Inspection Report

06 May 2021

The Tilery

Type of Service: Nursing Home
Address: 130 Swanlinbar Road,
Florencecourt, Enniskillen,
BT92 2DZ
Tel number: 028 6634 8811

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: The Tilery **Responsible Individuals:** Mrs Claire Stranney and Mr Stephen Stranney	**Registered Manager:** Miss Nicola Scovell **Date registered:** 13 April 2018
Person in charge at the time of inspection: Miss Nicola Scovell	**Number of registered places:** 40 The home is approved to provide care on a day basis to 2 persons and 1 named person in category NH-LD. There shall be a maximum of 2 named residents receiving residential care in category RC-I and 1 named patient in category NH-LD.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category.	**Number of patients accommodated in the nursing home on the day of this inspection:** 38
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides care for up to 40 persons. This is a single storey home with bedrooms situated on the ground floor over 4 wings; East Wing, South Wing, Riverside and Lakeside. Patients have access to communal lounges, a dining room and outdoor gardens.	

2.0 Inspection summary

An unannounced inspection took place on 6 May 2021 from 10.00 am to 5.30pm. 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 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.

Areas requiring improvement were identified in relation to recruitment, completion of recommendations within the fire risk assessment, infection prevention and control (IPC), pressure area care, care records, wound care, display of activity schedule, notifiable events and overall governance. Three areas for improvement have been stated for a second time as detailed in the report and the Quality Improvement Plan issued (QIP).

Patients spoke positively about living in The Tilery. 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 in The Tilery was safe, effective and compassionate and there were appropriate management arrangements within the home. RQIA were assured that the management team acknowledged the need for more robust oversight of the governance systems within the home to drive the improvements identified.

The findings of this report will provide the manager and 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, visiting 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 Persons in Charge at the conclusion of the inspection.

4.0 What people told us about the service

Eight patients and eight staff were spoken with. No questionnaires were returned and we received no feedback from the staff online survey. Patients told us that they felt well cared for, enjoyed the food and that staff were helpful and friendly. One patient said they felt that there should be "more staff at night" as it can be very busy. This information was shared with the

manager but there was evidence that staffing levels met the needs of patients and is monitored regularly.

Staff told us that they felt supported in their role and that there was enough staff both on day and night duty. Staff also said that the manager was very approachable, that there was great teamwork and that they felt supported in their role.

5.0 The inspection

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

Areas for improvement from the last inspection on 17 December 2020		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 12 (2) (b) **Stated:** First time	**Area for Improvement** The registered person should ensure that the process for checking equipment in the event of an emergency is recorded daily by relevant staff and monitored by management to ensure that equipment is in working order and ready for use at all times.	**Met**
	Action taken as confirmed during the inspection: Review of monitoring records, discussion with staff and observation of equipment evidenced that this area for improvement has been met.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 14.26 **Stated:** Third and final time	The registered person should ensure that an inventory of property belonging to each resident is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of inventory records and discussion with the manager evidenced that this area for improvement has been met. This is discussed further in section 5.2.8.	

Area for improvement 2 **Ref**: Standard 44.10 **Stated:** First time	The registered person shall ensure that procedures are implemented for the safe use of all bedrails in accordance with health and safety regulations. This shall include: • a record of daily/monthly safety checks on bedrails • risk assessment and care plan to reflect the safety checks being completed daily/monthly • the type of bedrail to be included within the risk assessment and care plan.	**Partially Met**
	Action taken as confirmed during the inspection: Review of a sample of care records evidenced that this area for improvement has not been fully met and has been stated for a second time. This is discussed further in section 5.2.5.	
Area for improvement 3 **Ref**: Standard 23 **Stated:** First time	The registered person shall ensure that there are clear and documented processes for the prevention, detection and treatment of pressure damage. With specific reference to ensuring that the recommended setting/type of pressure relieving mattress is maintained at the correct setting and included in the patients care plan.	**Not Met**
	Action taken as confirmed during the inspection: Review of a sample of care records and observation of pressure relieving mattresses evidenced that this area for improvement has not been met and has been stated for a second time. This is discussed further in section 5.2.5.	
Area for improvement 4 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure that nutritional care plans, supplementary charts and risk assessments are reflective of: • the current SALT assessment • International Dysphagia Diet Standardisation Initiative (IDDSI)	**Partially Met**

	terminology.	
	Action taken as confirmed during the inspection: Review of a sample of care records and supplementary charts evidenced that this area for improvement has not been fully met and has been stated for a second time. This is discussed further in section 5.2.5.	
Area for improvement 5 **Ref:** Standard 44 **Stated:** First time	The registered person shall ensure that all pull cords throughout the home are fitted with covers that can be wiped clean.	**Met**
	Action taken as confirmed during the inspection: Observation of the environment evidenced that this area for improvement has been met.	

5.2 Inspection findings

5.2.1 How does this service ensure that staffing is safe?

Safe staffing begins at the point of recruitment. Review of one employee's recruitment records evidenced that references had not been appropriately obtained. Gaps in employment history had not been explored and two different start dates were recorded. This was discussed in detail with the manager and an area for improvement was identified.

The manager told us that all new employees received a 'first day induction' which was signed by the employee and the person in charge. Review of an induction record identified that fire safety awareness had not been included. This was discussed with the manager who confirmed that all new staff were orientated to the layout of the home; including the location of the fire panel and the action to take in the event of a fire. The manager agreed to update the template to include this going forward.

Appropriate checks had been made to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC) and care workers with the Northern Ireland Social Care Council (NISCC).

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 confirmed that they were provided with relevant training to enable them to carry out their roles and responsibilities effectively.

Staff said teamwork was good, that the manager was approachable. Staff also said that, whilst they were kept busy, the number of staff on duty was satisfactory to meet the needs of the patients.

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 observed that there were enough staff on duty 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 commented "if I need anything I just have to ask" and referred to the staff as "lovely people".

There were safe systems in place to ensure staffing was safe 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 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.

On occasions some patients may be required to use equipment that can be considered to be restrictive, for example, bed rails and alarm mats. Review of patient records and discussion with the manager, and staff, confirmed that the correct procedures were followed if restrictive equipment was required. It was positive to note that patients and/or their relatives were involved in any discussion about the use of equipment.

Staff confirmed they had completed specialised training to ensure they were aware of the Department of Health's (DoH) Deprivation of Liberty Safeguards (DoLS) and restrictive practices. Staff knew where to access information regarding DoLS and demonstrated their knowledge of what constituted a restrictive practice.

There were systems in place to ensure that patients were safely looked after in the home and that staff were adequately trained for their role in keeping patients safe.

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, bathrooms, storage spaces and communal areas such as lounges. The home was warm, clean and comfortable. There was evidence that a number of areas had recently been painted or had flooring replaced; and new handrails had been fitted within corridor areas. The manager confirmed that refurbishment works were ongoing to ensure the home was well maintained. A system was in place to ensure any maintenance issues were reported and addressed in a timely way.

Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Review of the fire risk assessment carried out on the 27 January 2020, evidenced that two actions identified had not been signed off as completed. We requested that the recommendations

made by the fire assessor were actioned and confirmation of the action taken forwarded to RQIA. This was received by email after the inspection and the details were discussed with RQIA's estates inspector for the home. An area for improvement was identified.

We observed an oxygen cylinder which was not secured to the wall. This was discussed with the manager who immediately secured the oxygen and agreed to monitor this type of practice during daily walk arounds and to discuss with relevant staff.

Review of the home's legionella risk assessment completed on the 14 December 2020 evidenced that a number of recommendations had not be signed off as completed. Following the inspection the manager forwarded written confirmation that these actions had been completed. This confirmation was shared with RQIA's estates inspector.

Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated and suitably furnished. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices. The gardens were well maintained with areas for patients to sit and rest.

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.

Patients were complimentary in relation to the environment and with the cleanliness in the home.

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 Agency (PHA).

All visitors to the home had a temperature check and a health declaration completed when they arrived at the home. They were also required to wear personal protective equipment (PPE) such as aprons, masks and/or gloves. Visiting and care partner arrangements were managed in line with the DoH and infection prevention and control (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.

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.

There was a good supply of PPE and hand sanitising gel in the home. However, a number of issues were identified which required to be addressed. For example, there was limited availability of the correct type of gloves used in the delivery of personal care. A member of staff was wearing a wrist watch which would inhibit effective hand hygiene, hoist slings were not effectively decontaminated and emergency equipment was required to be cleaned and stored

correctly. The potential risks of harm associated with IPC practices and measures were discussed in detail with the manager and an area for improvement was identified.

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 met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly. This is good practice.

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 mostly well maintained. However, one patient's care records evidenced 'gaps' and inconsistencies regarding the recommended frequency of repositioning. Review of another patients care records identified that the frequency of repositioning was not included in their care plan. This was discussed with the manager and an area for improvement was identified.

It was noted that special pressure relieving mattresses were not all correctly set to effectively manage patients' pressure area care. No harm to patients was evidenced and the manager agreed to review patients care records and the setting of any pressure relieving mattresses in use. This was an area for improvement identified at the previous inspection and has been stated for a second time.

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.

Review of a sample of care records and discussion with staff evidenced that a record of daily safety checks on bedrails was completed by care staff, however, a monthly bedrail check by the maintenance man and/or manager to ensure that the function of the bedrail remains safe had not been completed. It was also noted that risk assessments and care plans about the use of bedrails did not include information regarding the frequency of safety checks, nor did they contain the type of bedrail in use. This was discussed in detail with the manager and an area for improvement has been stated for a second time.

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 and enjoyed their meal. 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 a 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.

Staff told us how they were made aware of patients' nutritional needs to ensure that recommendations made by the Speech and Language Therapist (SALT) were adhered to. Discussion with staff evidenced that they were providing the correct diet as recommended by SALT. However, there were inconsistencies in the records reviewed for two patients. An area for improvement has been stated for a second time.

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 spoke positively in relation to the food provision and their mealtime experience.

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

Review of three patient care records identified a number of deficits in relation to the accuracy and details of the care required to manage, dehydration, constipation, urinary catheters and wound care. Details were discussed with the manager and two areas for improvement were identified.

While some aspects of patients' care records had been accurately maintained, improvements were required.

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

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 go out for a walk when they wanted, remain in their bedroom or go to a communal room when they requested.

Patients were observed enjoying activities which had been arranged by the two activity coordinators. Patients' needs were met through a range of individual and group activities, such as reflective thoughts, arts and crafts, music, games, exercise and walks. Patients commented positively on the activities provided.

A weekly schedule of activities was not available. This was discussed with the manager and an area for improvement was identified.

Staff recognised the importance of maintaining good communication with families, 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.

It was evident that patients could choose how they spent their day and that staff supported them to make these choices.

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 has 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 the organisation.

A review of the records of accidents and incidents which had occurred in the home found that a recent incident had not been referred to RQIA. We requested that this be submitted retrospectively and an area for improvement was identified.

As mentioned above in section 5.1 there was evidence that the inventory of patient property had been reconciled at least quarterly. The initial record had been signed by two staff and then countersigned by the manager. However, on review of subsequent reconciliations there was only one signature recorded. This information was shared with RQIA's finance inspector who assessed this area for improvement as met with an agreement, with the manager, that going forward there would be a governance system in place to check that all reconciliations are countersigned by a senior member of staff.

Audits completed by the management team to ensure the quality of care and services provided to patients did not identify the issues RQIA evidenced during the inspection. Details were discussed with the manager and an area for improvement was identified.

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 and available for review by patients, their representatives, the Trust and RQIA.

There were management systems in place which need to be strengthened to enable the management team to correctly identify areas for improvement.

6.0 Conclusion

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. Care was provided in a caring and compassionate manner.

Nine new areas for improvement were identified. Five are in relation to safe and effective care and four are in relation to the service being well led. Positive improvements had been made to the refurbishment of the home since the last inspection.

Based on the inspection findings and discussions held it was evident that The Tilery Nursing Home was providing safe and effective care in a compassionate manner; and that the management team acknowledged the need for more robust oversight of the governance systems within the home to drive the necessary improvements.

7.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	6*	6*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Nicola Scovell, Registered Manager, and Caoimhe Sweeney, Clinical Lead, 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 21 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that staff are recruited in accordance with relevant statutory employment legislation. Records pertaining to the recruitment process must be accurately maintained to evidence the process is robust. Ref: 5.2.1
	Response by registered person detailing the actions taken: No potential employee shall commence without 2 satisfactory employment references being in place. All employment gaps shall be accounted for.
Area for improvement 2 **Ref:** Regulation 27 (4) (a) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the recommendations within the fire risk assessment are actioned. Ref: 5.2.3
	Response by registered person detailing the actions taken: All recommendations are now actioned and removed from most recent FRA, dated 19/05/2021
Area for improvement 3 **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 during the inspection are addressed. Ref: 5.2.4
	Response by registered person detailing the actions taken: All infection prevention and control issues discussed on day of inspection have been rectified and shall be monitored regulary.
Area for improvement 4 **Ref:** Regulation 16 (1) (2) (b) **Stated:** First time **To be completed by:** 6 June 2021	The registered person shall ensure that care plans are reflective of the needs of the patient and that these are kept under regular review. With specific reference to: • recommended daily fluid intake for patients at risk of dehydration • relevant information within care plans regarding a patients normal bowel pattern/type • recommended catheter size and frequency of renewal to be

	recorded within the care plan. Ref: 5.2.6
	Response by registered person detailing the actions taken: All care plans have now on staff laptop for all nurses. These have been updated to include fluid intake, bowel pattern and type and catheter care.
Area for improvement 5 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that RQIA are notified of any event in the home in accordance with Regulation 30. Ref: 5.2.8
	Response by registered person detailing the actions taken: All Reg 30 shall be forwarded to RQIA.
Area for improvement 6 **Ref:** Regulation 10 **Stated:** First time **To be completed by:** 6 June 2021	The registered person shall ensure that the governance system in place is reviewed to ensure it is robust and that it meets the needs of the management team in identifying deficits in the delivery of care and other services in the home. Ref: 5.2.8
	Response by registered person detailing the actions taken: The governance system shall be reviewed on an ongoing basis to identify and rectify deficits within the home.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 44.10 **Stated:** Second time **To be completed by:** 6 June 2021	The registered person shall ensure that procedures are implemented for the safe use of all bedrails in accordance with health and safety regulations. This shall include: • a record of monthly safety checks on bedrails • risk assessment and care plan to reflect the safety checks being completed daily/monthly • the type of bedrail to be included within the risk assessment and care plan. Ref: 5.1 and 5.2.5
	Response by registered person detailing the actions taken: Bedrail checks are maintained daily on repositioning charts and on a monthly basis by management team. These are also incorporated into the careplan / risk assessment. The frequency and type of bedrail has also been incorporated

	into careplan / risk assessment.
Area for improvement 2 **Ref:** Standard 23 **Stated:** Second time **To be completed by:** 6 June 2021	The registered person shall ensure that there are clear and documented processes for the prevention, detection and treatment of pressure damage. With specific reference to ensuring that the recommended setting/type of pressure relieving mattress is maintained at the correct setting and included in the patients care plan. Ref: 5.1 and 5.2.5
	Response by registered person detailing the actions taken: Daily checks are performed to ensure all mattress's remain at the correct setting for residents weight and are also included in the careplan and repositioning chart.
Area for improvement 3 **Ref:** Standard 12 **Stated:** Second time **To be completed by:** 6 June 2021	The registered person shall ensure that nutritional care plans, supplementary charts and risk assessments are reflective of: • the current SALT assessment. Ref: 5.1 and 5.2.5
	Response by registered person detailing the actions taken: All residents who have a SALT recommendation have the information cross referenced within careplan and risk assessment.
Area for improvement 4 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 6 June 2021	The registered person shall ensure that where a patient requires pressure area care a care plan is implemented detailing the recommended frequency of repositioning which is recorded within the chart and reflective of the care plan. Ref: 5.2.5
	Response by registered person detailing the actions taken: All residents requiring pressure relief care have the frequency of repositioning recorded in the repositioning chart and cross referenced in the careplan.
Area for improvement 5 **Ref:** Standard 23 **Stated:** First time **To be completed by:**	The registered person shall ensure that where a patient has been assessed as requiring wound care that a care plan is in place detailing the recommended dressings and frequency of wound care dressing renewal. Ref: 5.2.6

With immediate effect	**Response by registered person detailing the actions taken:** All residents with a wound shall have a careplan in place detailing dressing change, frequency and renewal dates. These will be carried forward in the Nurse diary after every dressing change.
Area for improvement 6 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 20 May 2021	The registered person shall ensure the programme of activities is displayed in a suitable format and location. Ref: 5.2.7
	Response by registered person detailing the actions taken: All activities programmes are displayed and dated in a suitable format.

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

The Regulation and Quality Improvement Authority

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