Inspection Report

4 November 2021

Clareview House

Type of service: Nursing Home
Address: 105 Doagh Road, Ballyclare BT39 9ES
Telephone number: 028 9334 9694

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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Hutchinson Homes Ltd **Responsible Individual:** Ms Naomi Carey	**Registered Manager:** Mrs Sharon Bell **Date registered:** 8 November 2010
Person in charge at the time of inspection: Mrs Sharon Bell - Registered Manager	**Number of registered places:** 35 comprising of: A maximum of 5 patients in category NH-DE. There shall be a maximum of 2 named residents receiving residential care in category RC-I.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category DE – Dementia PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 26
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 35 patients. The home is divided in two units over two floors. The ground floor and first floor provides general nursing care and there is a five bedroom unit on the ground floor which provides care for people with dementia.	

2.0 Inspection summary

An unannounced inspection took place on 4 November 2021 from 9.05 am to 4.45 pm by a care inspector.

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

New areas requiring improvement were identified during this inspection and this is discussed within the main body of the report and Section 7.0.

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

RQIA were assured that the delivery of care and service provided in Clareview House was provided in a compassionate manner.

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

3.0 How we inspect

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

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

Throughout the inspection patients and staff were asked for their opinion on the quality of the care and their experience of living, visiting or working in Clareview House. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

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

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

4.0 What people told us about the service

Nine patients and eight staff were spoken with. Six questionnaires were returned with respondents indicating they were happy with the care provided in the home. No feedback from the staff online survey was received within the timeframe for inclusion in this report.

Patients spoke highly of the care that they received and about their interactions with staff. Patients confirmed that staff treated them with dignity and respect and that they would have no issues in raising any concerns with staff.

Staff acknowledged the challenges of working through the COVID – 19 pandemic but all staff agreed that Clareview House was a good place to work. Staff were complimentary in regard to the home's management team and spoke of how much they enjoyed working with the patients.

5.0 The inspection

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

Areas for improvement from the last inspection on 20 August 2020		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref**: Regulation 21 **Stated:** First time	The registered person shall ensure that a robust system is put in place to monitor the registration status of care staff with NISCC.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref**: Standard 46 **Stated:** First time	The registered person shall ensure that equipment is appropriately stored and that access to facilities in sluice rooms is not restricted to staff in order to minimise the risk of infection.	**Partially met**
	Action taken as confirmed during the inspection: Observation of the environment evidenced some patient equipment was stored appropriately although other equipment was stored inappropriately in identified sluice rooms. This is discussed further in Section 5.2.3. This area for improvement has been partially met and is stated for a second time.	
Area for improvement 2 **Ref**: Standard 46.2 **Stated:** First time	The registered person shall ensure that all pull cords throughout the home are fitted with washable covers in order to adhere to infection prevention and control best practice.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

Area for improvement 3 **Ref**: Standard 4.9 **Stated:** First time	The registered person shall ensure that supplementary care records, specifically, repositioning records are completed in a comprehensive, accurate and contemporaneous manner in accordance with legislative and best practice guidance.	**Partially met**
	Action taken as confirmed during the inspection: It was evident that staff members were required to complete repositioning charts for specific patients to prevent the development of pressure ulcers. The chart required staff to complete a number of areas to evidence the delivery of care as recorded in the patients care plan. Examination of four patient records regarding repositioning evidenced that staff were not consistently and accurately recording the delivery of care. In some instances the records did not include the patients name and gaps in the recording could indicate that the care was not delivered as required. Details were discussed with the manager. This area for improvement has been partially met and is stated for a second time.	
Area for improvement 4 **Ref**: Standard 39 **Stated:** First time	The registered person shall ensure that all employed staff receive training in relation to the Mental Health Capacity Act – Deprivation of Liberty Safeguards (DoLS).	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

A review of staff selection and recruitment records evidenced that staff members were recruited safely ensuring that pre-employment checks had been completed prior to each staff member commencing in post. Minor deficits were noted regarding some of the pre-employment checks. These were discussed with the manager who agreed to review the current recruitment check list.

Staff were provided with an induction programme to prepare them for providing care to patients; the manager agreed to review the current arrangements for induction of agency staff to ensure accurate records are maintained. Checks were made to ensure that staff maintained their registrations with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

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

There were systems in place to ensure that staff were trained and supported to do their job. Staff consulted with confirmed that they received regular training in a range of topics such as moving and handling, infection prevention and control (IPC) and fire safety. The manager confirmed there was a balance in the training delivered between e-learning and face to face.

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

Staff said they felt well supported in their role and the level of communication between staff and management. While the majority of staff expressed satisfaction with staffing levels, some staff expressed dissatisfaction that staffing levels were, at times, negatively impacted by absences due to short notice staff sickness. The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met and confirmed that efforts were ongoing in relation to the recruitment of care staff.

Patients spoke highly about the care that they received and confirmed that staff attended to them in a timely manner; patients also said that they would have no issue with raising any concerns to staff. It was observed that staff responded to patients' requests for assistance in a prompt, caring and compassionate manner.

5.2.2 Care Delivery and Record Keeping

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

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

Patients who were less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly. Examination of the recording of repositioning records evidenced deficits in record keeping. This was identified as an area for improvement during the last inspection in August 2020 and is now stated for a second time.

Reviews of supplementary records such as personal care, bowel charts and food and fluid intake evidenced these were generally well completed.

Management of wound care was examined. Review of one identified patient's care records confirmed that wound assessments records were not consistently completed after the patient's wound was redressed and evaluations by nursing staff did not detail the progress or otherwise of the wound or the status of the patient. In addition, elements of the patient's care plan had not been personalised to reflect their specific care needs or when their needs changed. An area for improvement was identified.

Where a patient was at risk of falling, measures to reduce that risk were put in place, for example, through use of an alarm mat. Falls in the home were monitored monthly to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to prevent further falls from occurring.

There was a system in place to ensure that accidents and incidents were notified to patients' next of kin and their care manager.

Examination of two patients' care records regarding the management of falls indicated that at times nursing staff did not complete a full set of neurological observations post fall in keeping with the home's policy nor did they evaluate the status of the patient post fall. In addition, review of the specific care plans and falls risk assessments evidenced that these records were not consistently reviewed, post fall, to ensure they reflected the needs of the patients in preventing or managing falls or that nursing staff had evaluated the previous falls history and the potential impact on the patient. An area for improvement was identified.

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

A number of patients were on bed rest and were unable use the nurse call system due to their cognitive impairment. This was discussed with the manager who agreed to audit the use of the nurse call system to ensure those patients who cannot use the system are appropriately supervised and implement room checks as required. Appropriate care plans should be implemented.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Lunch was a pleasant and unhurried experience for the patients. The food served was attractively presented and smelled appetising and portions were generous. A variety of drinks were served with the meal. Patients may need support with meals ranging from simple encouragement to full assistance from staff. Staff attended to residents' dining needs in a caring and compassionate manner while maintaining written records of what residents had to eat and drink, as necessary. Patients spoke positively in relation to the quality of the meals provided.

Discussion with staff confirmed that changes to the planned menu were not recorded. In addition, plastic tumblers were used at mealtimes for serving drinks to patients; glassware was not available. Some patients spoken with said they would prefer to drink from a glass. It was disappointing to note that this had been discussed with the manager during a previous care inspection and no action was taken. An area for improvement was identified.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment, care plans should be developed to direct staff on how to meet patients' needs and include any advice or recommendations made by other healthcare professionals. Review of care records of one patient evidenced that not all care plans had been developed in a timely manner following admission to accurately reflect the patient's assessed needs. For example, after a period of two months there was no care plan in place to direct staff on the management of incontinence or on the management of sedation. An area for improvement was identified.

Patients' individual likes and preferences were reflected throughout the care records. Care plans were detailed and contained specific information on each patient's care needs and what or who was important to them. From review of a sample of care records it was noted that some of the evaluations of care contained repetitive statements which were not sufficiently patient centred. This was discussed with the manager who agreed to meet with registered nursing staff to address this matter and monitor completion of care records through their care record audit.

Daily records were kept of the care and support provided by staff. The outcome of visits from and consultations with any healthcare professional was also recorded.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment evidenced the home was warm, clean and comfortable. There were no malodours detected in the home. Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, clean and tidy. A small number of bedrooms did not have a table top facility. The manager agreed to audit the bedrooms in the home to ensure they were in keeping with standard E20 of the Care Standards for Nursing Homes 2015.

Fire safety measures were in place to ensure that patients, staff and visitors to the home were safe. Staff members were aware of their training in these areas and how to respond to any concerns or risks. A fire risk assessment had not been completed since the 5 October 2021. The manager confirmed in an email following the inspection that an updated assessment would be completed week commencing 15 November 2021.

The manager said that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. The home was participating in the regional testing arrangements for patients, staff and care partners and any outbreak of infection was reported to the Public Health Authority (PHA).

All visitors to the home had a temperature check when they arrived. They were also required to wear personal protective equipment (PPE). There were laminated posters displayed throughout the home to remind staff of good hand washing procedures. Posters regarding the correct method for applying and removing of PPE did not appear to be frequently displayed at PPE stations. This was discussed with the manager who agreed to have these put in place.

Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices. The lounge and dining areas were not arranged in such a way that patients could safely socially distance. This was discussed with the manager who agreed to review the seating arrangements to facilitate social distancing where possible.

Access to a number of sluice rooms was observed to be restricted due to the inappropriate storage of some patient equipment. The infection control risk this potentially poses was discussed with the manager and an area for improvement was partially met and stated for a second time.

Discussion with staff confirmed that training on IPC measures and the use of PPE had been provided. While some staff were observed to carry out hand hygiene at appropriate times and to use PPE correctly; other staff did not. Some staff members were not familiar with the correct procedure for the donning and doffing of PPE, while others were observed not adhering to social distancing during staff break times. In addition, PPE and hand sanitiser were not readily available in some identified areas of the home and inappropriate storage of patient toiletries was noted in an identified bathroom. This was discussed with the manager and an area for improvement was identified.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, some patients told us they liked the privacy of their bedrooms, but enjoyed going to the dining room for meals and choosing where to sit with their friends. Other patients preferred to enjoy their meals and socialise in the lounge. Patients were observed enjoying listening to music, reading newspapers/magazines and watching TV, while others enjoyed a visit from relatives.

Discussion with the manager confirmed that the activity therapist was on planned leave. Patients did not raise any concerns regarding the activity provision. However, staff said that activities were not planned at present and no staff had been allocated to provide activities in the absence of the activity therapist. Staff spoken with confirmed they found it difficult to provide activities due to ongoing work demands. In addition, the weekly activity planner displayed in the dementia unit had not been completed. Review of patients' daily progress notes confirmed staff did not regularly comment on how each patient spent their day and not all patients had an up to date activity care plan. This was discussed with the manager and an area for improvement was identified.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff told us they assisted patients to make phone or video calls. Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

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

There has been no change in the management of the home since the last inspection. Mrs Sharon Bell has been the registered manager in this home since 8 November 2010**.**

Discussions were held with management in relation to the current registration and conditions of registration. The manager followed up with the registration team at RQIA post inspection to ensure registration details were updated.

Review of records and information received by RQIA evidenced that at least three notifiable accidents and incidents had not been reported to RQIA in keeping with regulation. An area for improvement was identified.

Review of the audits undertaken for accidents and incidents, care records and hand hygiene practice found that the deficits noted during the inspection had not been identified through the audit process. In addition, no audits were in place to monitor restrictive practice, wounds or PPE use. This was discussed with the manager who provided a detailed action plan post inspection indicating how the above deficits would be addressed. While the action plan submitted by the manager provided RQIA with a level of assurance that improvements had been and would be made, an area for improvement was identified.

Review of records confirmed that systems were in place for staff appraisal and supervision.

There was a system in place to manage complaints. The manager told us that complaints were seen as an opportunity for the team to learn and improve. The manager agreed to review current recording systems to evidence the lessons learned from complaint outcomes and how this learning is shared among the staff. Patients said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

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

Review of records identified that monthly monitoring reports in accordance with Regulation 29 were undertaken on behalf of the responsible individual and available in the home as required. Following a review of the report from the visit undertaken on 12 October 2021 it was concerning that some of the issues found during this inspection had not been identified by the auditor given that RQIA reviewed some of the same records and timeframes. In addition, the reports provided to RQIA post inspection did contain information that would be patient identifiable. An area for improvement was identified.

6.0 Conclusion

Patients were observed to be comfortable in their surroundings and were attended to by staff in a timely and effective manner. Patients' dignity was maintained throughout the inspection and staff were observed to be polite and respectful to patients and each other.

New areas requiring improvement were identified in relation to falls management, planning of care, infection prevention and control practices, notifiable incidents, governance arrangements and monthly monitoring reports. Further areas for improvement were identified in relation to availability of glassware, recording of menu changes, wound care and activity provision.

Based on the inspection findings and discussions held, RQIA were satisfied that this service was providing care in a compassionate manner. Compliance with the areas for improvement identified will further enhance the service provided.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015) (Version 1.1).

	Regulations	Standards
Total number of Areas for Improvement	6	5*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Sharon Bell, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that nursing staff follow the home's policy and Regional Guidance on the management and evaluation of care during and following a fall. This includes but is not limited to evidencing that clinical or neurological observations are carried out for all patients following a fall and that accidental falls care plans and risk assessments are reflective of the patients' needs. Ref: 5.2.2
	Response by registered person detailing the actions taken: Clinical/Neurological observations **are** taken and recorded as per the homes falls protocol and current regional guidance. Evidenced on paper records which are held in Patient files and on epicare including any updates to care plans and risk assessments
Area for improvement 2 **Ref:** Regulation 16 (1) (2) (b) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure an initial plan of care based on the pre-admission assessment and referral information is in place within 24 hours of admission. The care plans should be further developed within five days of admission and kept under review to reflect the changes needs of the patients. Ref: 5.2.2
	Response by registered person detailing the actions taken: Initial care plans, risk assessments etc **are** in place based on the pre admission assessment and information within 24 hours of admission and are to be completed within five days of admission to the home and then it is continuingly reviewed/developed. Staff have devised an overview paper record for each staff member to sign off as tasks completed and to enable good communication among the team. Staff have been reminded again verbally at meeting and via memo of the need to ensure that they fully admit the new resident within the appropriate timescale.

Area for improvement 3 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that the training for staff on IPC measures is embedded into practice. For example. staff can clearly describe the steps for hand hygiene; know when to take opportunities for hand hygiene, and the donning and doffing of PPE is carried out as per regional guidelines. Ref: 5.2.3
	Response by registered person detailing the actions taken: All staff **are** appropriately trained in use of PPE and hand hygiene as per regional guidelines and are regularly updated through mandatory training both online and face to face.
Area for improvement 4 **Ref:** Regulation 30 (1) (d) (f) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall give notice to RQIA without delay of the occurrence of any notifiable incident. All relevant notifications should be submitted retrospectively. Ref: 5.2.5
	Response by registered person detailing the actions taken: The notifiable events occurred with an agency nurse on duty who does not have access to the RQIA portal to report the same. Protocol in place to ensure that if any incidents occur when agency nurse is on duty the permanent nurses on duty on next shift follow up with Form 1a. Form 1a for notifications completed retrospectively by manager as requested by inspector.
Area for improvement 5 **Ref:** Regulation 10 (1) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall review the home's current audit processes to ensure they are effective. Consideration should also be given to the scope of the audits undertaken which should include auditing of restrictive practice, and/or care records or staff use of PPE. Ref: 5.2.5
	Response by registered person detailing the actions taken: Audits in place include, care plan audits, hand hygiene audits(PHA/trust audit tool). Restrictive practice audit tool now in place and wound audit tool

Area for improvement 6 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall review the process for carrying out the monthly monitoring visits to ensure it provides the responsible individual with the necessary assurances regarding the quality of services and care delivery to patients and that the home is adhering to legislative requirements and regionally agreed guidance. In addition, the report should not contain information that may identify an individual living or working in the home. Ref: 5.2.5
	Response by registered person detailing the actions taken: Reg 29 visits are completed on a monthly basis. A review has been carried out by the Registered provider who is satisfied that the reports are robust and clear with action plans put in place as required which have to be actioned within a time frame and this is then checked up on during the next monthly Reg 29. The reports do not identify any individual living or working in the home without the permission of the individual concerned…usually a staff member who can give consent. **Full Copies of all Reg 29 reports are available for further consideration and review if required. This will demonstrate that they are not only robust but also adhere to confidentiality requirements.**
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for Improvement 1 **Ref**: Standard 4.9 **Stated:** Second time **To be completed by:** Immediate action required	The registered person shall ensure that supplementary care records, specifically, repositioning records are completed in a comprehensive, accurate and contemporaneous manner in accordance with legislative and best practice guidance. Ref: 5.1 & 5.2.2
	Response by registered person detailing the actions taken: Supplementary care records, specifically repositioning records overnight, **<u>are</u>** being completed in a comprehensive, accurate and contemporaneous manner in accordance with best practice and legislative This was disseminated to staff verbally and in memo form and continues to be addressed as required through staff meetings and at staff handovers and walk round checks by the manager and trained staff.

Area for Improvement 2 **Ref**: Standard 46 **Stated:** Second time **To be completed by:** Immediate action required	The registered person shall ensure that equipment is appropriately stored and that access to facilities in sluice rooms is not restricted to staff in order to minimise the risk of infection. Ref: 5.1 & 5.2.3
	Response by registered person detailing the actions taken: Commode storage has been rearranged so as there is unfettered access to the facilities in the sluice and to minimise the risk of infection.
Area for improvement 3 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 4 December 2021	The registered person shall ensure the following: • The patient dining experience is reviewed with regards to the availability of glassware • Variations to the planned menu are recorded. Ref: 5.2.2
	Response by registered person detailing the actions taken: Patients are offered glassware to use if that is their expressed preference taking into consideration their physical and mental capabilities, as the home has glass drinking receptacles for use as deemed appropriate. **We remain unclear as to what the inspection process is relating to in this regard and have previously submitted info relating to good practice in this area of service provision.** New polycarbonate glasses have been obtained and are in use. Variations to the menu are recorded in a timely manner.
Area for improvement 4 **Ref**: Standard 21.1 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that patients' wound care needs are managed in an effective manner at all times; this includes but is not limited to ensuring that: records are updated in a timely manner to reflect the assessed needs of patients; wound assessments and evaluations are completed after each dressing and daily progress notes include meaningful and patient centred entries regarding patients' skin condition. Ref: 5.2.2
	Response by registered person detailing the actions taken: Wound assessments and evaluations are completed after each dressing in skin integrity and daily progress notes also reflect patient skin conditions and any intervention from other multidisciplinary groups such as the GP, podiatrist, Tissue viability. Wound care audit in place

Area for improvement 5 **Ref:** Standard 11 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that the provision of activities in the home is reviewed to make sure that meaningful activities are provided to patients in the absence of the Personal Activity Lead. Activities must be integral part of the care process and care planned for. A contemporaneous record of activities delivered must be retained. Ref: 5.2.4
	Response by registered person detailing the actions taken: The activity therapist keeps records of all activities and records on epicare. It has been agreed with the activity therapist that she draws up an activity schedule for use in her absence to be delivered by care staff taking into consideration pressures on their time day to day delivering care to the residents. And in this instance staff have been tasked to record these interactions via touch care. Reg 29 reports during this time reflected the ongoing interaction between the staff and residents with resident comments and family input. Activities are part of the care planning process taking into account the overall physical and mental health wellbeing of the resident and their choice. **There also remain ongoing considerations about this inspection and these are being dealt with in a separate communication with RQIA.**

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

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