The Regulation and Quality Improvement Authority

Inspection Report

8 August 2024

Lansdowne Care Home

Type of service: Nursing Home
Address: 41-43 Somerton Road, Belfast, BT15 3LG
Telephone number: 028 9037 0911

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Beaumont Care Homes Limited **Responsible Individual:** Mrs Ruth Burrows	**Registered Manager:** Ms Claire Podmore **Date registered:** 5 June 2024
Person in charge at the time of inspection: Ms Claire Podmore	**Number of registered places:** 86 A maximum of 17 patients in category NH-DE to be accommodated in the Dementia Unit
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 46
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 86 patients. The home is divided in three units over three floors. The Annabella unit on the ground floor provides care for people with dementia. The Innisfayle and Cavehill units on the first floor and second floor provide general nursing care.	

2.0 Inspection summary

An unannounced inspection took place on 8 August 2024, from 9.30 am to 6.45 pm by a care inspector and an Inspection Support Volunteer.

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.

Areas requiring improvement were identified during this inspection and are discussed within the main body of the report and Section 6.0.

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

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

We found that there was safe, effective and compassionate care delivered in the home and the home was well led by the manager.

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

3.0 How we inspect

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

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

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

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

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

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

An Inspection Support Volunteer was present during this inspection and their comments are included within this report. An Inspection Support Volunteer is a member of the public who will bring their own experience, fresh insight and a public focus to our inspections.

The findings of the inspection were discussed with Claire Podmore, Registered Manager and Stephanie Flack, Regional Manager at the conclusion of the inspection.

4.0 What people told us about the service

Patients spoke positively about the care that they received and about their interactions with staff. Patients confirmed that staff treated them with dignity and respect. Patients said they felt safe in the home and liked living there. The patients did comment on how busy the staff were but how the staff were always courteous and kind to them. Patients told us "The staff are brilliant", "The staff are caring" and "I love the staff".

Discussions with staff confirmed that they felt positive about their roles and duties, the provision of care and teamwork.

The feedback received from the online survey was shared with Manager.

There were no questionnaire responses received within the allocated timeframe.

5.0 The inspection

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

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 29 February 2024</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td>Area for Improvement 1

Ref: Regulation 13 (7)

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

This area for improvement relates to the following:

• donning and doffing of personal protective equipment
• appropriate use of personal protective equipment
• staff knowledge and practice regarding hand hygiene.</td><td rowspan="2">Met</td></tr>
<tr><td></td><td>Action taken as confirmed during the inspection:
There was evidence that this area for improvement was met.</td></tr>
</table>

Area for Improvement 2 **Ref:** Regulation 16 (2) (b) **Stated:** Second time	The registered person shall ensure risk assessments and care plans are reviewed and updated following patient's admission to hospital.	**Not met**
	Action taken as confirmed during the inspection: A review of two patient's care records did not evidence that they were reviewed timely upon return from hospital. This area for improvement has not been met and is stated for a third time**.**	
Area for Improvement 3 **Ref:** Regulation 16 (1) **Stated:** First time	The registered person shall ensure that care plans clearly evidence they are developed in consultation with the patient or patient's representative.	**Carried forward to the next inspection**
	Action taken as confirmed during the inspection: There was evidence of ongoing work and progress with this area for improvement. This was discussed with the Manager and a decision was made that more time would be beneficial to ensure full compliance; therefore, this area for improvement was carried forward for review at the next care inspection.	
Area for Improvement 4 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure unnecessary risks to the health, welfare and safety of patients are identified and so far as possible eliminated. This area for improvement is made with specific reference to the shortfalls identified in the Annabella unit during this inspection.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		Validation of compliance
Area for Improvement 1 **Ref:** Standard 12 **Stated:** Second time	The registered person shall ensure that accurate and contemporaneous menu choice records for patients on modified diets are maintained.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 2 **Ref:** Standard 4.7 **Stated:** First time	The registered person shall ensure that prescribed pressure relieving mattresses are set correctly in accordance with the current patients' weight where appropriate.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 3 **Ref:** Standard 4.7 **Stated:** First time	The registered person shall ensure that patient's care plans are kept under review and reflect any changes in the patient's assessed care needs.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement has not been met and is stated for a second time**.** This is discussed further in 5.2.2.	
Area for Improvement 4 **Ref:** Standard 4.9 **Stated:** First time	The registered person shall ensure patient's care plans and all evaluations of care are meaningful and person centred.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 5 **Ref:** Standard 4.9 **Stated:** First time	The registered person shall ensure that shower and bath records are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

Area for Improvement 6 **Ref:** Standard 4.9 **Stated:** First time	The registered person shall ensure contemporaneous records are maintained. This area for improvement is made with specific reference to completion of supplementary care records.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 7 **Ref:** Standard 4.1 **Stated:** First time	The registered person shall review the home's current audit processes to ensure they are effective. This area for improvement is made with specific reference to oversight of care records and infection prevention and control practices.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a system was in place to ensure staff were recruited correctly to protect patients. Staff were provided with a comprehensive induction programme at the commencement of their employment to prepare them for working with the patients.

There were systems in place to ensure staff were trained and supported to do their job. The Manager retained oversight of staff compliance with their training requirements.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the Manager was not on duty. The Manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients can be met and there was evidence that recent audits identified the need for additional staff in the Cavehill Unit.

At the last care inspection RQIA were made aware of some reductions in care staff hours. At this inspection RQIA could see the impact of this reduced staffing levels in the Cavehill unit; discussion with staff identified they felt rushed in their duties and although they try their best they feel they are unable to deliver the care to the standard they would like to due to the number

of staff on duty and the acuity of the patients. Staff morale was also observed to be low with some staff considering leaving their jobs. Patients also shared with the inspectors that they don't think there is enough staff on duty, the patients said they feel rushed during personal care and that staff don't have enough time even to chat to them.

All the patient feedback was shared with the Manager and the Regional Manager who agreed to discuss with the senior management team. An area for improvement was identified.

Review of governance records provided assurance that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or Northern Ireland Social Care Council (NISCC) and that these registrations were effectively monitored by the Manager on a monthly basis.

Staff who take charge in the home in the absence of the manager had completed relevant competency and capability assessments.

A matrix system was in place for staff supervision and appraisals to record staff names and the date that the supervision had taken place.

Staff said that they felt well supported in their role and found the Manager accessible and approachable. Staff spoke positively on the teamwork in the home, and the patients consulted with spoke highly on the care that they received.

5.2.2 Care Delivery and Record Keeping

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

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. It was observed that staff provided care in a caring and compassionate manner.

Staff were experienced in recognising patients' needs and any early signs of distress, especially in those patients who had difficulty in making their wishes known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

Patients were well presented in their appearance and told us that they were happy living in the home, the patients spoke fondly about their good relationships with the staff.

The serving of the lunchtime meal was observed in two units. Staff ensured that patients were comfortable throughout their meal. A choice of meal was offered and the food was attractively presented and smelled appetising. An effective system was in place to identify which meal was for each individual patient, to ensure patients were served the right consistency of food and their preferred menu choice. Meals were appropriately covered on transfer whilst being taken to patients' rooms. There was a variety of drinks available. Patients wore clothing protectors if required and staff wore aprons when serving or assisting with meals.

Shortfalls were identified in the completion of patient menu choice records; these shortfalls were discussed with the Manager who agreed to review this documentation. An area for improvement was identified.

The care staff recorded what patients had to eat and drink daily where appropriate.

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. Care records were mostly well maintained and regularly reviewed. However, further review of other patient care records evidenced that they did not fully reflect some of the patient's assessed needs and review of care records for two patients who had recently spent some time in hospital did not evidence that their care records were reviewed timely upon readmission to the nursing home. Two areas for improvement in this regard identified as a result of the previous care inspection and are now stated for a second time and third time.

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

It was established that systems were in place to manage and monitor restrictive practices in use for patients, for example, bedrails, alarm mats and continuous supervision.

Patients who were less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly. Examination of the recording of repositioning evidenced these were well maintained.

Patients who required care for wounds had this clearly recorded in their care records and records evidenced the wounds were dressed by the nursing staff as planned.

Falls in the home were monitored monthly to enable the Manager to identify if any patterns were emerging which in turn could assist the Manager in taking actions to prevent further falls from occurring. Examination of records regarding the management of falls evidenced that these were generally well managed; we discussed the regional falls guidance and signposted the Manager to the resources available within this guidance.

5.2.3 Management of the Environment and Infection Prevention and Control

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. Patients' bedrooms were clean, tidy and personalised with items of importance to each patient, such as family photos and sentimental items.

A small number of storage areas throughout the home were found to be cluttered with items stored on the floor. This was discussed with the Manager who agreed to address.

Cleaning chemicals were observed in an unlocked sluice. An area for improvement was identified.

Fire safety measures were in place to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. It was observed in one identified unit that an unoccupied room door was wedged open, this was immediately brought to the attention of a member of staff and addressed.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the Manager and records were kept.

5.2.4 Quality of Life for Patients

Staff offered choices to patients throughout the day which included preferences for what clothes they wanted to wear and where and how they wished to spend their time. The atmosphere throughout the home was warm, welcoming and friendly. Patients looked well cared for and were seen to enjoy warm and friendly interactions with the staff.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. The programme of activities was displayed in several areas of the home advising patients of forthcoming events.

Patients' needs were mostly met through a range of individual activities. Discussion with a number of patients identified they would like more communal activities and some even said they would enjoy dining with others. Patient feedback was shared with the Manager.

Activity records were maintained which included the patient engagement with the activity sessions.

Staff were observed to be chatty, friendly and polite to the patients at all times and to communicate effectively with patients, including with those who had a cognitive impairment.

Staff recognised the importance of maintaining good communication between patients and their relatives. Visiting arrangements were in place and staff reported positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection however, Ms Claire Podmore has now been registered with RQIA as the Manager of Lansdowne Care Home.

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

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

Review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding care records, falls, wounds, accidents/incidents, complaints, the environment and IPC practices including hand hygiene. It was identified that the actions from a number of care plan audits had not been evidenced as completed. An area for improvement was identified.

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 and Deputy Manager are the safeguarding champions for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm.

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

The Manager maintained records of regular staff and departmental meetings. The records contained an attendance list and the agenda items discussed. Meeting minutes were available for those staff who could not attend.

Systems were in place to ensure that complaints were managed appropriately.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed 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.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	4*	3*

*the total number of areas for improvement includes one regulation that has been stated for a third time, one standard has been stated for a second time and further standard carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Claire Podmore, Registered Manager and Stephanie Flack, Regional 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 16 (2) (b) **Stated:** Third time	The registered person shall ensure risk assessments and care plans are reviewed and updated following patient's admission to hospital. Ref: 5.1 and 5.2.2
To be completed by: 9 August 2024	**Response by registered person detailing the actions taken**: On review of the resident's files, which were highlighted during inspection, it was found that whilst there was evidence of evaluation being completed these had not been completed at the point of admission or re-admission to the unit. They had been evaluated later on that month which meant that there was a delay between the point of admission and the care being evaluated within the unit. To address this the following has been put in place. Prior to a resident's hospital discharge, the Nurse receiving handover from the ward, will ensure that any changes to the person's plan of care are discussed with the Care team before the resident arrives in the unit. If there are any concerns in relation to the hospital discharge, advice will be sought from the Manager or Deputy Manager to ensure that their care needs can continue to be safely met upon the resident's discharge. This will be discussed at the daily flash meeting at which those in charge of their respective units meet with the Home Manager to discuss ongoing care. A return from hospital checklist will be completed by the admitting Staff Nurse immediately upon the resident's discharge from hospital. This will ensure that areas requiring to be updated will be promptly identified and that the resident's care needs can be assessed as being able to be met by the receiving care environment. Additionally, the Home Manager or Deputy Manager will review the resident's plan of care within 5 days of them being discharged from hospital. They will complete the hospital discharge audit and identify any areas which may have been missed by the receiving Nurse in the days immediately following the hospital discharge. This will ensure two levels of oversight and ensure that any issues identified are addressed timeously.

	We have also initiated a 'Resident of the Day' protocol which aims to provide a third level of oversight, this will mean that each resident's care plan is evaluated on a specific date every month. Where a resident has been discharged from hospital that day, their care plans will take priority to be evaluated on that day. This has been discussed at a meeting with night Staff Nurses so that staff responsible are aware of this protocol. To summarise, we will ensure that when a resident is readmitted to Lansdowne from hospital: 1. Nurse will receive a handover from the hospital ward and will discuss changing needs with Care team 2. The admitting Staff Nurse will complete a return from hospital checklist 3. The Manager or Deputy Manager will complete the return from hospital audit 4. The returning resident will take priority as 'Resident of the Day'. As part of the monthly monitoring visit the resident return from hospital audits will be checked to ensure they have been completed appropriately and evidence any change in the resident's needs.
Area for improvement 2 **Ref:** Regulation 20 (1) (a) **Stated:** First time **To be completed by:** 9 August 2024	The registered person shall ensure staffing levels are fully and comprehensively reviewed to ensure there are adequate staffing levels on at all times. The review should take account of but not be limited to dependencies of patients, the layout of the building, fire safety and evacuation procedures. Ref: 5.2.1
	Response by registered person detailing the actions taken: The staffing for the Cavehill Unit has been reviewed and Care Assistant hours have been redeployed to the 8am- 2pm shift. 1 Resident has been reassessed as requiring 1-1 support and this has been agreed by the appropriate Trust. The Home Manager will consider going forward the care requirements of individual referrals and whether the Unit can meet those needs before accepting the individual for placement. The Manager will keep under weekly review the number of Residents taking into consideration the following care KPI's: 1. Mobility assistance of 2 or more staff 2. Personal hygiene assistance of 2 or more staff 3. Bariatric management

	4. Wound management 5. Eating and drinking assistance – full assistance 6. Eating and drinking – 1-1 supervision 7. Cognitive impairment 8. Falls management – any Resident with 2 or more falls in a week 9. Medication management length of round 10. Syringe driver management 11. Controlled drug management 12. Insulin management These KPI's will be shared with the Operations Manager on a weekly basis for further discussion if required.
Area for improvement 3 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** 9 August 2024	The registered person shall ensure that sluice rooms are locked that contain chemicals; so that they are securely stored in accordance with COSHH regulations. Ref: 5.2.3
	Response by registered person detailing the actions taken: Once this concern had been discussed with the Home Manager the doors that were not locked where immediately secured. The Manager has since reviewed locks to sluice doors and found that some had been 'snibbed' which was a means of keeping them open for ease of access. New signage has been installed on sluice doors asking staff to refrain from this practice. The Manager will complete a quarterly Health and Safety audit of the Home at which safe storage of chemicals hazardous to health will be monitored. The Maintenance Person will complete a workplace inspection checklist monthly within which a section has been added to ensure sluice doors are locked securely which is quality assured by the Registered Home Manager. The Maintenance Person is met during each shift and any concerns in relation to health and safety will be discussed. In addition, the Home Manager's daily walk round audit will be adapted to include checks of the security of sluice rooms which store chemicals which may be hazardous to health. Staff will be reminded of the necessity to ensure that sluice doors are securely locked and this will be emphasised upon the induction of new or agency staff. Sluices and stores containing chemicals are checked as part of the monthly monitoring visit to ensure these areas remain locked.

Area for Improvement 4 **Ref:** Regulation 16 (1) **Stated:** First time **To be completed by:** 29 February 2024	The registered person shall ensure that care plans clearly evidence they are developed in consultation with the patient or patient's representative. **Response by registered person detailing the actions taken:** The importance of including the person and the people important to them in the writing of their plans of care is vital to ensure that these plans of care are meaningful and person centred. The Named Nurse system will be used to facilitate conversations which should take place with the resident in the first instance. Details of this conversation will be documented and will confirm the date of the conversation and whether the resident would like any alterations or additions to be made to their plans of care. Where a resident is unable to communicate or wishes their identified next of kin to discuss their plans of care on their behalf, the next of kin will have the opportunity to meet with the person's Named Nurse to discuss their plans of care. Details of these discussions will be documented and will identify any alterations or additions to the plan of care that the family member feels would be beneficial. As part of the monthly monitoring visit carried out by the Operations Manager a sample of care plans will be reviewed to ensure there have been discussions held with patient or their representative.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 4.7 **Stated:** Second time **To be completed by:** 9 August 2024	The registered person shall ensure that patient's care plans are kept under review and reflect any changes in the patient's assessed care needs. Ref: 5.1 and 5.2.2 **Response by registered person detailing the actions taken:** Patient's care needs change regularly and it is the responsibility of their Nurse to ensure that their care documentation reflects their changing needs. Following Inspection, care files were reviewed and some deficits highlighted with regards to Pain Management and changes in care not updated following visits from visiting professional i.e., SALT and Dietician. It is recognised that the Nurses must respond to any changes made, first by informing the Care team to ensure that care is carried out effectively and safely, and also by updating the

	relevant documentation such as care plans and risk assessments. A Staff meeting has taken place at which the 'Resident of the Day' protocol was introduced. This will result in each resident being allocated a day within the month for their care files to be closely reviewed. The only exception to this will be where another resident has been discharged from hospital that day, in that instance the resident will be allocated a different day. The care plans and risk assessments will be evaluated on this date. The system of Named Nurses will remain in place; they will have the ultimate responsibility to ensure that the resident's care plans reflect accurately the care needs of the person, and have been completed in consultation with the resident and/or their next of kin, where applicable. A checklist has been initiated and is reviewed daily by the Manager to ensure that the 'Resident of the Day' is being completed. Any actions requiring attention from the resident's Named Nurse are detailed on this checklist. A sample of care files are checked during the monthly monitoring visit to ensure they are up to date and reflect the resident's current needs.
Area for improvement 2 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 31 August 2024	The registered person shall ensure a comprehensive review of the menu choice documentation is conducted to ensure the full name of patients is recorded and accurate menu options are recorded for those patients on a modified diet. Ref: 5.2.2
	Response by registered person detailing the actions taken: The menu choice documentation was reviewed immediately upon the completion of the inspection. The Menu choice will be completed the day before by Care staff who ask residents their choice of meal from the menu. Where a resident is unable to verbally express a preference for their meal, staff will ensure that the choice is made that reflects the person's dietary preferences, and this is clearly indicated on the form. A review has also taken place in relation to the information that is sent from the kitchen to the nursing units. This was to ensure that the options available for those residents prescribed a modified diet is clearly recorded on the menu choice records. This enables staff to make informed decisions about meal choices for residents. Kitchen staff have been advised not to accept menu choice requests that do not specifically state a menu option for residents on modified diets.

	We have also discussed with staff the necessity of ensuring that each resident's full name is detailed on menu choice records. This is more respectful and reduces the risk of any resident receiving the wrong meal. Historical menu choice records will be filed in the kitchen store so that they may be available for review at a future date. The provision of meals and the resident choice is reviewed as part of the monthly monitoring visit and the daily menu checked to ensure it is reflective of the meals being served.
Area for improvement 3 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 31 August 2024	The registered person shall ensure care record audits evidence review and completion of associated action plans. Ref: 5.2.5
	Response by registered person detailing the actions taken: The Manager will review on a monthly basis all action plans that have been put in place that were required to address deficits highlighted during the audit process. All action plans will be clearly communicated to the member of staff who will be required to address. Audits will not be filed in the monthly audit folder as completed until the actions identified in these audits are carried out and there is evidence in place to substantiate this. Where no actions are required, this will be clearly indicated on the front sheet of any audit and signed and dated by the Home Manager. Where identified, support from the Manager and the Deputy Manager will be given to ensure that actions are completed in a timely manner. Audits will be reviewed during the monthly monitoring visit to ensure actions have been addressed and that the Registered Home Manager has reviewed these as part of her quality assurance and overall governance and has signed these as being complete

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

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