and an alcohol gel bottle were found to be sitting around the dementia unit. These safety concerns were highlighted to the nurse in charge who acted immediately to make safe. An area for improvement was identified.

Some environmental infection prevention and control issues were found and this is discussed further in section 6.2.3.

Corridors, stairwells and fire exits were seen to be free from clutter or obstruction. Linen supply stores were found to be clean and organised, with no inappropriate storage. Interior décor of the home was maintained to a satisfactory standard.

During the inspection it was noted that the majority of patients in the general nursing unit chose to spend most of their time in their own bedrooms. In contrast, the majority of patients in the dementia unit chose to spend most of their time in communal areas. It was observed that there were some challenges to facilitating social distancing in both the communal lounge and dining room in the dementia unit.

Whilst overall the communal space in the nursing home met the standards for premises, the dining room in the dementia unit could be quite cramped when full. This had been exacerbated by the impact of the pandemic and the need for optimal social distancing. This was discussed with the manager, and some strategies to manage this were suggested, for example having split mealtime sittings. The RQIA estates inspector agreed to liaise with the management to discuss how this could be improved.

At the time of the inspection a fire risk assessment was being conducted by an accredited fire assessor. The previous fire risk assessment had taken place on 16 October 2019 and was due for review in October 2020, however this was delayed due to COVID-19 pandemic and outbreaks. No actions were required as a result of the 2019 assessment and the risk assessor indicated that there were no major concerns on the day.

6.2.3 Infection prevention and control (IPC) and personal protective equipment (PPE)

Signage was displayed at the entrance to the home to reflect the current guidance on COVID-19. All visitors had their temperature checked and a health declaration completed on arrival. There was facility to carry out hand hygiene and put on the recommended Personal Protective Equipment (PPE) before proceeding into the home.

Staff said that the home had plenty of PPE available and stocks were regularly replenished. PPE stations were found to be well stocked throughout the home; training on infection prevention and control (IPC) measures and the use of PPE had been provided to staff.

Staff were seen to carry out hand hygiene at key moments and were observed to use PPE in accordance with the regional guidance, with the exception of one staff member whose mask was noted to be below their nose on two occasions. This was addressed with the staff member at the time and also discussed with the manager.

Staff recognised the importance of maintaining the home to a high standard of cleanliness and the domestic staff told us that in addition to the regular cleaning schedules, all frequently touched points, for example light switches and door handles, were cleaned more regularly. Records were maintained of all cleaning duties. Domestic staff also informed us that they had ample cleaning materials and supplies.

The general environment of the home was found to be clean; however there were some areas that required more attention to detail when cleaning, such as the underside of some towel, soap and alcohol gel dispensers, and the underside of some shower chairs. The majority of nurse pull cords were covered in a wipeable material, but some cords identified in the dementia unit were not easily wipeable. There was a further risk of cross-contamination when a trolley with clean linen was found to be stored in a cupboard with the laundry shoot for dirty linen. An area for improvement was identified.

As part of the regional programme for planned and regular testing for COVID-19, patients were tested every four weeks, and staff and care partners were tested weekly.

Visiting was facilitated by appointment in a designated room which had a clear partition and a nurse call bell for visitors to use when the visit was over or if the patient needed assistance. Patients were also assisted with window or garden visits. Care partner arrangements were communicated to all patients' next of kin and a number of people had taken on the role. Risk assessments and agreements were in place for care partners and the manager informed us that this was working well.

Patients, staff and relative feedback indicated that there were no concerns regarding the cleanliness of the home, the management of COVID-19 guidance, and that visiting and care partner arrangements were working well. The relative told us, "I have no issues with the visiting restrictions…they are keeping everyone safe…I get to visit inside once a week at the moment and the home have been very accommodating and considerate to our family…"

6.2.4 Care delivery

All patients should receive the right care at the right time to meet their daily needs. Staff confirmed that they met at the beginning of each shift to discuss the needs of patients and prioritised any special arrangements for that day, such as appointments or visiting schedules. In addition, care records were available to inform nursing and care staff of patients' needs.

The care records for four patients were reviewed. Patients' needs were assessed from the time of admission and care plans were developed. Patients' individual care needs were reviewed at least monthly by nursing staff.

Patients who are unable to mobilise or move independently are at greater risk of skin breakdown. It was noted that two of the patient records reviewed did not accurately reflect the frequency of repositioning required, or the repositioning charts did not consistently evidence that a change in position had occurred within the required timeframe. In one patient's records the care plan had not been updated to reflect a change in the patient's pressure ulcer risk assessment. In another patient's records the type of pressure relieving mattress was stated but detail about the correct setting was not clear, and the patient's mattress was not set to the correct setting for their weight. This was highlighted to the nurse on duty who corrected the setting. Two areas for improvement were identified in relation to pressure prevention record keeping and management of pressure relieving devices.

Patients' individual nutritional needs were assessed at least monthly using the Malnutrition Universal Screening Tool (MUST), in conjunction with oral and choking assessments. We noted in one patient's records that the MUST score had changed and this was not updated in the care plan. In another patient's records it was noted that speech and language therapy (SALT) recommendations had changed but the care plan was not updated to reflect these changes. This patient's food and fluid intake records had been updated to reflect the changes and the patient had been receiving the correct consistency of food. This same patient's records stated the recommended daily intake target of fluids but did not instruct staff what to do if the target was not met or when action was required. An area for improvement was identified.

Patients' weights were monitored monthly or more often if required. Patients with a history of unplanned weight loss were referred to dietetics and a care plan put in place.

One patient had been assessed has having moderate chronic pain following monthly review using the Abbey pain scale. There was evidence of communications with the patient's GP, pain relieving medication was prescribed and used when required, and medication was used to good effect, however no care plan was in place. An area for improvement was identified.

The above areas were discussed with the nurse on duty and the process for updating the identified patient records began.

We observed breakfast and lunch time servings. Menus were displayed as photos of food on a notice board and on some tables. It was noted that while the photos were large, coloured and laminated, there was no written description of the food. This was discussed with the manager and regional manager and an agreement was made to include a written description along with the visual aids. This will be reviewed at the next inspection.

Patients were offered at least two choices at each sitting and the food smelled and looked appetising. The majority of patients told us that they were satisfied with the food choice, quality and portion sizes, with one patient saying they "get too much". One patient expressed some dissatisfaction about the variety of food, but did confirm that if they did not like what was on the menu they could ask for something else. This was discussed with the manager who was already aware of this patient's dissatisfaction and informed us that the chef was also aware and working to improve this patient's experience.

At mealtimes, staff were observed to engage well with patients and appeared knowledgeable about patient likes and dislikes. Staff offered assistance where required and were verbally supportive and encouraging to patients. Low level background music was played during meals and there was a relaxed, unhurried and social atmosphere. Patients who chose to have their meals in their bedrooms had trays prepared. It was observed on several occasions that food was not appropriately covered when being transported from the dining area to patients' bedrooms. An area for improvement was identified.

Staff were seen to provide a social atmosphere in the communal lounge with various activities such as a ball game in the morning and a music and dance session in the afternoon. Patients were encouraged to take turns to select their favourite singers and bands and staff assisted some patients to dance on their feet or in chairs. All patients taking part looked happy and enjoyed the activities. In general patients looked well cared for. Staff were seen to spend some social one to one time with patients who chose to spend time in their bedrooms.

Patients told us that they get what they need when they need it and that they were happy with the care provided. Staff said that they felt supported in their roles to provide effective care; that the shift handover and supporting documentation was invaluable, that they had a good understanding of what was expected from them and that they loved working in Kilwee.

The relative feedback indicated that they were satisfied that the service was effective.

6.2.5 Governance and management

There had been no changes in management since the last inspection. There was a clear management structure within the home to ensure lines of accountability. Staff were familiar with the specific roles and responsibilities of the full team. The manager informed us that they were supported by a senior management team. There were written policies and procedures in place for all aspects of running the home and staff had access to these.

There was a system of quality assurance audits in place which covered a range of areas such as infection prevention and control, hand hygiene, restrictive practices, prevention of pressure ulcers, patient nutrition, care records, management of infections, and health and safety. A sample of the most recent audits were reviewed and found to be well maintained with good manager oversight.

Accident and incident records were maintained and the manager conducted a monthly analysis which looked for any patterns or trends and detailed outcomes for patients, for example referral to the Health and Social Care Trust falls team, occupational therapy or physiotherapy. A sample selection of incidents was cross-referenced with information held by RQIA and concluded that accidents and incidents were reported to relevant persons appropriately.

The manager maintained a recorded of compliments and complaints. The complaints records were reviewed monthly and included the nature of the complaint, the outcome and any learning, and the complainants' satisfaction level at closing. The record for 2021 showed one complaint which was managed appropriately and the complainant was satisfied with the outcome.

Thank you cards and letters to the home were shared with staff and kept. A recent compliment said, "Thank you all for the care and attention you gave…could not have been in better hands…we really appreciate it".

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. A review of the monthly monitoring records from March 2021 showed that visits were unannounced and resulted in a written report which was made available to the manager for ongoing quality improvement. The written reports contained an update on any progress made from the last visit, consultation with patients, relatives and staff, a review of records, and concluded with a further action plan to further drive improvement.

Patients spoken with did not raise any concerns in relation to the management of the home. Staff told us that they were very satisfied that the home was well led, and expressed that they felt reassured with the stability of management arrangements over the last two years. Staff said that they felt supported through a very difficult year due to the pandemic and that management were very approachable and fair.

The relative feedback indicated that they were satisfied that the service was well led.

Areas of good practice

Areas of good practice were identified in relation to staffs' awareness of patients' needs, how staff communicated with patients and team working.

Areas for improvement

Areas for improvement were identified in relation to; ensuring items with potential to cause harm were secured properly, personalisation of some patients' bedrooms, environmental IPC, and transportation of meals outside of the kitchen or dining rooms. Further areas for

improvement were identified with record keeping relating to pressure prevention, nutrition and hydration needs and pain management. It is important to note that the latter areas related only to record keeping and outcomes for patients were seen to be positive.

	Regulations	Standards
Total number of areas for improvement	2	8

6.3 Conclusion

As a result of the inspection four areas for improvement from the previous care and medicines management inspections were met and one area was carried forward to the next inspection. Nine new areas for improvement were identified.

There was some concern with regards to the communal space in the dementia unit. Challenges were identified with facilitating social distancing in both the main lounge and dining room. This was discussed with the manager and RQIA estates inspector and it was agreed that this will be further explored for possible solutions.

Several areas of good practice were identified in relation to how staff demonstrated their knowledge of patients' needs and preferences. The social atmosphere created by staff in the dementia unit was particularly positive.

Patients spoke in positive terms about their experiences with staff and staff availability. Staff and relative feedback indicated that they were satisfied the service was safe, effective, compassionate and well led.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Deborah Campbell, manager, 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 14 (2) (a) and (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all parts of the home to which patients have access are free from hazards to their safety and that all unnecessary risks to health and safety are eliminated as far as is reasonably practicable. Ref: 6.2.2
	Response by registered person detailing the actions taken: Housekeeping staff have been advised to ensure that cleaning stores are kept locked at all times. Items found in the wheelchair store have been removed and store to be kept locked. Nurse in charge of each floor to complete a daily check for inappropriate items to make units safe for our residents.
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the infection prevention and control issues identified with the home's environment are addressed. This is with specific reference to robust cleaning of hand towel, soap and alcohol dispensers, and shower chairs. Ensuring all pull cords are washable. And ensuring clean linen is kept in separate areas from used laundry. Ref: 6.2.3
	Response by registered person detailing the actions taken: Supervision completed with Housekeeping staff in relation to attention to detail when cleaning, paying particular attention to underside of dispensers and shower chairs. All pull cords are washable. Staff advised to take soiled washing directly to laundry and not to leave in linen store.

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 18 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall review and revise the management of distressed reactions to ensure that: • when more than one medicine is prescribed the personal medication records and care plans provide details of which medicine should be used first line and the timing interval before a second medicine can be administered • the reason for and outcome of administration are recorded. Ref: 6.1
	Response by registered person detailing the actions taken: Personal medication records and care plans now provide detail of which medicine is used first and the interval before a second medicine can be administered. The reason for administration and the effect of administration is recorded.
Area for improvement 2 **Ref**: Standard 43 Criteria (6) **Stated:** First time **To be completed by:** 5 July 2021	The registered person shall ensure that patients' bedrooms are personalised as far as reasonably possible. This is with specific reference to bedroom walls. Ref: 6.2.2
	Response by registered person detailing the actions taken: All residents and their families are encouraged to personalise their rooms according to their preferences.
Area for improvement 3 **Ref**: Standard 23 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that robust systems are in place to ensure that pressure relieving devices are being maintained at the correct setting. Ref: 6.2.4
	Response by registered person detailing the actions taken: A monthly audit is completed by the manager cross referencing residents weight with the settings on each mattress. This information is also recorded on the hand over sheets.

Area for improvement 4 **Ref**: Standard 4 Criteria (9) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that care records relating to prevention of pressure ulceration are maintained up to date and accurately reflect the care provided. This is with specific reference to accurate completion of supplementary repositioning records and ensuring care plans are updated to reflect changes in assessed needs. Ref: 6.2.4
	Response by registered person detailing the actions taken: Regular auditing of supplementary records in relation to repositioning by nurse in charge will ensure that care is accurately reflected. Monthly auditing of care plans of residents at risk of pressure ulceration to be completed to ensure that plan of care reflects any changes.
Area for improvement 5 **Ref**: Standard 12 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that care records consistently reflect patients' needs in relation to nutrition. Ref: 6.2.4
	Response by registered person detailing the actions taken: Staff nurses evaluate MUST monthly and have been advised to record this in the monthly evaluation as opposed to the body of the care plan thus reducing any confusion.
Area for improvement 6 **Ref**: Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that fluid intake management is documented clearly in individualised care plans. This should include the patients' expected daily fluid intake target, what action to take if a patient is not meeting their target for consecutive days, and the threshold for taking action. Ref:6.2.4
	Response by registered person detailing the actions taken: When a resident is not meeting their target for three days, staff will contact GP for advice. This instruction is now included in the care plan.
Area for improvement 7 **Ref**: Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that individualised care plans are developed to address assessed needs of the patient. This is with specific reference to pain management. Ref: 6.2.4
	Response by registered person detailing the actions taken: Audit completed of all care plans in relation to pain relief. One resident found not to have care plan. Care plan initiated on day of inspection.

Area for improvement 8 **Ref**: Standard 12 **Stated:** First time	The registered person shall review the transportation of meals to patients' bedrooms to ensure they are covered appropriately during transport. Ref: 6.2.4
To be completed by: With immediate effect	**Response by registered person detailing the actions taken:** All trays taken to residents room have plate covering in place

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

The Regulation and Quality Improvement Authority

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