Unannounced Care Inspection Report
12 January 2017

Ladyhill Lodge Private Nursing Home

Type of Service: Nursing Home
Address: 40 Creevery Road, Antrim, BT41 2LQ
Tel no: 028 9446 6905
Inspector: Lyn Buckley

1.0Summary

An unannounced inspection of Ladyhill Private Nursing Home took place on 12 January 2017 from 11:15 to 17:15 hours.

This inspection was carried out to follow up on information received by RQIA, on 15 December 2016 and 11 January 2017; from the Northern Health and Social Care Trust (NHSCT). Issues had been raised with the Trustas part of the complaints and adult safeguarding processes. Concerns related to the delivery of care when a patient was ill or deteriorating, management of falls, management of food and fluid intake and management of complaints. In addition, RQIA received information from a relative and an anonymous source on 28 December 2016 raising similar issues.

Following this inspection RQIA were satisfied that care delivered in Ladyhill Lodge Private Nursing Home was meeting the needs of patients. However, management must ensure that the requirements and recommendations made are addressed and embedded into practice. This will further enhance the quality and delivery of safe and effective care.

Details of the inspection process and findings can be viewed in the body of this report.

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.

1.1Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	8	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Dr Marina Lupari, Responsible Individual and acting 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.

1.2Actions/enforcement taken following the most recent care inspection

The last care inspection was undertaken on 14 September 2016. This inspection was announced. The actions required to address the QIP were reviewed as part of this inspection. Details can be viewed in section 4.2.Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Town & Country Care Homes Limited/ Dr Marina Lupari	**Registered manager:** Position vacant; Dr Marina Lupari is the acting manager since 29 November 2016.
Person in charge of the home at the time of inspection: Registered Nurse William Brimley	**Date manager registered:** Not applicable
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 31

3.0 Methods/processes

This inspection was carried out to follow up on information received by RQIA, on 15 December 2016 and 11 January 2017; from the Northern Health and Social Care Trust (NHSCT). Issues had been raised with the Trustas part of the complaints and adult safeguarding processes. Concerns related to the delivery of care, management of falls, management of food and fluid intake and management of complaints. In addition, RQIA received information from a relative and an anonymous source on 28 December 2016 raising similar issues.

It is not the remit of RQIA to investigate complaints or safeguarding allegations made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential breach of regulations or associated standards, it will review the matter and take whatever appropriate action is required; this may include an inspection of the home. Following discussion with senior management, it was agreed that an unannounced care inspection would be undertaken to review the following areas:

- delivery of safe and effective care
- management of accidents, incidents and notifiable events
- the management of nutrition and weight loss
- the management of complaints

Prior to inspection we analysed the following information:

- the registration status of the home
- written and verbal communication received by RQIA since the previous care inspection
- the previous care and medicines management inspection report
- the returned QIP from the previous care and medicines management inspection
- notifications received since the previous care inspection undertaken on 14 September 2016

The following records were examined during the inspection:

- staff duty rotas from 2 – 15 January 2017
- accident and incident records
- six patient care records
- complaints record
- patient register

We also undertook a general inspection of the premises which included a review of all bathrooms/shower rooms and communal spaces; and a number of patients' bedrooms. .

A number of patients were spoken with during the inspection and we had the opportunity to consult with one relative. We also spoke with one registered nurse, one adaptation nurse, three care assistants, two housekeeping staff and two catering staff.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 December 2016

The most recent inspection of the homewas an unannounced medicines managementinspection. The completed QIP was returned and approved by the pharmacist inspector.

During this inspection we followed up the improvements made regarding the following;

- delegation of nursing tasks to care assistants in relation to the management of thickening agents, external preparations/topical medications and nutritional supplements
- the management of nutritional supplements and enteral feeding regimes

Details of our findings can be viewed in the main body of the report.

4.2 Review of requirements and recommendations from the lastcare inspection dated 14 September 2016

Last careinspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 27(4) **Stated:** First time	The registered provider must ensure that fire doors are not wedged or propped open. If a door requires to be open to enable access then a hold open device linked to the fire alarm system should be fitted to the door.	**Met**
	Action taken as confirmed during the inspection: Observations during the inspection evidenced that this requirement had been met.	

Last careinspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 39.9 **Stated:** First time	The registered person should ensure that staff are aware of regional guidance and best practice evidence which underpins their practice and is commensurate with their role and function in the home.	**Met**
	Action taken as confirmed during the inspection: Discussion with the responsible individual confirmed that progress had been made in developing resource files for staff. Regional guidelines were available in the nurses' office.	

4.3 Inspection findings

4.3.1 Safe and effective care

Discussion with the nurse in charge of the home and with Dr Lupari confirmed the planned staffing levels for the home and that these levels were kept under review to ensure the assessed needs of the patients were met. Care assistants confirmed that they had time to meet patients' needs. Observations evidenced staff attending to patients needs in a caring and respectful manner.

It was evident that staff knew the patients well and interactions between patients and staff were appropriate. Those patients able to express their views confirmed that the care they received was good and that staff were kind and caring. One relative spoken with confirmed that they were very satisfied with how their loved one was cared for and that they had confidence in the management and staff to do the "right thing". Those patients unable to verbalise their views appeared relaxed and comfortable with staff.

Review of patient records evidenced that when a patient became unwell or their condition deteriorated that appropriate action was taken with timely referral to the patient's General Practitioner (GP) and other relevant healthcare professionals as required.

Review of two patient records evidenced that nursing needs and care plans had not be reviewed following changes to patients' health and well-being. For example, two identified patients' nursing assessments and care plans had not been updated sinceMarch 2016for one patient and August 2015 for the other.

Discussion with staff evidenced that they were aware of changes in the patients' care needs and had taken action to deliver the care required. However, it was concerning that nursing staff had not reviewed and updated nursing assessments and care plans to accurately reflect the patients' needs.Details of specific findings were discussed with Dr Lupari during feedback. Two requirements have been made in relation to assessment of nursing needs and care planning.

During feedback we acknowledged that Dr Lupari and her senior management team had previously identified deficits in the nursing process and record keeping standards and details of a care file audit undertaken in November 2016 were shared with RQIA on 20 January 2017 by email. We also acknowledged, one patient record reviewedwhich did evidence the improvements made to the assessment and care planning process. However, as stated previously, two of the patient records reviewed did not reflect the needs of the patients and requirements have been made.

Discussion with the nurse in charge confirmed that the home maintained a patient register. We reviewed this document but were unable to determine accurately the movement of patients into or out of the home. Dr Lupari confirmed that she was aware of the inaccuracies of the register and had taken advice from colleagues on how best to manage the patient register.
Dr Lupari agreed to provide RQIA with accurate information regarding patient deaths, admissions to hospital and return to the home by email. This was received by RQIA on 23 January 2017 by email. A recommendation has been made.

Areas for improvement

A requirement was made that the assessment of nursing needs is kept under review and revised at any time when it is necessary to do so and in particular when changes in the patient's needs occur.

A requirement was made that the patient's care plan is kept under review and reflects the care delivered to meet the patient's assessed needs.

A recommendation was made regarding the maintenance of a patient register.

Number of requirements	2	**Number of recommendations**	1

4.3.2 Management of accidents, incidents and notifiable events

Review of the home's accident/incident records evidenced that accidents/incidents were recorded as they occurred and included details of the persons involved and the action taken at the time. The nurse in charge and Dr Lupari both confirmed that there had been no falls occurring in at least three months and confirmed that the last incident had occurred on 18 December 2016 as recorded in the accident/incident book.

During feedback we discussed and confirmed the requirements to notify RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. This regulation includes the notification to RQIA of any concerns regarding staff conduct, referrals to the adult safeguarding team or when the Trust notified the manager of a safeguarding investigation. Dr Lupari confirmed she was aware of a recent complaint but had not been informed by the NHSCT that the complaint was referred to the adult safeguarding team. We advised that RQIA must be notifiedwhen this was confirmed.

In addition we also discussed historical notifications which had still to benotified to RQIA.On 19 December 2016, in Daisyhill Nursing Home, it was agreed that the historical notification from Ladyhill Lodge would be forwarded to RQIA. Dr Lupari advised that they had changed internet provider and that the notifications had been sent as agreed. RQIA had not received them and Dr Lupari agreed to resend them. At the time of issuing this report RQIA had still not received these notifications therefore a requirement has been made.

Areas for improvement

A requirement was made that RQIA are notified of any event occurring in the nursing home in accordance with The Nursing Homes Regulations (Northern Ireland) 20015 – regulation 30.

Number of requirements	1	Number of recommendations	0

4.3.3 Management of nutrition and weight loss

Discussion with staff evidenced that patients were weighed on a regular basis. Review of records confirmed this information. Staff were knowledgeable of patients' nutritional needs and were able to respond to specific enquiries. For example, the reasons why a patient might refuse to eat or drink or which certain foods were preferred or how fluids were to be thickened.

During the medicines management inspection in December 2016 thedelegation of administration of thickening agents and some topical medicines to care assistants had been identified as a concernand requirements were made. Since that inspection specific records for completion by care assistants had been developed and implemented. Staff confirmed that when a patient was prescribed a nutritional supplement or required use of a thickening agent for their food andfluids,care assistants delegated this task would sign they had administered this medicine on the new record sheet. The nurse in charge also confirmed this and that nursing staff checked that the administration had taken place.

However, review of three care assistant administration records evidenced that they had not been completed consistently, there was no evidence that nursing staff had monitored the administration of theses medicines and there was no record of administration after 9 January 2017. In addition it was established that a nutritional supplement, recorded on these records, for an identified patient, was not recorded on the patient's main prescription sheet, as required. This was concerning and the nurse in charge agreed to check this information with the patient's GP. While it was good to evidence the actions taken to drive improvement,it was evident that further improvements wererequired to ensure the safe administration of medicines. This concern was discussed with the pharmacist inspector for the home and a requirement was made in relation to the management of nursing task delegated to care assistants.

In addition to the administration of medicines we were informed that some care assistants undertook enteral feeding. This was discussed with Dr Lupari and advice provided to ensure formal training had been delivered and that any care assistant undertaking enteral feeding was assessed and deemed competent and capable of managing this specialised nursing task. A requirement has been made.

In relation to the management of patients' nutritional needs there was evidence within the care records reviewed that referrals had been made to dieticians and speech and language therapists (SALT). However, as stated previously RQIA were concerned that nursing staff had not reviewed and updated assessments and care plans as required; requirements have been made. Refer to section 4.3.1.

Patients' daily progress notes reviewed lacked evidence of nursing staff evaluating the delivery of care in relation to food and fluid intake. There was also a lack of evidence, within the record reviewed, to supportany subsequent actions taken when weight loss was identified or when patients had refused a meal/snack. Details of findings were provided to Dr Lupari during feedback. A recommendation was made.

The responsible individual discussed improvements put in place since the last inspection in relation to the management of therapeutic diets and the management of thickening agents for food and fluids. The improvements included the development and use of a resource file containing specific details regarding consistencies of food and fluids and a recorded process to support staff in achieving competency in the delivery of this care.

Review of food and fluid intake charts evidenced a number of issues that should be addressed as follows:

- fluid intake and output charts did not record the desired fluid intake levels for each patient as required on the form
- staff did not record the type (thickness) of fluid for the patient as requiredon the form
- staff did not record enteral feed intake on the charts – this was also identified during the medicines management inspection and a recommendation was made
- different charts were in place for the management of enteral feeding regimes – a consistent approach should be implemented to avoid confusion

A recommendation has been made.

Inspectors observed an enteral feeding syringe, containing a small amount of milky fluid and a sterile water pouch on a shelf of the bookcase in one lounge. During discussion it was confirmed that the syringe and water belonged to a patient and staff stored these items for ease of use. This practice is not in accordance with best practice guidelines and should cease. Equipment used for patients must be stored appropriately and in keeping with best practice guidelines for enteral feeding and infection prevention and control. A requirement has been made.

In addition it was also observed that single use syringes were used to administer liquid medicines then the syringes were washed and reused communally along with specific medicine syringes and medicines cups. These items were also stored wet on top of the medicine trolley in a container or stacked. This practice must cease in keeping with infection prevention and control practice guidance and manufacturer's instructions for single use items. Details were discussed with Dr Lupari and the nurse in charge. A requirement was made.

The serving and management of the lunch time meal was observed. The meal served was pork chops with a peppercorn sauce, peas, sweetcorn and potatoes and the meal was modified, as required for patients requiring a therapeutic diet.There was no dessert served. Patients came into the dining room at different times which enabled staff to manage the individual needs of patients in a timely and appropriate manner. One patient,who refused their meal was offereda choice of ham or cheese sandwich as an alternative. During discussion it was confirmed that patients would not be offered a choice of meal unless they expressed their preference and observations confirmed that a menu for patients was not available. Details were discussed with Dr Lupari during feedback and a recommendation was made to review the mealtime experience of patients.

Patients were also assisted with their meal in one of the lounges or in their bedroom. Trays were provided by catering staff but the food was not covered when being transported through the home. The bowls of two meals observed in the supervised lounge felt cold to the touch. A care assistant returned the bowls of food to the kitchen to be re heated. This was concerning because the bowls of food were observed to be taken immediately from the kitchen to the lounge. Catering staff confirmed that they routinely checked the cooking temperatures of foods but not the serving temperature. During feedback Dr Lupari agreed to review this matter immediately.

Areas for improvement

A requirement was made that where the administration of medicines is delegated to a care assistant by a registered nurse that both staff are aware of their responsibilities and that the registered nurse is still accountable for the administration of the medicine. Where there is approval for care assistants to undertake administration of certain medicines such as thickening agents, nutritional supplements or topical medicines; there is evidence that they have been formally trained and deemed competent and capable to do so.

A requirement was made that until the practice of care assistantsmanaging enteral feeding regimes is reviewed in conjunction with the identified patients' care manager/dietician, that this practice ceases due to the risk to patients. Where there is approval for care assistants to undertake this procedure there is evidence that they have been formally trained and deemed competent and capable of delivering enteral feeding.

A requirement was made that syringes and water used for enteral feeding are appropriately stored; that single use syringes are used only once and then discarded; that any medicine syringe is used for the named patient only and is not used communally.

A recommendation was made that nursing staff clearly record their evaluation of the delivery of care to patients within each individual patient care record. Details of any action taken when prescribed care has had to change should also be clearly recorded.

A recommendation was made that records pertaining to food and fluid intake are reviewed to ensure they accurately reflect and meet patient needs; and records should be consistently and accurately maintained.

A recommendation was made that the mealtime experience of patients be reviewed in accordance with regional nutritional guidelines and DHSSPS Care Standards for Nursing Homes.

Number of requirements	3	**Number of recommendations**	3

4.3.4 Management of complaints

The complaints book was reviewed; the last recorded complaint was on 8 November 2016 and prior to that the 9 August 2016. The recording of the details of the complaint was incompleteas no outcome or actions taken had been recorded for either and onecomplaint was not signed by the person recording it.

As stated previously RQIA were aware of a complaint received by the home in December 2016. This complaint had not been recorded and a requirement was made.

Areas for improvement

A requirement was made that a record of all complaints is kept in the nursing home.

Number of requirements	1	**Number of recommendations**	0

4.3.5 Premises

An inspection of the premises was undertaken and the lounges, dining room and the majority of bedrooms were reviewed. Since the previous care inspection there was evidence of improvements to the bedrooms and communal areas of the home. Dr Lupari confirmed that plans for other changes would be notified as required to RQIA.

The home was presented to a high standard of hygiene and cleanliness and was warm and comfortable throughout.

The following risks were identified and require to be addressed:

- a number of wardrobes in bedrooms were not secured to the wall
- a free standing electric radiator was observed in one bedroom
- a coiled electric extension lead was in use in one bedroom
- the toilet opposite the kitchen had no running water. It was confirmed this was to be decommissioned and was not in use – there was no signage indicating 'out of use'

Areas for improvement

A requirement was made that that all parts of the home to which patients have access are free from hazards to their safety; and that unnecessary risks to the health or safety of patients are identified and so far as possible eliminated.

Number of requirements	1	Number of recommendations	0

5.0 Quality improvement plan

Any issuesidentified during this inspection are detailed in the QIP. Details of the QIP were discussed with Dr Marina Lupari, Responsible Individual and acting manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to the RQIA web portal for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlinedin this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 15 **Stated:** First time **To be completed by:** Immediate action required	The registered provider must ensure that the assessment of nursing needs is kept under review and revised at any time when it is necessary to do so and in particular when changes in the patient's needs occur. **Ref: Section 4.3.1**
	Response by registered providerdetailing the actions taken: All registered nurses have been advised to review care plans monthly and update as required or when a patients needs change.
Requirement 2 **Ref:** Regulation 16 **Stated:** First time **To be completed by:**Immediate action required	The registered provider must ensure that the patient's care plan is kept under review and reflects the care delivered to meet the patient's assessed needs. **Ref: Section 4.3.1**
	Response by registered providerdetailing the actions taken: We have now in place a procedure where care plans are reviewed on a monthly basis by each patients lead nurse and we have an audit process in place to ensure that each nurse responsible is adhering to this. This will be managed through operational supervision.
Requirement 3 **Ref:** Regulation 30 **Stated:** First time **To be completed by:**Immediate action required	The registered provider must ensure that RQIA are notified of any event occurring in the nursing home in accordance with The Nursing Homes Regulations (Northern Ireland) 2005 – regulation 30. **Ref: section 4.3.2**
	Response by registered providerdetailing the actions taken: All Registered Nurses have been updated on what events require this notification again. All RNs have been directed in the completion of the required documentation and notify RQIA. The Registered Provider has resent the notifications to RQIA that had been sent previously on 16th October 2017.

Requirement 4 **Ref:** Regulation13(4) **Stated:** First time **To be completed by:** Immediate action required with completion by 31 March 2017	The registered provider must ensurethat where the administration of medicines is delegated to a care assistant, by a registered nurse, that both staff are aware of their responsibilities and that the registered nurse is still accountable for the administration of the medicine. Where there is approval for care assistants to undertake administration of certain medicines such as thickening agents, nutritional supplements or topical medicines; there is evidence that they have been formally trained and deemed competent and capable to do so. **Ref: Section 4.3.3**
	Response by registered providerdetailing the actions taken: Training for care assistants on the use and administration of certain medications is cntinuing. This incluses evidnece that they have been formally trained and deemed competent. All RNs have been reminded of their accountability.
Requirement 5 **Ref:** Regulation 20 (1) **Stated:**First time **To be completed by:** Immediate action required with completion by 31 March 2017	The registered provider must ensure that until the practice of care assistants managing enteral feeding regimes is reviewed,in conjunction with the identified patients' care manager/dietician, that this practice is ceased due to the risk to patients. Where there is approval for care assistants to undertake this procedure there is evidence that they have been formally trained and deemed competent and capable of delivering enteral feeding. **Ref: Section 4.3.3**
	Response by registered providerdetailing the actions taken: The practice of care assistants managing entreal feeding regimes has now ceased.
Requirement 6 **Ref:** Regulation 12(1) (2) and (3) **Stated:** First time **To be completed by:** Immediate action required	The registered provider must ensure that • syringes and water used for enteral feeding are appropriately stored • that single use syringes are used only once and then discarded • that any medicine syringe is used for the named patient only and is not used communally **Ref: Section 4.3.3**
	Response by registered providerdetailing the actions taken: The syinges and water used for the enteral feeding are stored in the treatment room or individual patients bedroom. All Registered Nurses have been informed of this. Single use syringes are discarded after each use.

Requirement 7 **Ref:** Regulation 19(2) Schedule 4(11) **Stated:** First time **To be completed by:** Immediate action required	The registered provider must ensure that a record of all complaints is kept in the nursing home. **Ref: Section 4.3.4**
	Response by registered providerdetailing the actions taken: A Complaints book is in place for documenting any complaints received and has been updated accordingly.
Requirement 8 **Ref:** Regulation 14(2) (a)(b) and (c) **Stated:** First time **To be completed by:** Immediate action required	The registered provider must ensure that all parts of the home to which patients have access are free from hazards to their safety; and thatunnecessary risks to the health or safety of patients are identified and so far as possible eliminated. **Ref: Section 4.3.5**
	Response by registered providerdetailing the actions taken: A recent Estates inspection has deemed the home to be safe.
Recommendations	
Recommendation 1 **Ref**: Appendix 1 of DHSSPS Care Standards for Nursing homes (2015). **Stated:**First time **To be completed by:**28 February 2017	The registered provider should ensure, the patient register in place is accurately maintained in accordance with DHSSPS Care Standards for Nursing homes (2015). **Ref: Section 4.3.1**
	Response by registered providerdetailing the actions taken: All Registered Nurses have been informed that they must complete the patient register as and when a patient is admitted or discharged from the home. This will be monitored by the Registered Provider to ensure that Registered Nurses are adhering to this.
Recommendation 2 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:**Immediate action required	The registered provider should ensure that nursing staff clearly record their evaluation of the delivery of care to patients within each individual patient care record. Details of any action taken when prescribed care has had to change should also be clearly recorded. **Ref: Section 4.3.3**
	Response by registered providerdetailing the actions taken: All staff have been reminded that they are required to document all delivery of care to the patients in their individual progress notes and care plan amended on a ongoing basis. This will be audited on a regular basis to ensure that all records are being maintained correctly.

Recommendation 3 **Ref**: Standard 4.9 **Stated:**First time **To be completed by:**28 February 2017	The registered provider should ensure that records pertaining to food and fluid intake are reviewed to confirm they accurately reflect and meet patient needs and that the recordisconsistently and accurately maintained. **Ref: Section 4.3.3**
	Response by registered providerdetailing the actions taken: All staff have been advised to complete all food and fluid documentation as soon as is possible after food or fluid has been given in order to ensure that the correct information is documented.
Recommendation 4 **Ref**: Standard 12 **Stated:** First time **To be completed by:**31 March 2017	The registered provider should ensure that the mealtime experience of patients is reviewed and the necessary improvements made; in accordance with regional nutritional guidelines and DHSSPS Care Standards for Nursing Homes. **Ref: Section 4.3.3**
	Response by registered providerdetailing the actions taken: We are currently working with all care and kitchen staff to ensure that all meals provided adhere to regional nutritional guidelines and that each patients meal provided is person centred as per their likes and dislikes while meeting their individual needs as advised by both the dietican and S.A.L.T. It is important to note that we provide dessert for our residents at 3pm each day and it is taken much better than when given at 12.45pm.

Please ensure this document is completed in full and returned to the RQIA web portal

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