Inspection Report
8 October 2020

Richmond

Type of Service: Nursing Home
Address: 19 Seafront Road, Cultra, BT18 0BB
Tel No: 028 9042 6558
Inspectors: Gillian Dowds, Judith Taylor & Joseph McRandle

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.0 What we look for

2.0 Profile of service

This is a nursing home which is registered to provide care for up to 35 patients.

3.0 Service details

Organisation/Registered Provider: Richmond Nursing Home Ltd **Responsible Individual:** Sharon Ruth Radcliffe-Bryans	**Registered Manager and date registered:** Sharon Ruth Radcliffe-Bryans 1 April 2005
Person in charge at the time of inspection: Liezl Pimenter (Staff Nurse) until 14.00 and Sharon Ruth Radcliffe-Bryans thereafter	**Number of registered places:** 35
Categories of care: Nursing (NH): 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	**Total number of patients in the nursing home on the day of this inspection:** 30

4.0 Inspection summary

An unannounced inspection was undertaken by a care inspector and a pharmacist inspector on 8 October 2020 from 10.00 to 17.20. A remote finance inspection was undertaken on 22 October 2020 from 09.30 to 18.00.

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

The inspection sought to assess progress with issues raised in the last care, medicines management and finance quality improvement plans.

The following areas were examined during the inspection:

- staffing
- the homes environment and infection prevention and control (IPC) measures
- care delivery
- care records
- governance and management arrangements
- medicines management
- management of patients' finances.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	5	8

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Jennifer Carson, Sister and Sharon Radcliffe-Bryans, Manager as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the last care, medicines management and finance inspections
- the registration status of the home
- written and verbal communication received since the last care, medicines management and finance inspections
- the returned QIP from the last care, medicines management and finance inspections
- the last care, medicines management and finance inspection reports.

During the inspection we met with five patients and five staff. Questionnaires were left in the home to obtain feedback from patients and patients' relatives. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The manager was provided with 'Tell Us' cards with contact details to enable patients, staff and visitors to provide feedback.

The following care and financial records were examined during the inspection:

- duty rota for all staff from 27 September to 10 October 2020
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- two staff recruitment files
- three patients' care records
- three supplementary care records
- complaints and compliments
- a sample of monthly monitoring reports
- accident/incident records
- a sample of governance audits
- records of adult safeguarding referrals
- COVID-19 information file.
- a sample of patients' financial records

In relation to medicines management, a sample of the following was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drugs records
- care plans related to medicines management
- governance and audit regarding medicines management
- staff training and competency records
- medicine storage temperatures
- management of medicine related incidents

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from previous inspection(s)

The most recent inspection of the home was an unannounced care inspection undertaken on 17 December 2019.

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</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 rowspan="2">Area for improvement 1

Ref: Regulation 5

Stated: First time</td><td>The registered person shall ensure that there is evidence that each patient or their representative has been provided with an individual written agreement setting out the terms and conditions of their residency in the home.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of records evidenced that since the last finance inspection in February 2019 an agreement was provided to the patient identified during the inspection. The agreement reviewed set out the terms and conditions of the patient’s residency within the home.</td></tr>
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Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref**: Standard 14.12 **Stated:** First time	The registered person shall ensure a reconciliation of patients' personal monies and valuables in the safe place are carried out and signed and dated by two people at least quarterly.	**Met**
	Action taken as confirmed during the inspection: A review of records confirmed that reconciliations of patients' monies and valuables were undertaken in line with the Care Standards for Nursing Homes (2015). The records of the reconciliations were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.	
Area for improvement 2 **Ref**: Standard 14.10 **Stated:** First time	The registered person shall ensure that each transaction in the patients' income and expenditure records are signed by two people.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of records of transactions undertaken on behalf of two patients showed that all of the transactions were signed by at least two members of staff.	
Area for improvement 3 **Ref**: Standard 14.13 **Stated:** First time	The registered person shall ensure that hairdressing and podiatry treatment records are maintained in the home and detail the information required by standard 14.13.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of records for the hairdresser and podiatrist showed that the required information was included in the records e.g. names of patients receiving treatment, details of the treatment provided and the cost of each treatment. The records were signed by both the hairdresser and podiatrist and countersigned by a member of staff to confirm that the treatments took place and the cost of each treatment.	

Area for improvement 4 **Ref**: Standard 14.26 **Stated:** First time	The registered person shall ensure that records of patients' furniture and personal possessions which they have brought to their rooms are reconciled and signed and dated by a staff member and countersigned by a senior member of staff at least quarterly.	**Met**
	Action taken as confirmed during the inspection: A review of two patients' property records evidenced that, since the last inspection, the records had been updated and reconciled in line with the Care Standards for Nursing Homes (2015). The records were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.	
Area for improvement 5 **Ref**: Standard 36.4 **Stated:** First time	The registered person shall ensure that financial policies and procedures are subject to review at least every three years.	**Met**
	Action taken as confirmed during the inspection: A review of a copy of the financial policies and procedures confirmed that the policies had been reviewed in January 2020. A review date was included in the policies for January 2023. This area for improvement had been met.	
Area for improvement 6 **Ref**: Standard 14.6 **Stated:** First time	The registered person shall ensure that each patient is provided with a personal monies authorisation record for signature detailing the authority the home had been provided with to spend each individual patient's money on identified goods and services.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced that since the last finance inspection in February 2019 a written authorisation form was in place for the patient identified during the inspection. The authorisation form detailed the items members of staff were authorised to purchase from the patient's monies. The form was signed by the patient's representative.	

Area for improvement 7 **Ref**: Standard 18 **Stated:** Second time	The registered person shall ensure that the reason for and the outcome of administration of medicines prescribed for administration on a "when required" basis for the management of distressed reactions are recorded.	**Met**
	Action taken as confirmed during the inspection: There was evidence of improvement in the record keeping for medicines administered to manage distressed reactions. See also Section 6.2.6.	
Area for improvement 8 **Ref:** Standard 4 **Stated:** Second time	The registered person shall ensure that bowel management records are accurately recorded and that nursing staff evaluate the effectiveness of care.	**Met**
	Action taken as confirmed during the inspection: A review of records evidenced that bowel management records were accurately recorded and this was evidenced in the daily evaluation of are by the registered nurses.	
Area for improvement 9 **Ref:** Standard 4 **Stated:** Second time	The registered person shall ensure contemporaneous recording on supplementary care charts is reflected in the daily evaluation of care.	**Not met**
	Action taken as confirmed during the inspection: A review of records evidenced gaps in the recording of some of the supplementary care and that this did not appear to be identified. This is discussed further in section 6.2.4 This area for improvement has been subsumed under an area for improvement under regulation.	

6.2 Inspection findings

6.2.1 Staffing

On the day of the inspection we observed that staffing levels were satisfactory and patients' needs were met by the levels and skill mix of staff on duty. One staff member spoken to advised they were "busy in the morning and could do with more staff." This was discussed with the manager who advised that the dependency level in the home had previously increased and staffing had been adjusted accordingly. She advised that staffing levels were subject to regular review.

Staff felt that they had been well supported during the outbreak of COVID-19 in the home. The staff also told us that they felt well equipped for their role and that they had been kept updated with developments and guidance relating to COVID-19; an up to date COVID-19 file was maintained for staff reference and information.

We reviewed two staff recruitment files; this evidenced that the required employment checks were carried out prior to a staff member commencing work in the home. In one file we observed that the original application form was not in place; however, a curriculum vitae (CV) was in place with all relevant information. This was discussed with the manager who agreed to address this.

There was a system in place to monitor the registration status of nurses with the NMC and care staff with NISCC.

Comments made by staff included:

- "Staffing is ok most days."
- "We are kept up to date with any changes."
- "Management are supportive the door is always open."

6.2.2 The environment and infection prevention and control (IPC) measures

Signage had been displayed at the entrance to the home to reflect the current guidance on COVID-19. Staff had a temperature check on arrival to the home.

Personal protective equipment (PPE) was readily available throughout the home and PPE stations were well stocked. Staff told us that they had had sufficient supplies of PPE at all times.

We observed that staff were compliant in relation to wearing their masks. However, we observed some occasions when staff were required to wear additional PPE, such as gloves. A small number of staff were observed not sanitising their hands when necessary and did not adhere to IPC best practice of 'bare below the elbow' for effective handwashing by wearing jewellery and/or nail polish. An area for improvement was identified regarding staff's adherence to IPC measures and management oversight of this.

We reviewed the home's environment; this included observations of a sample of bedrooms, bathrooms, lounges, dining room, sluices and storage areas. We observed the ongoing cleaning in the home and discussed the enhanced cleaning with the manager. We further discussed the preparation of the environment if the home did have an outbreak and also the identification of further donning (putting on) and doffing (taking off) PPE stations. The manager agreed to address this.

We observed opened boxes of gloves in the bathrooms and also the underneath of some of the hand soap dispensers we not effectively cleaned. We discussed this with the manager and an area for improvement was identified.

We also observed a hoist stored in an identified corridor when not in use. We discussed this with the manager who advised that this was not the usual storage area for the hoist. We also observed a small table in a corridor partially occluding a fire exit. An area for improvement was identified in relation to fire safety precautions.

6.2.3 Care delivery

We observed that patients looked well cared for and were content and settled in their surroundings. Patients who were in their rooms had call bells within reach. Patients who were in the lounge were observed to enjoy listening to music and singing along with staff.

There was a calm and friendly atmosphere in the home. Staff were seen to treat patients with kindness and respect. Patients spoken to told us:

- "Staff are very pleasant."
- "It's good I like it here very nice staff."
- "Perfectly good."
- "I like it here. Everything is ok."

We observed the serving of lunch in the dining room and found this to be a pleasant and unhurried experience for the patients. Staff were helpful and attentive and patients were offered alternative meals if required. Staff were seen to assist patients with their eating and drinking needs as required.

Feedback from the patients in relation to the meal was positive and comments included:

- "Lovely."
- "Very nice."

6.2.4 Care records

We reviewed three patients' care records which evidenced that individualised care plans had been developed to direct the care required. We also observed that on one record, the manual handling equipment prescribed for use in the care plan, did not reflect the required equipment documented in the risk assessment. This was discussed with the manager and an area for improvement was identified.

We reviewed the management of patient's weights. We evidenced that when a patient had refused to be weighed, there was no evidence of any remedial actions taken. However, we did evidence that the patient was under the care of the dietician and had gained weight the following month. We also observed on two records, gaps in the recording of the monthly weight or the malnutrition universal screening tool (MUST) tool on at least one occasion. We discussed this with the manager and an area for improvement was identified.

A review of a sample of supplementary care charts evidenced gaps in the recording of patients repositioning and food and fluid intake. These gaps did not appear to be identified by the registered nurses. Oversight of supplementary care was an area for improvement from the last inspection and had been stated for a second time. Given the deficits found in the records this area for improvement will therefore be subsumed to an area for improvement under regulation.

We reviewed the care records for one wound and observed that relevant wound care documentation was in place.

We reviewed the records for one patient who was at risk of skin breakdown and who used a pressure relieving mattress. We saw that there was a care plan in place to direct the care required; relevant documentation evidenced that staff checked the setting required. We identified, however, that the mattress was not/had not been maintained at the required setting. An area for improvement was made.

We reviewed the records for one patient who had sustained a fall. We observed that the neurological observations had not been recorded in line with best practice guidance; an area for improvement was identified.

6.2.5 Governance and management arrangements

We reviewed a sample of governance audits in the home. These audits identified areas that required improvement; we observed that action plans were developed and timeframes for completion were recorded.

A record of written compliments and thank you cards was maintained and staff were made aware of these; comments included:

- "Many thanks to everyone who cared for xxx he often told me how well he was looked after."
- "My love and thanks to all the staff."
- "Thank you to all the staff at Richmond for keeping xxx safe well and happy during these trying times."

Staff were kept up to date with guidance relating to COVID-19; information regarding this was readily available in the home.

Medicines Management

6.2.6 Personal medication records and associated care plans

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs will change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, medical consultant or pharmacist.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals eg medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had signed the personal medication records when they were written and updated to check that they were accurate.

Copies of patients' prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription. This is good practice.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets, self-administration etc.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was administered, the reason it was given and what the outcome was. If staff record the reason and outcome of administering the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Directions for use were clearly recorded on the personal medication records. Care plans were in place; however, some did not include details of the medicine prescribed. A small number of patients were administered these medicines on a regular basis; staff advised that the patient's GP was aware.

The management of pain was discussed. Staff stated that they were familiar with how each patient expressed pain and that pain relief was administered when required. Care plans and pain assessments were observed. Staff should ensure that the medicine details are also included in the care plan. An area for improvement was identified.

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 should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

We reviewed the management of thickening agents. There was evidence that speech and language assessment reports and care plans were in place. Records completed by nursing staff included the recommended consistency level of thickening agent. We noted that one of the records was inaccurate and this was being addressed during the inspection. A separate

system was in place for care staff; they were provided with a list of all patients' food/fluid requirements and administration was recorded. It was agreed that these administration records would be updated to include the level of fluid administered.

6.2.7 Medicine storage and record keeping

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error. A record of all incoming and outgoing medicines must be maintained.

The records inspected showed that medicines were available for administration when patients required them; however, a record of the receipt of some medicines had not been maintained; this was identified as an area for improvement.

Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage areas, including the controlled drug cabinet and medicine trolleys were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located.

A medicines refrigerator was in use for the cold storage of medicines. Daily temperatures were recorded. However, we identified several eye preparations which did not require or must not be stored in the refrigerator. Eye preparations must be stored in accordance with the manufacturers' instructions to ensure they are stable and suitable for use. We also noted that two of the same eye preparations were opened for one patient; only one type of a patient's eye preparation should be opened at a time. This was identified as an area for improvement.

We reviewed the disposal arrangements for medicines. Discontinued medicines in a registered nursing home are identified as clinical waste, and therefore they must be removed by a company who holds a clinical waste licence. All discontinued medicines must be placed into a specific disposal bin for medicines by two members of trained staff and they should both sign the disposal record. At the time of the inspection, there appeared to be different systems in place as on occasion the medicines were put in the disposal bin, or on other occasions, they were returned to the community pharmacy.

In relation to discontinued controlled drugs in Schedule 2, 3 and 4 (Part 1), these must be denatured as stated in guidance per formulation of controlled drugs, to ensure the controlled drug cannot be retrieved, before leaving the nursing home. This occurred on some occasions, however, in some instances they were not denatured and were returned to the community pharmacy. Advice was given and an area for improvement was identified.

6.2.8 Administration of medicines

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed. We identified some missing signatures in relation to eye preparations and were unable to determine if the medicine had been administered. An area for improvement regarding the management of eye preparations was identified in Section 7.2. Records were securely filed at the end of each medicine cycle.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs are recorded in a controlled drug record book. Stock checks and administration should involve two trained staff and both staff should sign the entry. We found that there were missing signatures in the entries in this book and established that two staff were not involved in the administration of controlled drugs. This was discussed in relation to professional guidance. An area for improvement was identified.

Management and staff audited medicine administration on a regular basis within the home. This is necessary to ensure that robust systems are in place for the safe management of medicines and also to ensure that the patient has been administered their medicines. There was evidence that the date of opening was recorded on all medicines so that they could be easily audited. Staff had also recorded daily stock balances for the majority of inhaled and oral medicines, and the stock balance of medicines which were carried over for use in the next medicine cycle. These are areas of good practice and enable staff to identify if there are any errors. The majority of audits completed during this inspection showed that medicines had been given as prescribed. Some minor discrepancies were identified and highlighted for attention.

6.2.9 Management of medicines on admission/re-admission to the home

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one care setting to another.

We reviewed the management of medicines for patients who had a hospital stay and were discharged back to this home. Hospital discharge letters had been received and a copy had been forwarded to the patients' GPs. The patients' personal medication records had been updated to reflect medication changes which had been initiated during the hospital stay. Medicines had been accurately received into the home and administered in accordance with the most recent directions. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

6.2.10 Medicine related incidents

Occasionally medicine incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident.

The audit system in place helps staff to identify medicine related incidents. There have been no medicine related incidents reported to RQIA since the last medicines management inspection.

This was discussed with staff and they were familiar with the type of incidents that should be reported.

6.2.11 Medicines management training

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported. In addition to training, staff should have reference to up to date policies and procedures for medicines management.

Staff in the home had received induction training, which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. Records of training and competency assessments were maintained.

We noted that the medicines management policies and procedures had not been updated for some time; they should be reviewed at least every three years to ensure they are reflective of current practice and include all aspects of medicines management. An area for improvement was identified.

Areas of good practice

Areas of good practice were observed in the personalisation of patients' bedrooms. Further areas of good practice were identified in relation to staff interaction with patients and the teamwork within the home.

Areas for improvement

Areas for improvement were identified in relation to IPC practices, detailing in patients care plans, recording and oversight of supplementary care. Further areas for improvement were identified in relation to weight, falls management and fire safety precautions.

We identified areas for improvement regarding medicines managements and procedures, management of controlled drugs, disposal of medicines and record-keeping.

	Regulations	Standards
Total number of areas for improvement	5	8

6.3 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

During the inspection patients were observed to be well presented and content in their surroundings. Staff were observed interacting with patients in a friendly and caring manner. Patients spoken to were positive about their experiences in Richmond.

In relation to medicines management, the outcome of this inspection concluded that overall patients were being administered their medicines as prescribed by their GP and the area for

improvement identified at the last medicines management inspection had been addressed. However, new areas for improvement were identified and are detailed in the QIP.

We would like to thank the patients and staff for their assistance throughout the inspection

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Jennifer Carson, Sister, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

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

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure the infection prevention and control issues identified on the inspection are managed to minimise the risk and spread of infection. This is stated with regards but not limited to: • the effective cleaning of the hand soap dispensers. • gloves are appropriately stored. Ref: 6.2.2
	Response by registered person detailing the actions taken: Both addressed with immediate effect.
Area for improvement 2 **Ref**: Regulation 27 (4) (d) (iii) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that the corridors in the home are maintained free from any obstruction that would impede in the event of an evacuation of the home. Ref: 6.2.2
	Response by registered person detailing the actions taken: All corridors free from any items that would impede in the event of an evacuation of the home with immediate effect.
Area for improvement 3 **Ref**: Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** 11 December 2020	The registered person shall ensure that nursing staff promote and make proper provision for the nursing, health and welfare of patients and where appropriate treatment and supervision of patients. This area for improvement is made in reference to the following: • contemporaneous recording on supplementary care charts • registered nurses have oversight and evaluate the care recorded on the supplementary care records. Ref: 6.2.4
	Response by registered person detailing the actions taken: Supplementary care charts revised. Registered nurses check all supplementary charts morning, afternoon and evening. Supplementary care charts are reflected in daily evaluation.

Area for improvement 4 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that all unwitnessed falls are managed in line with best practice guidance and that neurological observations are recorded accordingly. Ref: 6.2.4
	Response by registered person detailing the actions taken: All registered nurses have been refreshed in Post Falls Management Protocol.
Area for improvement 5 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall review the management of controlled drugs in relation to disposal, administration and record-keeping. Ref: 6.2.8
	Response by registered person detailing the actions taken: RN x 2 sign disposal, administration and record keeping of disposal of controlled drugs.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 46 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that training on the use of PPE and hand hygiene is embedded into practice. Ref:6.2.2
	Response by registered person detailing the actions taken: Ongoing training on the use of PPE continues. Frequent PPE audits are carried out.
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 21 December 2020	The registered person shall ensure that robust patient centred care plans are in place for each patient's assessed need, with specific reference but not limited to the pain management and the equipment required for use for mobility as documented in care plans. Ref: 6.2.4 & 6.2.6
	Response by registered person detailing the actions taken: All care plans updated and include all of the above.

Area for improvement 3 **Ref**: Standard 12 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall put a system is in place to ensure • the monthly recording of nutritional risk assessments • patients' weights are recorded at least monthly or more frequently depending on individual assessed need. Ref: 6.2.4
	Response by registered person detailing the actions taken: Nutritional risk assessments in place. Weights recorded and reviewed monthly and nutritional needs addressed throughout the month.
Area for improvement 4 **Ref**: Standard 23 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure in regard to the use of a pressure relieving device • the device is maintained at the correct setting for each individual patient. • the care records are reflective of the correct setting. • a checking system is in place to ensure the device setting is correct. Ref: 6.2.4
	Response by registered person detailing the actions taken: Care Plans reflect correct setting of device. Device checked morning and evening and recorded.
Area for improvement 5 **Ref**: Standard 28 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that a record of all incoming medicines is maintained. Ref: 6.2.7
	Response by registered person detailing the actions taken: Incoming medicines are recorded on MARS and signed by RN x 2.
Area for improvement 6 **Ref**: Standard 28 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall review the management of eye preparations to ensure these are stored appropriately and administered as prescribed. Ref: 6.2.7
	Response by registered person detailing the actions taken: Eye preparations removed from fridge on day of inspection as advised.

Area for improvement 7 **Ref**: Standard 29 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall review the management of the disposal of medicines to ensure the appropriate procedures for nursing homes are being followed. Ref: 6.2.7 **Response by registered person detailing the actions taken:** All RN staff dispose of medicines in Cannon waste bin and record in disposal records.
Area for improvement 8 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 8 January 2021	The registered manager shall ensure that the medicines management policies and procedures are reviewed and developed to ensure they are reflective of current practice. Ref: 6.2.11 **Response by registered person detailing the actions taken:** Policies have been reviewed and developed and are reflective of current practice.

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

The Regulation and Quality Improvement Authority

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