Inspection Report

04 May 2021

Templemoyle

Type of service: Nursing Home
Address: 41a Whitehill Road, Eglinton, BT47 3JT
Telephone number: 028 7181 1461

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: Mrs Elizabeth Kathleen Mary Lisk **Responsible Individual:** Mrs Elizabeth Kathleen Mary Lisk	**Registered Manager:** Mrs Jeya Pratheeksha **Date Registered** 10 November 2014
Person in charge at the time of inspection: Mrs Jeya Pratheeksha	**Number of registered places:** 30
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 30
Brief description of the accommodation/how the service operates: This is a registered Nursing Home which provides nursing care for up to 30 persons. The home is divided into three units located over three floors. Patients have access to communal lounges, dining rooms and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 4 May 2021 from 11.10 am until 4.30 pm. The inspection was undertaken by a care inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to care delivery, teamwork and maintaining good working relationships.

It was positive to note that most of the existing areas for improvement had been met and no new areas for improvement were identified.

Patients said that living in the home was a good experience. 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 staff, are included in the main body of this report.

RQIA were assured that the delivery of care and service provided in Templemoyle was safe, effective, compassionate and that the home was well led.

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

3.0 How we inspect

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

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

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were provided to the Registered Manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we spoke with eight patients, both individually and in small groups and six staff. Patients told us that they felt well cared for, enjoyed the food and that staff were helpful and friendly. Staff said that the manager was very approachable, there was great teamwork and that they felt supported in their role.

Following the inspection we received two completed questionnaires. One from a patient who indicated that they were satisfied/very satisfied that the care provided was safe, effective, compassionate and well led. One questionnaire from a relative indicated that they were very satisfied across all four domains.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to Templemoyle was undertaken 29 January 2021 by a care inspector.

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 (7) **Stated:** First time	The registered person shall ensure that all staff employed to work in the home are aware of and adhere to the IPC guidelines and best practice requirements.	**Partially met**
	Action taken as confirmed during the inspection: Observation of staff practices evidenced that the majority of staff were compliant with IPC best practice. However, one member of staff with overseeing responsibilities was observed wearing nail polish. We further observed inappropriate storage of a variety of items and equipment and there was limited availability of nitrile gloves. This is discussed further in section 5.2.4. This area for improvement has not been fully met and has been stated for a second time.	
Area for improvement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that the delivery of care is provided in accordance to the assessed needs of patients in a safe and timely manner.	**Met**
	Action taken as confirmed during the inspection: Observation of staff interactions with patients evidenced that the assessed needs of patients was provided in a safe and timely manner.	

Area for improvement 3 **Ref:** Regulation 14 (2) (a) **Stated:** First time	The registered persons must ensure that all areas of the home to which patients have access are free from hazards to their safety. With specific reference to ensuring that: • chemicals are securely stored in keeping with COSHH legislation • the electrical cupboard is kept locked • a suitable locking system is installed to the identified door • all grades of staff are aware of their responsibility to report and action any actual or potential hazards.	**Partially met**
	Action taken as confirmed during the inspection: Observation of the environment evidenced that most of the actions within this area for improvement has been met. However, a sluice room door was unlocked where chemicals were accessible to patients. This is discussed further in section 5.2.3. This area for improvement has not been fully met and has been stated for a second time.	
Area for improvement 4 **Ref:** Regulation 15 (1) (e) (2) (a) (b) **Stated:** First time	The registered persons must ensure that the nursing home has been registered for the category of nursing appropriate to the patient's needs and that assessments of patients' needs are kept under review and revised at any time.	**Met**
	Action taken as confirmed during the inspection: Review of one patient's assessment of needs evidenced that the manager had liaised with the commissioning trust and relevant action had been taken.	

Area for improvement 5 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure that: • medicines are stored safely and securely at all times • systems are in place to ensure expired medicines are removed for disposal • prescribed topical preparations and wound care dressings are clearly segregated to identify patient supplies and to facilitate stock control • a monitoring system is implemented to ensure the correct supplement is administered to patients.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment and discussion with staff evidenced that this area for improvement has been met.	
Area for improvement 6 **Ref**: Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that robust systems are in place to ensure that staff complete supplementary care records such as repositioning charts accurately and that pressure reliving mattresses are 'set' as per manufacturer's instructions.	**Met**
	Action taken as confirmed during the inspection: Review of care records, repositioning charts and pressure relieving mattresses evidenced that this area for improvement has been met.	
Area for improvement 7 **Ref**: Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall review the management of patients' nutritional care needs to ensure that : • the recommended dietary/fluid type is documented as per the IDDSI terminology within the patients' care records and supplementary recording charts • SALT recommendations are consistently recorded within the patients' care records and supplementary recording charts • relevant staff are aware of patients' dietary needs as per SALT and IDDSI terminology • a system is implemented to follow up referrals made to SALT for patients experiencing difficulties with swallowing in a timely manner. •	**Partially met**

	Action taken as confirmed during the inspection: Review of care records and discussion with staff evidenced that this area for improvement has not been fully met. This is discussed further in section 5.2.5. This area for improvement has not been fully met and has been stated for a second time.	
Area for improvement 8 **Ref**: Regulation 16 (1) (2) (b) **Stated:** First time	The registered person shall ensure that patients care plans are kept under review to ensure they are reflective of the patients assessed needs and the recommendations of other health care professionals. With specific reference to care planning: • for personal hygiene • care plans for patients with a relevant medical history including the identified patient • the normal type/frequency or bowel pattern to be routinely recorded for patients with a history of constipation.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of care records and discussion with staff evidenced that this area for improvement has been met. This is discussed further in section 5.2.6.	
Area for improvement 9 **Ref:** Regulation 27 (2) (b) (d) **Stated:** First time	The registered person shall ensure that the premises are kept in good state of repair, kept clean and reasonably decorated. With specific reference to: • surface damage to identified radiator covers, skirting boards, door frames, over bed tables, bedframes, vanity units and bedframes • wardrobes and drawers are repaired/replaced where necessary • toilet seat and pedal bins within the staff changing room • light fittings throughout the home are cleaned • light pull cords are covered • flooring is replaced to identified bedroom and corridor	**Met**

	• bed sheets and curtains are replaced where necessary • identified bedrooms are personalised with items of memorabilia and special interests.	
	Action taken as confirmed during the inspection: Observation of the environment evidenced that refurbishment works were ongoing within the home. Improvements had been made since the last inspection and most of the actions detailed above have been addressed. Following the inspection the manager confirmed in writing that all of the refurbishment works had now been completed.	
Area for improvement 10 **Ref:** Regulation 27 (4) (b) **Stated:** First time	The registered person shall take adequate precautions against the risk of fire to ensure the safety and wellbeing of patients in the home. Specific reference to ensuring: • that fire doors are not propped open • the cracked glass panel to the fire door in the laundry area is replaced • the use of a multi block electric extension lead in an identified patient's bedroom is reviewed • gaps on ceiling surfaces around a number of emergency fire exit signs are reviewed.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment evidenced that this area for improvement has been met.	

Area for improvement 11 **Ref:** Regulation 10 (1) **Stated:** First time	The registered person shall ensure that a robust governance system is implemented and maintained to promote and assure the quality of nursing and other services in the home.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of audits and governance records evidenced that this area for improvement has been met.	
Area for improvement 12 **Ref:** Regulation 29 **Stated:** First time	The registered person shall ensure that the monthly quality monitoring visit report is robust, that it provides sufficient information on the conduct of the home; with an action plan and timescales to address any deficits identified in a timely manner.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of monthly monitoring visit reports evidenced that this area for improvement has been met.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 41 **Stated:** First time	The registered person shall ensure the staff duty rota includes: • the hours worked by the manager and the capacity in which they are worked • abbreviations have clear codes to reflect what they represent and provide the hours worked by staff.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of staff duty rotas evidenced that this area for improvement has been met.	

Area for improvement 2 **Ref**: Standard 6 **Stated:** First time	The registered person shall ensure that patients' personal care and grooming needs are met and that care records reflect specific measures on how to maintain patients' personal care where an assessed need is identified.	**Met**
	Action taken as confirmed during the inspection: Review of care records and observation of patients evidenced that this area for improvement has been met. This is discussed further in section 5.2.2.	
Area for improvement 3 **Ref**: Standard 37 **Stated:** First time	The registered person shall ensure that any record retained in the home which details patient information is stored safely in accordance with the General Data Protection Regulation and best practice standards.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment evidenced that this area for improvement has been met.	
Area for improvement 4 **Ref**: Standard 44 **Stated:** First time	The registered persons must ensure that the nursing home, including all spaces, is only used for the purpose for which it is registered. A retrospective variation is to be submitted if any of the rooms identified are to remain permanently.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment and discussion with the manager evidenced that this area for improvement has been met. A retrospective variation is not required in relation to a shower room which is now a store as this had previously been agreed by RQIA.	

5.2.1 How does this service ensure that staffing is safe?

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 including moving and handling, fire safety and adult safeguarding. Staff said that they were provided with relevant training to

enable them to carry out their roles and responsibilities effectively. Regular staff meetings were held; as a result of the COVID-19 pandemic these were currently attended via Zoom.

Staff said teamwork was good, the manager was approachable and that they felt well supported in their role. Staff also said that, whilst they were kept busy, staffing levels were generally satisfactory.

The manager told us that the number of staff on duty was reviewed on at least a monthly basis to ensure the needs of the patients were met. The staff duty rota accurately reflected all of the staff working in the home on a daily basis and clearly identified the person in charge when the manager was not on duty. It was noted that there were enough staff in the home to respond to the needs of the patients in a timely way. Call bells were answered promptly by staff who were observed to respond to requests for assistance in a caring and compassionate manner.

Patients said that they felt well looked after and that staff were attentive. One patient described the care as being "well cared for" and referred to the staff as "lovely people". Another patient told us that Templemoyle is a "home from home". One questionnaire was returned from a patient with the following comment: "I am very comfortable and well cared for in Templemoyle".

There were safe systems in place to ensure staff are trained properly and also to ensure that patients' needs were met by the number and skill mix of the staff on duty.

5.2.2 How does this service ensure patients feel safe from harm and are safe in the home?

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed adult safeguarding champion for the home.

Review of staff training records confirmed that all staff were required to complete adult safeguarding training on a yearly basis. Staff told us they were confident about reporting concerns regarding, for example, patients' safety or poor practice.

Staff confirmed they had attended specialised training to ensure they were aware of deprivation of liberty safeguards (DoLS) and restrictive practices. Staff were aware of how to ensure that, if restrictive practices could not be avoided, best interest decisions were made safely for all patients but particularly those who were unable to make their own decisions. Staff knew where to access information regarding DoLS and demonstrated their knowledge of what constituted a restrictive practice.

Staff were seen to communicate effectively with patients; they were kind, respectful and sensitive to their needs. For example, staff told us that two particular patients wouldn't always accept assistance with their nail care; they recognised the importance of ensuring that assistance was given when the patient was in a more relaxed and receptive frame of mind. As mentioned in section 5.1 above, a review of personal care records evidenced that any refusal of personal care was documented and the manager agreed to ensure that this information is also included within the patients care plan.

5.2.3 Is the home's environment well managed to ensure patients are comfortable and safe?

Examination of the home's environment included reviewing a sample of bedrooms, storage spaces, the treatment room and communal areas such as lounges and bathrooms. There was evidence that the environment had undergone some refurbishment works and the manager advised that these were ongoing. It was also noted that the home had been recently painted and new vinyl flooring had been fitted to a corridor and identified bedroom. New bedroom furniture, bed linen and curtains had been purchased and installed within a number of bedrooms. However, a number of floor coverings, vanity units and bedroom furniture remained damaged. The manager advised that these were on the home's refurbishment plan to complete. Following the inspection the manager provided written confirmation on the 29 May 2021 that all refurbishment works had now been completed.

The gardens to both the front and back of the home were overgrown and had not been maintained to an acceptable standard. We further observed patient equipment stored in an outside area at the front of the home and discussed this with the manager who advised that the equipment was no longer in use and was removed prior to the completion of the inspection. Following the inspection on the 5 May 2021 verbal confirmation was received from the manager that the outdoor grounds had been attended to with ongoing monitoring to ensure they are maintained going forward. This will be reviewed at a future inspection.

A sluice room door was unlocked. This meant that patients could have access to cleaning agents in the room. Staff should ensure that substances which are hazardous to health are safely and securely stored. As mentioned in section 5.1 above this area for improvement has been stated for a second time.

Patients' bedrooms were personalised with items important to the patient and the manager advised that the activity person was assisting patients with personalising their rooms further. Bedrooms and communal areas were clean and tidy and patients could choose where to sit or where to take their meals. Staff were observed supporting patients to make these choices.

Jugs of juice were available in lounges and patients were offered suitable drinks and snacks between their main meals. Staff were seen to ask patients in the communal lounges if they preferred to watch TV or listen to music; it was positive to see that patients opinions were sought and taken into account.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors and fire exits were clear from clutter and obstruction. A valid fire risk assessment was available for review.

There were systems in place to ensure that the home was kept clean, tidy and well maintained in order that patients were comfortable and safe in their environment.

5.2.4 How does this service manage the risk of infection?

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

All visitors to the home had a temperature check and completed a health declaration on arrival. They were also required to wear personal protective equipment (PPE) such as aprons, masks and/or gloves.

Staff were observed wearing appropriate PPE and carrying out hand hygiene at relevant intervals throughout the inspection. There was a good supply of PPE in the home, however, as mentioned in section 5.1 above there was limited availability of nitrile gloves for carrying out personal care interventions in accordance with the regional guidance. In addition, a variety of items and equipment were stored inappropriately in four areas of the home and a member of staff with overseeing responsibilities was identified wearing nail polish. The potential risks were discussed in detail with the manager and an area for improvement in relation to IPC has been stated for a second time. Following the inspection on the 5 May 2021, the manager verbally confirmed that the staff member had removed the nail polish prior to the end of their shift and that action had been taken to address all of the deficits with ongoing monitoring to ensure sustained compliance.

The manager said that cleaning schedules included frequent touch point cleaning and this was carried out by both domestic and care staff on a regular basis. The manager also said that any issues observed regarding IPC measures or the use of PPE were immediately addressed.

Visiting and care partner arrangements were managed in line with the Department of Health (DoH) and IPC guidance. Policies regarding visiting and the care partner initiative had been developed and the manager advised that these would be updated to reflect the most recent guidelines.

There were systems in place to manage the risk of infection and to ensure that guidelines regarding the current COVID-19 pandemic were adhered to.

5.2.5 What arrangements are in place to ensure patients receive the right care at the right time? This includes how staff communicate patients' care needs, ensure patients' rights to privacy and dignity; manage skin care, falls and nutrition.

Staff received a handover at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable about individual patients' needs including their daily routine preferences. Staff respected patients' privacy and spoke to them with respect.

Patients who were less able to mobilise require special attention to their skin care. These patients were assisted by staff to change their position regularly. Care records relating to repositioning were maintained.

Where a patient was at risk of falling, measures to reduce this risk were put in place, for example, call bells were accessible, aids such as floor alarm mats were in use if recommended and staff carried out regular checks on patients as per the recommendations in individual care records.

Examination of records and discussion with the manager and staff confirmed that the risk of falling and falls were well managed. Review of records showed that staff took appropriate action in the event of a fall, for example, they completed neurological observations and sought medical assistance if required. Staff also completed a post fall review to determine if anything more could have been done to prevent the fall.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The lunchtime dining experience was seen to be a pleasant opportunity for patients to socialise and the atmosphere was calm and relaxed. Staff had made an effort to ensure patients were comfortably seated. There was evidence that patients' needs in relation to nutrition and the dining experience were being met. For example, staff recognised that patients may need a range of support with meals and were seen to helpfully encourage and assist patients as required.

There was choice of meals offered, the food was attractively presented and smelled appetising. Staff knew which patients preferred a smaller portion and demonstrated their knowledge of individual patient's likes and dislikes. There was a variety of drinks available. Patients told us they very much enjoyed the food provided in the home.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. If required, records were kept of what patients had to eat and drink daily. Patients told us they enjoyed the food in the home.

Staff told us how they were made aware of patients' nutritional needs to ensure that recommendations made by the Speech and Language Therapist (SALT) are adhered to. The International Dysphagia Diet Standardisation Initiative (IDDSI) terminology was documented throughout patients' care plans and supplementary recording charts. However, as mentioned in section 5.1 above, there were inconsistencies in the recording charts and care plans regarding the recommended type of diet/fluids for one patient. We further identified that a referral to SALT had not been completed for one patient with a change in their swallowing ability. This was discussed in detail with the manager and an area for improvement has been stated for a second time. Following the inspection on the 5 May 2021 the manager verbally confirmed that a referral had been made to SALT in respect of the identified patient.

5.2.6 What systems are in place to ensure care records reflect the changing care needs of patients?

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; these included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Care records were generally well maintained; regularly reviewed and updated to ensure they continued to meet the patients' needs. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

Patients' individual preferences were mostly reflected throughout the records and care plans contained specific information on each patient's care needs. We observed some scoring out in care records where the original entry could not be fully seen and information regarding the patients' normal bowel frequency and bowel type was not routinely documented within the elimination care plan but within other care plans such as 'risk of dehydration'. The manager agreed to discuss these findings with relevant staff and to monitor through monthly care record audits. This will be reviewed at a future inspection.

Daily records were kept of how each patient spent their day and the care and support provided by staff. Referrals to, or visits from, any healthcare professional was recorded, along with the outcome, for example, if staff contacted the GP regarding a patient.

5.2.7 How does the service support patients to have meaning and purpose to their day?

It was observed that staff offered choices to patients throughout the day which included, for example, preferences for food and drink options. Patients told us that they were given the choice of where to sit and where to take their meals; some patients preferred to spend most of their time in their room and staff were observed supporting patients to make these choices.

The manager said that patients' views and opinions were sought via patient meetings and during her daily walk arounds of the home. Review of records showed that patients had the opportunity to participate in regular meetings to give them an opportunity to comment on the running of the home and make suggestions as to how things could be improved further.

Staff recognised the importance of maintaining good communication between patients and their relatives, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff assisted patients to make phone or video calls. Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients. Staff also maintained good communication links directly with relatives' video and telephone calls.

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.

There were suitable systems in place to support patients to have meaning and purpose to their day and to allow them the opportunity to make their views and opinions known.

5.2.8 What management systems are in place to monitor the quality of care and services provided by the home and to drive improvement?

Staff 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. Staff said that the manager was approachable and accessible.

There had been no change to management arrangements for the home since the last inspection. The manager said they felt well supported by the responsible individual and their organisation.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to patients. Regular audits were completed to review, for example, IPC measures, the environment, falls and care records. The audits contained clear action plans where required.

A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly and reported appropriately to patients' next of kin, their care manager and to RQIA if required.

The home was visited each month by a representative of the responsible individual to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by patients, their representatives, the Trust and RQIA.

There were systems were in place to monitor the quality of care and services provided and to drive improvement in the home.

6.0 Conclusion

The outcome of this inspection concluded that most of the areas for improvement identified at the last care inspection had been met and no new areas for improvement were identified. Three areas for improvement have been stated for a second time.

Positive improvements had been made to the refurbishment of the home since the last inspection. Patients were seen to be content and settled in the home and in their interactions with staff. Staff treated patients with respect and kindness.

There were safe systems in place to ensure staff were trained properly; and that patient's needs were met by the number and skill of the staff on duty. Patients' care records had been generally well maintained.

Based on the inspection findings and discussions held we are satisfied that Templemoyle Nursing Home is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the Manager.

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.

	Regulations	Standards
Total number of Areas for Improvement	*3	0

* The total number of areas for improvement includes 3 regulations that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Jeya Pratheeksha, 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 14 (2) (a) **Stated:** Second time **To be completed by:** With immediate effect	The registered persons must ensure that all areas of the home to which patients have access are free from hazards to their safety. With specific reference to ensuring that chemicals are securely stored in keeping with COSHH legislation. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: Staff have again been advised of COSHH legislation and the need for ensuring that chemicals and cleaning products are securely stored. This has been advised during a meeting with all staff, spot checks are also being carried out during the day to ensure that the home is compliant with this legislation.
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that all staff employed to work in the home are aware of and adhere to the IPC guidelines and best practice requirements. Ref: 5.1 and 5.2.4
	Response by registered person detailing the actions taken: Staff have again been advised of the importance of IPC guidelines, paying attention to items like wearing nail varnish/false nails. This is checked daily. Staff informed of these guidelines at a staff meeting.
Area for improvement 3 **Ref:** Regulation 13 (1) (a) (b) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall review the management of patients' nutritional care needs to ensure that : • SALT recommendations are consistently recorded within the patients' care records and supplementary recording charts • relevant staff are aware of patients' dietary needs as per SALT and IDDSI terminology • a system is implemented to follow up referrals made to SALT for patients experiencing difficulties with swallowing in a timely manner. Ref: 5.1 and 5.2.5
	Response by registered person detailing the actions taken: The resident was referred back to SALT, care plan and all relevant notes have been updated. Staff have been made aware of the importance of SALT recommendations and that they are matching on care and supplementary recording charts.

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

The Regulation and Quality Improvement Authority

9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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

Assurance, Challenge and Improvement in Health and Social Care