The Regulation and Quality Improvement Authority

Inspection Report

29 February 2024

Lansdowne Care Home

Type of Service: Nursing Home
Address: 41-43 Somerton Road, Belfast BT15 3LG
Tel no: 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/Registered Provider: Beaumont Care Homes Limited **Responsible Individual:** Mrs Ruth Burrows	**Registered Manager:** Miss Claire Podmore – registration pending
Person in charge at the time of inspection: Miss Claire Podmore - Manager	**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) DE – Dementia I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 51
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 Annabelle 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 29 February 2024 from 9.05 am to 5.45 pm by two care inspectors. The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

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

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

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

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

3.0 How we inspect

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

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

Throughout the inspection patients, relatives and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in Lansdowne Care 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 were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were provided to the manager at the conclusion of the inspection.

4.0 What people told us about the service

Patients spoke positively about the care that they received and about their interactions with staff. Patients confirmed that staff treated them with dignity and respect and that they would have no issues in raising any concerns with staff. One patient said, "They are all good to me. I love this place", while another patient said, "The staff are very nice." A further patient said, "The staff are excellent, it's nearly as good as home". A patient who was in the home for a period of rehabilitation commented on how he will miss the staff when he goes home.

Relatives spoken with were complimentary of the care provided in the home. One relative said, "The care is brilliant. You couldn't fault the girls" while another relative said, "The staff are excellent, we are kept up to date".

Staff spoken with said that Lansdowne Care Home was a good place to work but acknowledged some recent staffing challenges. Staff commented positively about the manager and described them as supportive and approachable. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

No responses were received to the online staff survey and no questionnaires were returned by patients or their relatives.

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 20 February 2023		
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:** Second time	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.	**Partially met**
	Action taken as confirmed during the inspection: This area for improvement is partially met and is stated for a third time. This is discussed further in section 5.2.3.	

Area for improvement 2 **Ref:** Regulation 16 (2) (b) **Stated:** First time	The registered person shall ensure risk assessments and care plans are reviewed and updated following patients' admission to hospital.	**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 3 **Ref:** Regulation 18 (2) (c) (e) **Stated:** First time	The registered person shall ensure adequate bedding is available at all times suitable to the needs of patients. Arrangements must be in place for the regular laundering of linen.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 4 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure as far as is reasonably practicable that all parts of the home to which the residents have access are free from hazards to their safety, and unnecessary risks to the health and safety of residents are identified and so far as possible eliminated. This area for improvement is made with specific reference to the safe storage and supervision of cleaning chemicals.	**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 (April 2015)		Validation of compliance
Area for improvement 1 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure that accurate and contemporaneous menu choice records for patients on modified diets are maintained.	**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 2 **Ref**: Standard 13 **Stated:** First time	The registered person shall ensure that a structured programme of varied activities is provided for patients. Arrangements should be made for the provision of activities in the absence of the activity co-ordinator.	**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

A review of a selection of recruitment records confirmed that pre-employment checks had been completed prior to each staff member commencing in post. Staff members were provided with a comprehensive induction programme to prepare them for providing care to patients.

Checks were made to ensure that staff maintained their registration with the Nursing and Midwifery Council (NMC) or with the Northern Ireland Social Care Council (NISCC). The manager agreed to introduce a system to have oversight of the registration of nurses who work on the flexi bank.

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

Review of records confirmed all of the staff who take charge of the home in the absence of the manager had completed a competency and capability assessment to be able to do so.

There were systems in place to ensure that staff were trained and supported to do their job. Staff consulted with confirmed that they received regular training in a range of topics such as first aid, infection prevention and control (IPC) and fire safety.

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

Staff said they felt well supported in their role and were satisfied with the level of communication between staff and management. Staff reported good team work when planned staffing levels were adhered to. Staff said there had been a reduction in the number of hours allocated for both catering and care roles; they said this had an impact on their ability to do their job. One staff member said, “we are getting the work done but it feels like we are cutting corners.”

Patients spoke positively about the care that they received and confirmed that staff attended to them in a timely manner. One patient said, “they come quick enough when I press the buzzer but sometimes they are short staffed.”

These concerns regarding staffing levels were discussed with the manager who provided assurances that patient dependency levels were checked frequently and that staffing levels would continue to be kept under review.

It was observed that staff responded to patients’ requests for assistance in a prompt, caring and compassionate manner.

5.2.2 Care Delivery and Record Keeping

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

It was observed that staff respected patients’ privacy by their actions such as knocking on doors before entering, discussing patients’ care in a confidential manner and by offering personal care to patients discreetly. Staff members were observed to be prompt in recognising patients’ needs and any early signs of distress, especially in those patients who had difficulty in making their wishes known. Staff members were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

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 generally well completed although not always recorded contemporaneously. This is discussed further in 5.2.2.

It was observed that a number of airflow mattresses were not set correctly to the patients’ current weight. This was discussed with the manager and an area for improvement was identified.

A number of bedrooms within the dementia unit were observed to have no access to the nurse call system. In addition, a small number of patients were observed to have their call bell out of reach in the general nursing unit. This was discussed with the manager who agreed to audit to the use of the nurse call system to ensure those patients who cannot use the system are appropriately supervised. Appropriate care plans should be implemented and records maintained. This will be reviewed at a future care inspection.

Management of wound care was examined. Care records confirmed that wound care was managed in keeping with best practice guidance. The manager provided additional assurances that each wound would have a separate care plan in place.

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 consistently managed in keeping with best practice guidance.

At times, some patients may be required to use equipment that can be considered to be restrictive, for example, bed rails. Review of patients' records and discussion with the manager and staff confirmed that the correct procedures were followed if restrictive equipment was used.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The lunchtime experience was observed in the Annabella and Cavehill units. Lunch was a pleasant and unhurried experience for the patients. The food served was attractively presented and smelled appetising and portions were generous. A variety of drinks were served with the meal. Most patients spoke positively in relation to the quality of the meals provided. Comments received from patients regarding the dining experience were shared with the manager for follow up directly with the patients concerned.

Patients may need support with meals ranging from simple encouragement to full assistance from staff. Staff attended to patients' dining needs in a caring and compassionate manner while maintaining written records of what patients had to eat and drink, as necessary.

It was noted that patients in the Cavehill unit chose to eat their meals in their bedrooms. Observation of both dining rooms in this unit noted that a menu was not displayed and there appeared to be a lack of condiments and seating available. This was discussed with the manager who agreed to review the mealtime experience in this unit.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake were in place to direct staff. Staff told us how they were made aware of patients' nutritional needs to ensure that patients received the right consistency of food and fluids.

Examination of menu choice records confirmed conflicting information regarding the consistency levels of food and fluid recommended for at least five patients was recorded when compared to information retained in the patients care files. In addition, menu choice records did not consistently contain patients' full name; this had the potential to cause confusion in relation to the delivery of patient care. This was discussed with the manager during the previous care inspection who provided assurances that a system would be implemented to review these records of a regular basis. It was disappointing to note these shortfalls persist. Discussion with catering staff and review of records evidenced that accurate information for patients who required their diet to be modified was held in the kitchen. An area for improvement identified at the previous care inspection was stated for a second time.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment, care plans should be developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals.

Review of a selection of care records evidenced that most care plans had been developed within a timely manner to accurately reflect their assessed needs. It was pleasing to note that some nursing staff had updated care plans to reflect the changing needs of patients, although this was not on a consistent basis.

There was evidence that a number of care plans for one identified patient had not been reviewed for up to two weeks following readmission to the home after a period of time in hospital. This was identified as an area for improvement at the previous care inspection and is stated for a second time. In addition, there was evidence that care plans had not been updated to reflect the changes in further identified patient's care needs. An area for improvement was identified.

Records reviewed did not provide assurances that all patient care plans were consistently developed in consultation with the patient or patient's representative. In addition, many of the care plans, monthly and daily evaluations were not person centred and contained repetitive statements. This was discussed with the previous manager during the last care inspection and despite assurances this would be reviewed during care record auditing, no improvements were noted. The manager confirmed they planned to offer additional supports for the registered nurses by arranging care plan coaching. Areas for improvement were identified to drive the necessary improvements.

Shortfalls were identified in the completion of supplementary care records such as charts for repositioning, food and fluid intake, sleep/activity and bedrails checks. Discussion with staff and observation of practice confirmed that these records were not completed contemporaneously. Patient's appeared clean and well cared for, however recording gaps of up to two weeks were noted on shower and bath records. Care staff should record when care has been offered but refused and evidence any further attempts that were made for care delivery. This was discussed with the manager and areas for improvement were identified.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was warm, clean and comfortable. Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated and suitably furnished. A small number of storage areas throughout the home were found to be cluttered with items stored on the floor. The manager agreed to review the management of the linen and storage cupboards and the arrangements for storage of gloves in the Annabella unit.

It was noted that patient ensuites did not have waste bins to dispose of

Food and fluid thickening agents, topical creams and staff's personal belongings were observed to be stored in areas accessible to patients in the Annabella unit. This was discussed with staff who took immediate action. An area for improvement was identified. Assurances were provided by the manager that further action would be taken to reduce risks to residents in the home.

Fire safety measures were in place to ensure that patients, staff and visitors to the home were safe. Staff members were aware of their training in these areas and how to respond to any concerns or risks. A fire risk assessment had been completed on 18 May 2023; all actions identified by the fire risk assessor had been addressed in a timely manner.

There were laminated posters displayed throughout the home to remind staff of good hand washing procedures. Hand sanitisers were readily available throughout the home.

Discussion with staff confirmed that training on IPC measures and the use of personal protective equipment (PPE) had been provided, although shortfalls in staff practice were noted. Some staff members were observed to carry out hand hygiene at appropriate times and to use PPE correctly; other staff did not. Some staff members were not familiar with the correct procedure for the donning and doffing of PPE. Some improvements were noted since the previous care inspection as all staff were observed to be bare below the elbow.

This was discussed with the manager who agreed to address these matters with all staff who work in the home and ensure the nurse in charge monitors compliance on their daily walk about. This area for improvement has previously been stated for a second time. Given that some improvement had been achieved since the previous inspection and the assurances provided during the inspection, it was agreed that the area for improvement would be stated for a third and final time. Failure to meet this area for improvement may lead to enforcement action.

5.2.4 Quality of Life for Patients

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

Patients were observed enjoying listening to music, reading and watching TV, while others enjoyed a visit from relatives. Photos were on display in the foyer of the home of patients enjoying many of the varied activities provided.

There was evidence that planned activities were being delivered within the home. An activity planner displayed throughout the home included upcoming activities such as one to one, arts and crafts, nail care and bingo. Plans were also in place to celebrate patient's birthdays and Mother's day; a sweet cart was also available. The activity therapists said they did a variety of one to one and group activities to ensure all patients availed of meaningful engagement with staff.

It was pleasing to note that a monthly bulletin is printed for patients and staff which highlights events in the home.

5.2.5 Management and Governance Arrangements

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

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

There has been a change in the management of the home since the last inspection; RQIA were notified appropriately. Miss Claire Podmore has been the manager since 15 January 2024.

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

There was a system in place to manage complaints. There was evidence that the manager ensured that complaints were analysed on a monthly basis.

A review of the records of accidents and incidents which had occurred in the home found that these were well managed and reported appropriately.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. The manager or delegated staff members completed regular audits to quality assure care delivery and service provision within the home. Given the inspection findings and following review of a sample of audits, improvements were required regarding the oversight of care records and infection prevention and control practices. An area for improvement was identified.

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. 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	*7

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Claire Podmore, 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 13 (7) **Stated:** Third time **To be completed by:** 29 February 2024	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. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: A comprehensive action plan has been agreed and initiated with input from external stakeholders at BHSCT to address this area for improvement. This is to include practical, face to face training for all staff in the principles of infection control, donning and doffing of PPE, hand hygiene and waste management. Three 'infection control' champions have been nominated within the care team, they will carry out additional hand hygiene and PPE audits and act as advocates for infection prevention and control throughout their respective units. The audit processes will be examined to ensure that they are being completed meaningfully (see also, Care Standards Area for Improvement 7). Multi-disciplinary team members working within the Intermediate Care Unit will be included in audit systems and processes relating to infection prevention and control. Additional waste bins will be obtained to ensure the proper disposal of PPE and to facilitate effective and timeous hand hygiene. The Home Manager and our Quality Assurance Manager will observe staff practices and offer support when any deficits are identified relating to infection control. Posters will be updated and disseminated relating to infection control best practice guidance and clarity will be sought in relation to training and learning provided to external members of the multidisciplinary team, with specific reference to infection control. Additional sanitising gel dispensers will be obtained and positioned at key points for hand hygiene throughout the Home. Hand hygiene will be improved at mealtimes through

	the use of disposable hand wipes for every resident. Alcohol gel pump dispensers will be available for staff to use between residents when assisting people with their meals. Mealtime experience audits (see also, Care Standards Area for Improvement 7) will be evaluated to ensure that proper attention is being paid to infection control and PPE measures at mealtimes. Staff understanding of the correct use of PPE will be improved through training, support and development in practice. This will help to reduce the incidence of over use of PPE or situations where PPE is being used inappropriately. We will liaise with the visiting multidisciplinary team in working to achieve this goal to ensure that everyone within the Home is working in accordance with best practice guidelines relating to infection control.
Area for improvement 2 **Ref:** Regulation 16 (2) (b) **Stated:** Second time **To be completed by:** 29 February 2024	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 **Response by registered person detailing the actions taken:** All Staff have been made aware that all risk assessments and care plans need to be updated within 72 hrs on return from hospital. All identified key risks must be updated on the day of re-admission. A return from hospital audit will be completed within 72hrs of residents return from hospital. Any identified deficits will be discussed with the nursing team with clear timelines for completion. Compliance will be monitored by the Home Manager as part as her walkabout audit and via the Operations Manager during the Regulation 29 monitoring visit.
Area for improvement 3 **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. Ref: 5.2.2 **Response by registered person detailing the actions taken**: Residents will be allocated a named nurse. This nurse will be responsible for planning and allocating protected time (to be scheduled within unit diary) to meet with individual residents and/or their next of kin. This time will be used to discuss plans of care and ensure that they are meaningful to the person and contain agreed outcomes. Interventions will be realistic, achievable and specific to the person. To achieve this, we will

	require to improve detail in care plans and utilise information gathered from the person and/or their next of kin to inform these. Initial care planning discussion meetings were held on 21st and 22nd March. Sample care plans will be provided and opportunity will be given for nurses to have a group discussion relating to care planning (see also, Care Standards Area for Improvement 3). Compliance to be monitored through internal governance and via the Operations Manager during the Reg 29 audit.
Area for improvement 4 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** 29 February 2024	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. Ref: 5.2.3
	Response by registered person detailing the actions taken: Lockable storage containers for the safe storage of thickening agents will be purchased. Staff reminded that these need to be locked away when not in use. The safe storage of thickening agents will be monitored as part of the Manager's walk round. Storage of linen and PPE will also be monitored as part of this walk round to ensure that no items are being inappropriately stored. Additional bins for ensuite bathrooms have been purchased to ensure that waste can be safely disposed of prior to staff leaving bedrooms. Additional clinical waste bins have also been purchased to facilitate safe disposal of PPE. Compliance will be further checked as part of the monthly monitoring visit.

<table>
<tr><th colspan="2">Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)</th></tr>
<tr><td>Area for improvement 1

Ref: Standard 12

Stated: Second time

To be completed by:
29 February 2024</td><td>The registered person shall ensure that accurate and contemporaneous menu choice records for patients on modified diets are maintained.

Ref: 5.1 and 5.2.2</td></tr>
<tr><td></td><td>Response by registered person detailing the actions taken:
A new IDDSI audit has been implemented to ensure accurate cross referencing with the following documents:
- Dietician/SLT recommendation
- Care plan
- Choking risk assessment
- Supplementary charts
- Key risk summary
- Dietary notification in kitchen

This will be checked at least monthly by a member of the management team and via the return from hospital audit (see also, Regulations Area for Improvement 2) to ensure any change to IDDSI requirement has been updated.
Compliance to be monitored by the Operations Manager during the Reg 29 audit.</td></tr>
<tr><td>Area for improvement 2

Ref: Standard 4.7

Stated: First time

To be completed by:
29 February 2024</td><td>The registered person shall ensure that prescribed pressure relieving mattresses are set correctly in accordance with the current patients’ weight where appropriate.</td></tr>
<tr><td></td><td>Response by registered person detailing the actions taken:
The monthly mattress audit will be completed throughout all three units which checks every pressure relieving mattress to ensure that the patient’s weight is accurately reflected in the setting of the mattress.
Compliance will be monitored via the Manager/designated deputy as part of their walkaround and via the Operations Manager during the Reg 29 visit.</td></tr>
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Area for improvement 3 **Ref:** Standard 4.7 **Stated:** First time **To be completed by:** 29 February 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: 5.2.2
	Response by registered person detailing the actions taken: A full review of care plans and risk assessments is required in the Dementia Care Unit and Nursing Unit. As identified in our response to Regulations Area for Improvement 3, we aim to implement a named nurse system which will improve oversight and accountability for maintaining effective care planning. We will also look at the information contained within the care plans and named nurses will critically assess these to ensure that they are meaningful for the person. Information will be obtained through meeting with residents and their relatives which can be used in identifying suitable interventions within care plans. Key risk summaries and social interaction care plans will be contained in supplementary booklets. This will ensure that Care Assistants have access to the information that they need to care for the individual safely. Care plan audits will be completed monthly by senior staff and actions arising from these will be quality assured checked by the Manager. A timescale for completion of these actions will be given to the named nurse to complete. The Manager will ensure that this is being done through spot checks with particular reference to residents having recently returned from hospital, been admitted or with complex nursing needs.
Area for improvement 4 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** 29 February 2024	The registered person shall ensure patient's care plans and all evaluations of care are meaningful and person centred. Ref: 5.2.2
	Response by registered person detailing the actions taken: We need to ensure that evaluations of care plans are meaningful and effective. This means that the person evaluating the care plan must read the care plan in its entirety and ensure that the information contained in the care plan remains relevant. In the event that the care plan does not remain relevant, the care plan will require to be rewritten. The Manager, as part of auditing process, will check to ensure that the evaluations are of good quality and reflective of the resident's experience. This issue has been discussed at length during nursing staff meetings and nurses were able to give their perception of good quality care plan evaluations. Training has been requested to

	ensure that all nurses have the necessary skills to complete care plans to an acceptable standard. Compliance will be monitored by the Operations Manager as part of the Regulation 29 visit.
Area for improvement 5 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** 29 February 2024	The registered person shall ensure that shower and bath records are accurately maintained. Ref: 5.2.2
	Response by registered person detailing the actions taken: With specific reference to the Nursing care unit, management oversight of personal care records has been improved through the use of a personal care checklist chart. This means that resident's choice of bath or shower can be recorded and a visual check can be performed by the Manager for her assurance that this is being completed regularly and in accordance with the person's care plan. Compliance will be monitored as part of the monthly monitoring visit by the Operations Manager.
Area for improvement 6 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** 29 February 2024	The registered person shall ensure contemporaneous records are maintained. This area for improvement is made with specific reference to completion of supplementary care records. Ref: 5.2.2
	Response by registered person detailing the actions taken: Supplementary care records will be stored in the resident's bedrooms or in the place in which the care is being delivered. This will ensure that records are being completed at the 'point of care' and not after the event, thus reducing the risk of erroneous record keeping. Several staff meetings have been held and the rationale for contemporaneous record keeping has been discussed at some length with the care team. Supplementary charts will continue to be checked as part of the Manager's walk around as well as part of Reg 29 visits which take place monthly.

Area for improvement 7 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** 29 February 2024	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. Ref 5.2.5
	Response by registered person detailing the actions taken: The purpose and function of audit processes in identifying areas for improvement has been discussed at length with all staff responsible for their completion. It has been emphasised that we should be using audits to measure our progress accurately and discussed within staff meetings. The Manager will monitor the information provided within audits and cross reference to ensure that this is an accurate depiction of care delivery. The individuals responsible for auditing care plans, as well as other audits, will receive support from management to ensure that they are aware of the purpose of auditing and the implications of auditing for care delivery. With specific reference to infection prevention and control auditing, we need to ensure that individual staff members completing the audits receive sufficient support in the completion of these. Audits will be peer reviewed by the Manager to ensure that any deficits identified have clear actions to be taken, who needs to complete and within what timescale. The Manager will then review to ensure completed. Audits and outcomes will be further reviewed as part of the monthly monitoring visit.

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

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