Unannounced Care Inspection Report
20 July 2018

Hamilton Care Home

Type of Service: Nursing Home (NH)
Address: The Plantain, 168 Ballycorr Road,
Ballyclare, BT39 9DF
Tel No: 02893341396
Inspector: Karen Scarlett

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 36 persons.

3.0 Service details

Organisation/Registered Provider: Heather Hamilton Responsible Individual: Heather Hamilton	Registered Manager: See box below
Person in charge at the time of inspection: Linzi Tweedy from 07:35 to 12:40 Janis Todd (nurse in charge) from 12.40 to 15:15	**Date manager registered:** Linzi Tweedy – acting no application required
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment.	**Number of registered places:** 36 Category NH-PH for 2 identified patients only. There shall be a maximum of 1 named resident receiving residential care in category RC-I.

4.0 Inspection summary

An unannounced inspection took place on 19 July 2018 from 07.35 to 15.15.

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.

The term 'patient' is used to describe those living in Hamilton Private Nursing Home which provides both nursing and residential care.

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

Evidence of good practice was found in relation to staffing and their ongoing training and development. The home's environment was maintained to a high standard and care was delivered in a timely and caring manner. Records were generally maintained to a good standard and there was effective team work and communication amongst the team and with other professionals. The culture and ethos of the home was conducive to the delivery of compassionate care. Staff were very knowledgeable around the needs of their patients and good relationships were evident. The activities and facilities in the home were particularly valued by relatives. Governance arrangements were also in place to manage complaints and incidents and there was evidence of ongoing quality improvement.

Areas requiring improvement were identified in relation to staff awareness of out of hours adult safeguarding arrangements, staff adherence to best practice in infection control, care planning for behaviours which challenge and infections and the use of a key pad lock to exit the home.

Patients said they were very happy living in the home and spoke highly of the staff and the care provided. There was evidence that the management team listened to and valued patients and their representatives and taking account of the views of patients.

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	0	6*

*The total number of areas for improvement includes one under the standards which has been stated for a second time.

Preliminary feedback was given to Linzi Tweedie, manager and Lucy Hamilton, registered manager (who attended for some of the inspection from her leave) prior to their departure on the afternoon of the inspection.

Details of the Quality Improvement Plan (QIP) were discussed with Janis Todd, nurse in charge, and Patrick Hamilton, home 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 28 November 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 28 November 2017. There were no further actions required to be taken following the most recent inspection.

5.0 How we inspect

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

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents(SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report

During the inspection we met with six patients, nine staff and five patients' visitors/representatives. Questionnaires were also left in the home to obtain feedback from patients and patients' representatives. A poster was provided which directed staff to an online survey and staff not on duty during the inspection. The inspector provided the manager with 'Have we missed you cards' which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

The following records were examined during the inspection:

- duty rota for all staff from 16 to 29 July 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one staff recruitment and induction file
- four patient care records
- four patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits
- complaints record
- compliments received
- RQIA registration certificate
- patient register
- a sample of monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

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

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

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 28 November 2017

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 27 September 2017

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><td colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</td><td>Validation of compliance</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 30

Stated: Second time</td><td>The registered persons must ensure that all notifiable events are reported to RQIA in accordance with regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Review of the notifications submitted to RQIA since the previous care inspection evidenced that this had been met.</td></tr>
<tr><td colspan="2">Action required to ensure compliance with The Care Standards for Nursing Homes (2015)</td><td>Validation of compliance</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 38

Stated: First time</td><td>The registered person shall ensure that a record of an applicant’s employment history is sought and any gaps in employment are identified, explored and reasons documented.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Review of a recruitment record for a recently employed registered nurse evidenced that this had been met.</td></tr>
<tr><td>Area for improvement 2

Ref: Standard 4 criterion 8

Stated: First time</td><td>The registered provider should ensure that following a suspected or confirmed head injury that neurological observations are carried out in accordance with best practice guidelines, documented and responded to appropriately. The registered provider should ensure that a local protocol is developed to guide staff.</td><td>Partially met</td></tr>
</table>

	Action taken as confirmed during the inspection: Since the previous care inspection post falls checklists had been introduced in the home as an aide memoire for staff. A new neurological observation chart had been introduced and this outlined the frequency with which these observations should be undertaken. Staff spoken with were fully aware of the new documentation and spoke knowledgeably about the management of a patient with an actual or potential head injury. Although this represented significant progress since the last care inspection, a review of one patient's charts evidenced that the observations were not being completed consistently in accordance with the home's own policy. This area for improvement has been partially met and has been stated for a second time.	
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that the wound care needs of patients are set out in an individualised care plan and the frequency of wound re-assessment is specified in the care plan. Contemporaneous notes of the wound care delivered should be consistently maintained	**Met**
	Action taken as confirmed during the inspection: A review of the care records of one patient with a wound confirmed that a care plan was in place to direct the care, which stated the type of dressing and the frequency of dressings. There was evidence that the wound observation chart was kept up to date in accordance with the care plan. This area for improvement has been met.	

6.3 Inspection findings

6.4 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 regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 16 to 29 July evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patients needs in a timely and caring manner. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. There was an allocation sheet completed for each shift allocating staff to different areas of the home and the tasks for the day.

Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Hamilton Private Nursing Home. Relatives spoken with raised no concerns in relation to staffing levels.

Review of a staff recruitment files evidenced that these were maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records also evidenced that enhanced AccessNI checks were sought, received and reviewed prior to staff commencing work. Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

A review of records confirmed that a process was in place to monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC. There were systems and processes in place to ensure that alerts issued by Chief Nursing Officer (CNO) were managed appropriately and shared with key staff.

We discussed the provision of mandatory training with staff and reviewed staff training records for 2018. Staff confirmed that they were enabled to attend training and that the training provided them with the necessary skills and knowledge to care for the patients. Training records were maintained in accordance with Standard 39 of The Nursing Homes Care Standards. Observation of the delivery of care evidenced that training had been embedded into practice, for example, the moving and handling of patients.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Two registered nurses spoken with were unfamiliar with the out of hours duty social worker for adult safeguarding. An area for improvement under the standards was made. A recent safeguarding referral was discussed with the manager who was co-operating with the Trust and RQIA in this regard. Please refer to section 6.7 for further information.

Discussion with the manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

Review of four patients' care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process.

We reviewed accidents/incidents records since the previous care inspection in comparison with the notifications submitted by the home to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Discussion with the manager and review of records confirmed that she wished to develop a more detailed falls audit to analyse falls occurring in the home and identify if any patterns or trends were emerging. Information regarding falls was also reviewed as part of the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

From a review of records, observation of practices and discussion with the manager and staff there was evidence of proactive management of falls.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, and dining room and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients, their representatives and staff spoken with were highly complementary in respect of the home's environment. Fire exits and corridors were observed to be clear of clutter and obstruction.

Observation of practices/care delivery, discussion with staff and review of records evidenced that infection prevention and control measures were consistently in place. A monthly audit was carried out monthly and identified areas requiring action. This had highlighted that a member of staff was observed not adhering to the home's dress code policy. This was also identified on inspection and would be contrary to good practice in infection prevention and control. An area for improvement under the standards has been made.

The manager had an awareness of the importance to monitor the incidents of HCAI's and/or when antibiotics were prescribed. There was discussion with the manager around maintaining a more detailed record of these incidences.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last care inspection confirmed that these were appropriately managed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing and their ongoing training and development. The home's environment was maintained to a high standard and care was delivered in a timely and caring manner.

Areas for improvement

Areas for improvement under the standards were identified in relation to staff awareness of the out of hours adult safeguarding arrangements and staff adherence to best practice in infection prevention and control.

	Regulations	Standards
Total number of areas for improvement	0	2

6.5 Is care effective?

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

Review of four patient care records evidenced that care plans were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of nutrition, patients' weight, management of infections and wound care. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

Patients' nutritional risk assessments and weights were monitored on at least, a monthly basis. There was evidence that the advice of the speech and language therapist (SALT) and Dietician had been sought and care plans were reflective of their recommendations.

A review of the care records of one patient with a wound evidenced that an up to date care plan was in place and that the care prescribed was being delivered. An area for improvement in this regard identified at the previous care inspection had been met. A review of repositioning charts for two patients evidenced that these were exceptionally well maintained in accordance with best practice guidelines. There was no incidence of avoidable pressure sores in the home.

A review of the medicine kardex for one patient evidenced that they had been commenced on an antibiotic. On discussion with staff they were aware of the use of the antibiotic and it had been referenced in the daily progress notes. A review of the care records noted that there was no care plan in place to inform staff of the reason for its use or to direct the care. An area for improvement under the standards has been made.

A review of two patient's care records evidenced that they had care plans in place to manage behaviours that challenge. These care plans lacked sufficient detail in relation to the type of behaviours, the triggers for these behaviours or guidance for staff in how to manage these. An area for improvement under the standards has been made.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care managers, General Practitioners (GPs), SALT and dieticians. Supplementary care charts such as food and fluid intake records evidenced that contemporaneous records were maintained. There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals such as, the tissue viability nurse (TVN), the speech and language therapist (SALT) or the dietician changed.

We attended the morning handover meeting and noted that all registered nurses and care staff were present. Relevant information was discussed and a handover sheet was in use to provide structure for the staff. Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the manager or the nurse in charge.

All grades of staff consulted demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Patients and five representatives spoken with expressed their confidence in raising concerns with the home's staff and management, with the exception of one relative who had raised a concern in the past and was not happy with the manager's response. They clarified that the matter had been resolved to their satisfaction but they would not be keen to raise concerns in future. Advice was given in relation to how to raise concerns and our 'calling card' was given. The concern was shared with the nurse in charge and the home manager at the conclusion of the inspection. Patients and representatives were aware of who their named nurse was and knew the manager.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping and the effectiveness of the team work and communication amongst the team and with other professionals.

Areas for improvement

Two areas for improvement were identified in relation to record keeping for patients with challenging behaviours and those with infections.

	Regulations	Standards
Total number of areas for improvement	0	2

6.6 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.

We arrived in the home at 07:35 and were greeted by staff who were helpful and attentive. The home was calm and quiet and staff were noted to be attending to some patients in their rooms. One patient was dressed and sitting up in their bedroom as they preferred to rise early. It was evident that patient's preferences for rising times were respected and the morning routine was leisurely and relaxed. Patients began to go to the dining room for breakfast around 08:20 and breakfast continued late into the morning to facilitate patients' choice. Some patients took breakfast in their rooms or the lounge areas as was their preference. A range of cereals, toast and beverages were available. Some patients remained in bed, again in keeping with their personal preference or their assessed needs. Staff were observed attending to patients' needs and offering assistance as required. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Discussion with patients and staff and review of the activity programme displayed in the foyer evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. Relatives spoken with were enthusiastic in relation to the activities and complimented the activities leader for her efforts, particularly in relation to the terraced garden which she had planted with patients. In the afternoon a music quiz was being held in the main lounge with good participation from patients. A barbeque was also planned for the end of this month encouraging friends and relative to attend.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences.

We observed the serving of the lunchtime meal. Patients were assisted to the dining room or had trays delivered to them as required. Staff were observed assisting patients with their meal appropriately and a registered nurse was overseeing the mealtime. Patients able to communicate indicated that they enjoyed their meal and the food appeared appetising. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes.

Regular drinks and snacks were available between meal times and options for those on modified diets were available. Patients and their visitors particularly enjoyed the ice cream cones provided in the late afternoon.

Cards and letters of compliment and thanks were displayed in the home. Some of the comments recorded included:

'XX and I were treated with kindness and friendliness. Hamilton Private Nursing Home has an ethos of hospitality, homeliness and is immaculate.'

There were systems in place to obtain the views of patients and their representatives on the running of the home.

Consultation with six patients individually, and with others in smaller groups, confirmed that living in the home was a pleasure. One patient described the staff as ‘marvellous’. Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Five relatives spoke with RQIA and gave very positive feedback in relation to the home and the staff. All commented positively on the environment and particularly on the river café area in which they could socialise with their relative in a relaxed environment. Two relatives commented on the quality of the communication with staff and how they proactively managed the care to prevent potentially distressing hospital admissions. Ten relative questionnaires were provided but none were returned within the timescale for inclusion in the report.

Nine staff spoke with us and all were very happy working in the home and felt well supported by the manager and the owners of the home. They confirmed that they worked well as a team. Good relationships were evident between staff, patients and relatives.

Staff were asked to complete an on line survey, we had no responses within the timescale specified.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home. Staff were very knowledgeable around the needs of their patients and good relationships were evident. The activities and facilities in the home were particularly valued by relatives.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 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 appropriately displayed in the foyer of the home. A referral was made by RQIA to the Northern Health and Social care Trust (NHSCT) on 18 July 2018. This related to a notification received by RQIA, the nature of which raised concerns that the home was potentially operating outside of their registered categories of care. An investigation by NHSCT is to commence. The manager was in the process of collating information for RQIA and agreed to keep us informed of the progress of the investigation. RQIA will continue to monitor this in light of the findings.

Since the last inspection there has been a temporary change in management arrangements. RQIA were notified appropriately. An acting manager, Linzi Tweedy, is in post to cover a period of leave by the registered manager, Lucy Hamilton. A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff, patients and their representatives evidenced that the manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the manager.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The equality data collected was managed in line with best practice. Training in equality and diversity was available to staff.

It was noted that a keypad lock was fitted to the front door. A keypad code was required to exit the home. The potentially restrictive nature of this arrangement was discussed with the registered manager, Lucy Hamilton. An area for improvement under the standards was made to review this arrangement in accordance with current best practice and the Deprivation of Liberty (DOL's) guidelines.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

Discussion with the manager and review of records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding infection prevention and control practices, medications, pressure ulcer incidence and care records. An audit schedule was in place and the manager was working on a more robust falls audit in order to further improve practice.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis by the responsible individual in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

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

Areas for improvement

An area for improvement under the standards was identified in relation to the use of a keypad exit at the front door.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Janis Todd, nurse in charge, and Patrick Hamilton, home manager, 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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4 Criterion 8 **Stated:** Second time **To be completed by:** 19 August 2018	The registered provider should ensure that following a suspected or confirmed head injury that neurological observations are carried out in accordance with best practice guidelines, documented and responded to appropriately. The registered provider should ensure that a local protocol is developed to guide staff. Ref: Section 6.2
	Response by registered person detailing the actions taken: Following the previous RQIA inspection a post falls protocol was devised and implemented to guide staff on what action to take following a fall. Neurological observations are now being completed in line with the guidance developed over a 24 hour period following falls.
Area for improvement 2 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 19 August 2018	The registered person shall ensure that staff are aware of the contact details for the duty, out of hours social worker and their role in adult safeguarding. Ref: Section 6.4
	Response by registered person detailing the actions taken: A policy and procedure is in place regarding Adult safeguarding. All staff have been made aware and have easy access to the Out of Hours social worker telephone numbers and are aware situations that may require out of hours social work involvement. All staff are up to date with Adult Safeguarding training.
Area for improvement 3 **Ref**: Standard 46 **Stated:** First time **To be completed by:** immediately from date of inspection	The registered person shall ensure that staff adheres to the home's dress code policy in accordance with best practice in infection prevention and control. Ref: Section 6.4
	Response by registered person detailing the actions taken: Following the inspection all staff were advised that the Home's dress code policy must always be adhered too. Prior to the commencement of each shift the nurse in charge checks no one is wearing nail polish or earrings and clothing is in line with policy.

Area for improvement 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 19 August 2018	The registered person shall ensure that for patients presenting with behaviours which challenge that a care plan is put in place with specific detail of the type of behaviour, the triggers for such behaviour and the actions staff should take to manage these. Ref: Section 6.5
	Response by registered person detailing the actions taken: All care plans have now been reviewed and those residents who may have behaviours which challenge have a detailed care plan in place to reflect same.
Area for improvement 5 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 19 August 2018	The registered person shall ensure that care plans are in place to manage the care of patients presenting with an infection. Ref: Section 6.5
	Response by registered person detailing the actions taken: A new care plan template for infections has been devised since the inspection took place. All nurses are now familiar with these documents and implement the necessary care plans when a resident is prescribed an antibiotic.
Area for improvement 6 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 19 October 2018	The registered person shall ensure that the arrangements for a keypad exit on the front door are reviewed in accordance with best practice and the Deprivation of Liberty (DoLs) guidelines. Ref: Section 6.7
	Response by registered person detailing the actions taken: The keypad exit on the front door remains in place but is under review.

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

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