Unannounced Care Inspection Report
29 July 2019

Leabank

Type of Service: Nursing Home
Address: 1 Beechwood Avenue, Ballycastle BT54 6BL
Tel no: 028 2076 3392
Inspectors: Gillian Dowds & Judith Taylor

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 registered nursing home which provides care for up to 53 patients.

3.0 Service details

Organisation/Registered Provider: Leabank **Responsible Individuals:** Brian Macklin & Mary Macklin	**Registered Manager and date registered:** Matilda Kathleen Annette Lindsay Acting
Person in charge at the time of inspection: Annette Lindsay	**Number of registered places:** 53
Categories of care: Nursing Home (NH) I – Old age not falling within any other category DE – Dementia PH – Physical disability other than sensory impairment A maximum of nine patients in category NH-DE. There shall be a maximum of one named resident receiving residential care in category RC-I.	**Number of patients accommodated in the nursing home on the day of this inspection:** 53

4.0 Inspection summary

An unannounced inspection took place on 29 July 2019 from 09.40 to 19.20.

This inspection was undertaken by the care and pharmacist inspectors.

The term ‘patient’ is used to describe those living in Leabank which provides nursing and residential care.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

In relation to care, evidence of good practice was found regarding staff knowledge of their patients likes and dislikes interaction between staff and patients, recruitment and staff training, the environment and infection prevention and control.

Areas requiring improvement were identified in relation to supervision arrangements in the dementia unit, management of unwitnessed falls, patient access to equipment, fluid target and evaluation of wound care, supplementary care recording and oversight by nurses, care planning in relation to infections.

In relation to medicines management, there was evidence of good practice regarding the auditing processes for medicines, the completion of personal medication records, the management of controlled drugs and the storage of most medicines.

We identified areas for improvement in relation to medicine related incidents, the administration of medicines, the management of thickening agents and the completion of records.

Patients described living in the home as being a good experience. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others and with staff.

Comments received from patients, people who visit them and staff during and after the inspection, are included in the main body of this report.

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

Details of the Quality Improvement Plan (QIP) were discussed with Annette Lindsay, Manager and Christine Thompson, Regional 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.

4.2 Action/enforcement taken following the most recent inspection dated 22 March 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 22 March 2019. Other than the actions detailed in the QIP, no further actions were required to be taken following the most recent inspection on 22 March 2019.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including medicines management, registration information, and any other written or verbal information received. For example serious adverse incidents.

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire.

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from 15 July 2019 to 04 August 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records and competency assessments
- incident and accident records
- two staff recruitment and induction files
- six patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits/records
- complaints record
- compliments received
- a sample of reports of visits by the registered provider
- RQIA registration certificate
- medicines received
- personal medication records
- medicine administration records
- medicines disposed of
- controlled drug record books
- medicine storage temperatures
- medicine audits and action plans
- medicines management care plans

Areas for improvement identified at the last 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 inspections

Areas for improvement from the last care inspection on 22 March 2019		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time	The registered person shall review the process for the administration of medicines as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: Observation of the medication rounds satisfactory met as stated.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered person shall review the existing 'falls prevention' policy and procedure with consideration of the points mentioned in this report.	**Met**
	Action taken as confirmed during the inspection: The falls prevention and procedure were reviewed as stated.	

Areas for improvement from the last medicines management inspection on 7 January 2019		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 18 **Stated:** Second time	The registered person shall review the management of distressed reactions to ensure that a care plan is maintained and that the reason for and the outcome of administration is recorded on each occasion, for medicines prescribed on a "when required" basis.	**Met**
	Action taken as confirmed during the inspection: The management of distressed reactions had been further developed. Examination of a sample of records indicated that a care plan was in place and evaluated on a regular basis. A separate administration record had been brought into use and included the reason for and outcome of any administration.	

	We observed that these medicines were infrequently administered.	
Area for improvement 2 **Ref**: Standard 31 **Stated:** First time	The registered person shall review the management of controlled drugs.	**Met**
	Action taken as confirmed during the inspection: We reviewed the management of controlled drugs. Records were well maintained and controlled drugs were safely disposed of.	
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that patients' care plans are reflective of their healthcare needs.	**Met**
	Action taken as confirmed during the inspection: We examined a selection of care plans in relation to their healthcare needs e.g. diabetes, pain, warfarin and swallowing difficulty; the necessary information had been recorded.	
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time	The registered person shall make the necessary arrangements to ensure correlation with personal medication records and corresponding medication administration records.	**Met**
	Action taken as confirmed during the inspection: There were systems in place to review these records every month. There was evidence of correlation of records in the sample of records examined.	

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The manager confirmed the planned daily staffing levels for the home and that these levels were subject to monthly review to ensure the assessed needs of the patients were met. A review of the staffing rota evidenced that the planned daily staffing levels were adhered to. The manager also confirmed that agency staff would be employed to cover sick leave if necessary to ensure the assessed needs of the patients were met.

Staff spoken with were satisfied there were sufficient staff on duty to meet the needs of the patients and did not raise any concerns about staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Staff attended to patients' needs in a timely and caring manner, call bells were answered promptly and staff were observed to be helpful and attentive towards patients.

However, it was observed that the lounge in the dementia unit was left unsupervised at times when staff were attending to patients needs and happened on more than one occasion during the inspection. This was discussed with staff in the unit and also with the manager and regional manager at the time of inspection around staffing and supervision of patients in this unit and an area for improvement was identified.

During the course of the inspection we were advised of a lack of co-operation and effective communication between day and night staff. We reviewed the staff training register and this confirmed that staff had received training in dementia care. This information was raised with the manager and regional manager at the time of the inspection; they agreed to review this with immediate effect.

We also sought staff opinion on staffing via the online survey; no responses were received. Patients spoken with were generally satisfied with staffing levels.

Review of two staff recruitment and induction files evidenced that appropriate pre-employment checks had been completed. Discussion with staff and review of records confirmed they had completed a period of induction and that they received regular supervision and a yearly appraisal Review of records confirmed there was a system in place to monitor the registration status of nursing and care staff with the NMC and the NISCC and this clearly identified the registration status of all staff.

Discussion with staff confirmed they were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding. Review of training records confirmed staff had completed mandatory training in this area and also that the manager had completed training in the role of adult safeguarding champion (ASC).

Infection prevention and control (IPC) measures were observed to be adhered to within the home. Staff were observed to use personal protective equipment (PPE) which was readily available and also to carry out hand hygiene appropriately.

Discussion with the manager and review of records confirmed that falls occurring in the home were analysed to identify if any patterns or trends were emerging and an action plan was devised if necessary. However, it was identified that neurological observations were not consistently recorded when an unwitnessed fall occurred, particularly at night. Please refer to section 6.4 for further information.

We reviewed the home's environment; this included observations of a sample of bedrooms, bathrooms, lounges, dining rooms, treatment rooms, sluices and storage areas. The home was found to be warm, well decorated and fresh smelling throughout. Patients' bedrooms were personalised and tastefully decorated. Sluices were found to be clean and tidy. Corridors and fire exits were clear and free from obstruction.

In the downstairs lounge/dining area there also was a portable hot plate sitting on a trolley this was discussed with the manager and she agreed to remove it. In the dementia unit there was an unlocked electrical supply cupboard. These presented a potential risk to the health and safety of patients. An area for improvement was made.

The dementia unit was discussed with the manager in respect of decoration and signage and she confirmed she had already identified this and was in touch with an organisation to review and supply this for her. This will be reviewed at the next care inspection.

Medicines Management

The following areas were examined during the medicines management element of the inspection and were found to be satisfactory:

- staff training and competency
- admission process with regards to medicines management
- disposal of medicines records
- personal medication records
- medicine administration records
- management of controlled drugs
- management of distressed reactions
- management of antibiotics
- management of insulin
- management of pain

We reviewed the ordering processes for medicines and confirmed with staff that all medicines were available for administration. However, we did note that in the last few months there had been some instances where patients did not have a continuous supply of their medicines. Whilst staff advised of the action taken to resolve, there was no evidence that any missed doses due to lack of supply of the medicine, were reported to management or considered as notifiable events to RQIA. An area for improvement was made.

The audit trails of the majority of medicines produced satisfactory outcomes. The date of opening of medicines was routinely recorded. However, we observed discrepancies in five liquid medicines and one inhaled medicine. These were brought to the attention of management and staff and it was agreed the patients' prescribers would be made aware. The measuring of liquids was also discussed. Management advised they had already identified this through their recent internal audit and advised of the planned action to closely monitor these medicines. An area for improvement was made.

With the exception of records for incoming medicines, the medicine records were well maintained. We noted that not all of the medicines had been receipted accurately for the current medicine cycle. This is necessary to ensure there is a clear audit trail. An area for improvement was made.

The management of thickening agents was reviewed. We observed that the relevant care plans and speech and language assessment reports were in place. The prescribed consistency level was recorded on the personal medication records, medication administration records and shift handover sheet. Administration was recorded by nursing staff but there was no system to enable the care staff to do this. Advice was given. In relation to storage, thickening agents were not stored securely and were observed in the dining room and bedrooms. These should be stored securely to prevent any unintended use. An area for improvement was made.

The management of enteral feeding was reviewed. The relevant details were recorded on the personal medication records and the written regime was in place. Staff had not recorded the total daily fluid intake each day and there was no evidence that this was checked to ensure the prescribed daily target fluid intake had been achieved. An area for improvement was made.

All medicine trolleys and cupboards were kept locked and keys held by nursing staff. One medicine trolley needed to be cleaned, this was discussed with management and staff and assurances were provided that it would be cleaned following the inspection.

The auditing arrangements for medicines were reviewed. From discussion with management and a review of the governance arrangements for medicines management, we acknowledged that most of the above issues had been identified and plans were in place to address them. The manager also provided us with an action plan regarding medicines management.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to recruitment, training, the environment and infection prevention control, the auditing processes for medicines, the management of controlled drugs and the completion of personal medication records.

Areas for improvement

Areas for improvement were identified in relation to supervision of the lounge in the dementia unit, patient access to hot plate/electric cupboard, reporting of medicine related incidents, records for incoming medicines, the administration of medicines, storage and administration of thickening agents and records of total daily fluid intake.

	Regulations	Standards
Total number of areas for improvement	3	4

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

We observed the delivery of care to patients throughout the inspection and it was obvious staff knew them well and had a good understanding of their care needs. We observed that patients received the right care at the right time. Staff demonstrated effective communication skills and were seen to attend to patients in a caring and timely manner.

We reviewed six patients' care records in relation to the management of nutrition, falls, wounds, pressure area care and the use of potentially restrictive practices such as bedrails. Care records contained details of the specific care requirements in the areas reviewed and a daily record was maintained to evidence the delivery of care. Care records reflected that, were necessary, referrals were made to other healthcare professionals and care plans had been reviewed in accordance with any recommendations they made.

Patients nutritional needs had been identified and validated risk assessments were completed to inform care planning. Patients' weights were monitored on at least a monthly basis and there was evidence of referral to, and recommendations from, the dietician and the speech and language therapist (SALT) where required. Review of supplemental care records evidenced that patients' daily food and fluid intake was recorded and these records were up to date. However some patients had a 24hr fluid intake recorded but no specific fluid target recorded in a care plan. There was no evidence of any actions taken if a patient's fluid intake was poor. An area for improvement was identified as per section 6.3.

We reviewed the management of falls in the home; the care records reviewed evidenced that validated risk assessments and care plans were in place to direct the care required. Staff demonstrated their knowledge of the management of falls and how to care for patients who had a fall. Patient's risk assessments and care plans were reviewed and updated following a fall. In some of the recorded unwitnessed falls it was evident that these had not been considered a potential head injury and neurological observations were not evidenced to be recorded in line with best practice guidance. This was discussed with the home manager and an area for improvement was identified.

We reviewed the management of wounds for four patients. There was evidence of referral to other healthcare professionals and their recommendations were included in the care plans. Daily records were not fully reflective of dressing changes. Gaps in the recording of wound care was evident and also in one case there was a detailed care plan for a wound but no wound chart was in place to indicate care provided. On discussion with the manager it was clarified that this particular wound had healed. An area for improvement was identified.

Validated risk assessments and care plans were in place to direct care for the prevention of pressure ulceration in the care records reviewed. Patients had appropriate pressure relieving aids, such as mattresses and cushions, if required. However, we observed 'gaps' in the recording on one of the repositioning charts reviewed. While feedback from staff provided assurance that the skin condition of identified patients was satisfactory, the repositioning charts viewed did not provide assurance that staff were repositioning patients as frequently as required. An area for improvement was identified.

We also evidenced that mattress settings were recorded in the patients plan of care and a system was in place for the daily checking of the settings of each mattress. It was identified that the mattress setting for one patient was incorrect, although it was indicated it had been checked. This was discussed with the manager during the inspection and she assured us that she would address this.

We reviewed care records for the management of the use of bedrails. These could potentially restrict a patient's choice and control and we found that the appropriate validated risk assessments had been completed. Care plans evidenced a rationale for the use of bedrails and were regularly reviewed and discussion form in place.

We reviewed the records of a patient who had been on antibiotic medication for a chest infection and no care plan was in place to direct the care required. An area for improvement was identified.

Supplemental care records were reviewed in relation to bowel management and evidenced good system for recording. However, the oversight of these records by the registered nurses was not evident in the daily evaluation of care this was discussed with the manager. An area for improvement was identified.

Areas of good practice

There were examples of good practice found throughout the inspection in relation communication between staff and patients, management of the use of bedrails.

Areas for improvement

The following areas were identified for improvement in relation to management of unwitnessed falls, wound care, recording of repositioning, management of infections and bowel monitoring management.

	Regulations	Standards
Total number of areas for improvement	2	3

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

During the inspection we spoke to 10 patients and one visitor to discuss their experience in the home. Patients who could not communicate their needs looked relaxed and well cared for. Comments from patients were positive and complimentary about life in the home these included:

- ‘‘Great place.”
- “Couldn’t beat it with a big stick.”
- “No better place.”
- “Staff very good.”
- “Look after me very well.”

A visitor spoken to felt staff were very good with patients but were of the opinion that the dementia unit was understaffed, particularly at night. This was discussed with the manager and we discussed the staffing levels and supervision in the home as discussed in section 6.3.

Staff were observed to treat the patients with respect and dignity and maintained their privacy. Staff were observed knocking patients bedroom doors before entry.

On the day of inspection we observed the serving of lunch. Patients were encouraged to eat at the dining table and staff were observed to be present in the dining area and offered the patients choice and encouragement to eat their meal. Staff were also observed offering assistance to patients with their meal. Patients able to communicate indicated that they enjoyed their meals. Tables in the dementia unit did not have place settings or condiments to enable patient choice. An area for improvement was identified.

Patients spoken with indicated they were happy with their meals comments such as:

- “Good.”
- “Food is very good.”
- “Plenty to eat.”

Staff spoken to were able to discuss their roles and responsibilities in the home and reported that they work well together and were able to discuss the patient’s likes and dislikes and understood their needs.

Staff spoken to were mostly positive about teamwork and working within the home with commenting that

- “Good team work “
- “Staffing is fine, as long as no one rings in sick”

We provided 10 questionnaires two were returned one indicated they were satisfied with the service received in Leabank the other indicated they were not satisfied and the comments on this were shared with the manager for her information and to action as required.

We provided a poster inviting staff to provide us with their views and opinions of the home and the care delivered, on-line; no responses were received before the issue of this report.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff interaction with patients, staff knowledge of patients like and dislikes.

Areas for improvement

An area for improvement was identified in relation to the dining experience in the dementia unit.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was displayed in the entrance hall of the home. Discussions with staff and observations confirmed that the home was operating within the categories of care for which it was registered.

A review of the duty rota evidenced that the manager’s working hours and the capacity in which these were worked was not recorded; an area for improvement was made. Discussion with staff, patients and visitors confirmed that the manager’s working pattern allowed for plenty of opportunities to meet with her if necessary and that she was approachable and accessible. We discussed with the manager how she was developing in her role, managing change within the home and the level of support provided by the regional manager who agreed support would continue to be available.

Discussion with the manager and review of a selection of governance audits evidenced that systems were in place to monitor the quality of nursing care and other services provided in the home. Audits were completed to review, for example, accidents/incidents, IPC measures, falls, complaints and care plans. These audits identified shortfalls and action plans were in place to ensure improvement.

Discussion with the manager and review of records evidenced that systems were in place to ensure notifiable events were investigated and reported to RQIA or other relevant bodies appropriately; however, it was identified in some cases when no supply of a medication was available RQIA were not notified as discussed in section 6.3.

Review of records confirmed the home provided mandatory training to ensure staff were adequately trained for their roles and responsibilities. A mandatory training schedule was maintained and staff were reminded when training was due. Discussion with staff confirmed they were satisfied their mandatory training needs were met and that they had sufficient time to access training.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, quality improvement and developing good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Annette Lindsay, Manager and Christine Thompson, Regional Manager, as part of the inspection process, 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 14 (2) (a) (b) and (c) **Stated:** First time **To be completed by:** Immediately from the day of inspection	The registered person shall ensure as far as reasonably practicable unnecessary risks to the health and safety of the patients is identified and so far as possible eliminated. This is in relation to the portable hotplate outside the kitchen area and also access to the electrical supply cupboard. Ref: 6.3
	Response by registered person detailing the actions taken: The portable hotplate was removed on the day of inspection and has not been used in the dining area since.The electrical supply cupboards have now been locked and the key is placed in the general office, all responsible staff have access when required.
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 29 August 2019	The registered person shall review the management of incidents to ensure that staff recognise that when there is no supply of a medicine, this is reported to management and RQIA. Ref: 6.3
	Response by registered person detailing the actions taken: All nurses have been informed of the need to report to management when there is no supply of a resident's medication.Notice has been placed in both nurses stations.On a Wednesday all as and when required medications stock is checked, ordered on a Thursday and delivered on Friday. Night staff do this stock check. There is a stock check done on Sunday night pre monthly order.
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 29 August 2019	The registered person shall make the necessary arrangements to ensure that all medicines are administered as prescribed. Ref: 6.3
	Response by registered person detailing the actions taken: Medication issues identified in the recent inspection have been discussed with all nurses. New audit forms have been placed in the drug administarion files. All boxed and liquid medications are now audited as are metered inhalers. New Warfarin record documentation has been implemented. New insulin recording documentation has been implemented. New medicated patch documentation has been implemented. Nurses are now allocated to do a drug audit every month.

Area for improvement 4 **Ref:** Regulation 13 (1) (b) **Stated:** First time **To be completed by:** 1 October 2019	The registered person shall ensure that all unwitnessed falls are managed in line with current best practice guidelines and neurological observations are recorded. Ref: 6.4
	Response by registered person detailing the actions taken: Further training has taken place in house to ensure all staff are adhering to policy and completing necessary documentation. Management audit falls on a monthly basis and look for patterns. Following a fall, management are now investigating as soon as possible post fall, using reflective practice to learn from the incident and identify any training needs of the staff involved or identify the need for . A poster has been placed in each nurses station with the recent changes to the timings for recording of CNS observations, now 72 hours.
Area for improvement 5 **Ref:** Regulation 12 (1) (a)(b) **Stated:** First time **To be completed by:** 1 October 2019	The registered person shall ensure record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. Ref: 6.4
	Response by registered person detailing the actions taken: In house training has taken place on wound care management in an attempt to ensure all nurses comply with the guidance provided. A training session has been arranged for the 22nd October to be delivered by the Tissue Viabilty nurse.
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 41 **Stated:** First time **To be completed by:** immediately from day of inspection	The registered person shall review the supervision arrangements within the lounges in the home to ensure the patients are appropriately supervised. This is in particular reference to the dementia unit. Ref: 6.3
	Response by registered person detailing the actions taken: The ratio of carer to resident has been recently increased. We now have an extra carer on from 8am until 2pm. This extra carer pre inspection had been mainly worked in the nursing unit of the ground floor although they now go between both units. Timings depend on the needs of the residents in the dementia unit on any given day.Nurse working downstairs now spends more time in the dementia unit, completing medication administration at 10:00hrs, 14:00hrs and 18:00hrs. Nurse also supervises at meal times in the dementia unit. The relevant resident documentation is kept in the unit in a secure cupboard, nurse attends the unit to complete the progress notes.

Area for improvement 2 **Ref**: Standards 29 &30 **Stated:** First time **To be completed by:** 29 August 2019	The registered person shall review the management of thickening agents to ensure that these are safely stored and records clearly indicate when they have been administered. Ref: 6.3
	Response by registered person detailing the actions taken: Staff have been informed of the need to store thickening agents in a locked cupboard when not in use. New documentation for food and fluid recording has been implemented. On this new documentation the person giving the drink signs to confirm thickening agent has been added.
Area for improvement 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 29 August 2019	The registered person shall review the receipt of medicines process to ensure that staff maintain a record all incoming medicines. Ref: 6.3
	Response by registered person detailing the actions taken: A new stock control form has been implemented and staff have had in house training on how to manage stock with the use of new documentaion.
Area for improvement 4 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 29 August 2019	The registered person shall review the fluid management arrangements in the home to ensure daily fluid targets are reflective of individual assessed needs. The registered nurses review and evaluate anyone requiring a daily fluid target to assess the effectiveness of care. Ref: 6.3 and 6.4
	Response by registered person detailing the actions taken: All named nurses have been informed of the need for review of fluid targets for their residents. A list of the fluid targets are available in the food and fluid recording files. Carers are now totalling fluid intake between 14:00 hrs and 15:00 hrs as well as 20:00 hrs to identify any shortfall earlier in the day allowing time for action to be taken.
Area for improvement 5 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 1 October 2019	The registered person shall ensure care plans are developed in response to acute infections whereby patients have been prescribed antibiotics. Ref: 6.4
	Response by registered person detailing the actions taken: All named nurses have been informed of the need to have a careplan when a resident has been commenced on an antibiotic. Spot checks have shown care plans have been developed when a resident has been prescribed an antibiotic.

Area for improvement 6 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 1 October 2019	The registered person shall ensure that bowel management records are accurately recorded and nursing staff evaluate the effectiveness of this care. Ref: 6.4 **Response by registered person detailing the actions taken:** Nurses have been informed of the requirement to record bowel movements in the progress notes and record any interventions taken. Record aperients given or withheld when necessary.
Area for improvement 7 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 1 October 2019	The registered person shall ensure repositioning charts are completed in full at the time of each repositioning and nursing staff evaluate the effectiveness of this care. Ref: 6.4 **Response by registered person detailing the actions taken:** A new floor audit has been devised for management to check the correct completion of repositioning charts is being adhered to. Nurses have been advised it is their responsibility when in charge of each unit to monitor carer's adherence to completion of repositioning charts, investigating any discrepancies .
Area for improvement 8 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 1 October 2019	The registered person shall ensure the dining experience is reviewed and enhanced in accordance to best practice. This is in particular reference to the dementia unit. Ref: 6.5 **Response by registered person detailing the actions taken:** The dining experience throughout the home has been reviewed. Staff, families and residents have come together to discuss ways the dining experience can be improved. Before residents attend the table for meals more effort has been placed on preparation as in place mats on, cutlery set out and glasses ready for drinks. All residents are encouraged to eat at the dining table. More improvements are being discussed although not implemented at time of reporting.

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

The Regulation and Quality Improvement Authority

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