The Regulation and Quality Improvement Authority

Inspection Report

12 & 14 October 2021

St Joseph's

Type of Service: Nursing Home
Address: 16 Princes Street, Warrenpoint, BT34 3NH
Tel no: 028 4175 3572

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Kilmorey Care Ltd **Responsible Individual:** Mr Cathal O'Neill	**Registered Manager:** Ms Ann Begley – Not registered
Person in charge at the time of inspection: Ms Emma Carter - Deputy Manager	**Number of registered places:** 50 The home is approved to provide care on a day basis to 12 persons.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years LD(E) – learning disability – over 65 years LD – learning disability	**Number of patients accommodated in the nursing home on the day of this inspection:** 39 (12 October 2021) 40 (14 October 2021)
Brief description of the accommodation/how the service operates: This is a nursing home registered to provide nursing care for up to 50 patients. Patients' bedrooms are located over three floors. The home offers communal dining and seating areas with garden spaces also available for patients.	

2.0 Inspection summary

An unannounced inspection took place on 12 October 2021 from 10.30am to 4.00pm and on 14 October 2021 from 9.35am to 5.15pm. The inspection was completed by care and pharmacist inspectors to assess progress with the area for improvement identified in the home 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.

Patients spoke positively on living in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff are included in the main body of this report.

RQIA was assured that the delivery of care and service provided in St. Josephs was safe, effective and compassionate and that the home was well led. Staff promoted the dignity and

well-being of patients and were knowledgeable and well trained to deliver safe and effective care.

The findings of this report will provide the manager and management team 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.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the Commissioning Trust.

To complete the medicines management inspection the following were reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. We also spoke to staff and management about how they plan, deliver and monitor the management of medicines in the home.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this 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 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.

The findings of the inspection were discussed with the deputy manager at the conclusion of the inspection.

4.0 What people told us about the service

During the care inspection we spoke with nine patients and seven staff. Patients spoke positively on the care that they received and with their interactions with staff describing staff as lovely and friendly. Staff were confident that they worked well together and enjoyed working in the home and interacting with the patients.

During the medicines management inspection we met with three nurses and the deputy manager.

Staff were warm and friendly and it was evident from discussions that they knew the patients well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The staff members spoken with expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

5.0 The inspection

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

No areas for improvement were identified at the last medicines management inspection (17 October 2017).

Areas for improvement from the last inspection on 18 September 2020		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that the identified patient's nutrition care plans are updated to reflect the patient's current nutritional plan of care. All out of date information should be discontinued and/or archived.	**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

All staff were provided with a comprehensive induction programme to prepare them for working with the patients. Checks were made to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics such as infection prevention and control (IPC), patient moving and handling and fire safety. A system was in place to ensure that staff completed their training. Staff confirmed that they were further supported through staff supervisions and appraisals.

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Staff agreed that patients' needs were met with the number and skill mix of staff on duty. Staff said there was good teamwork in the home.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and the designation in which they worked. The duty rota identified the nurse in charge of the home when the manager was not on duty.

Patients spoke highly on the care that they received and confirmed that staff attended to them when they needed them and that they would have no issues on raising any concerns that they may have to staff. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through these interactions that the staff and patients knew one another well and were comfortable in each other's company.

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. An allocation sheet identified the areas of the home each staff member was to work in and which specific duties staff members were responsible for.

Staff were knowledgeable of patients' needs, their daily routine, wishes and preferences. A diary was maintained to ensure important daily activities were not missed such as blood tests or appointments. 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. This was good practice. Staff 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 were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Patients' care records were held confidentially.

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. A record of repositioning had been maintained and included evidence of skin checks on repositioning. Where a patient had a wound, a detailed wound care plan was in place to direct the care of the wound. Wound evaluation charts were completed at the time of wound dressing to monitor the progress of the care delivery.

Where a patient was at risk of falling, a dedicated falls care plan was in place to direct staff in how to manage this area of care. 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. Accident records reviewed confirmed that the correct actions had been taken following the fall and the correct persons had been notified. A falls analysis was completed the following day to ensure the actions taken and persons notified had been completed correctly. This is a good practice.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, alarm mats and/or bed rails. Review of a patient's care records and discussion with the manager confirmed that the correct procedures had been followed when restrictive practices had been used.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this could include simple encouragement through to full assistance from staff. Staff assisted patients throughout the day with food and fluids in an unhurried manner. Records of patients' intake and outputs were recorded where this was required. Nutritional risk assessments were carried out monthly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST). However, while it was evident in the dining room that patients were being given a choice of meal, patients who remained in bedrooms confirmed that they were not given this option. This was discussed with the manager and identified as an area for improvement.

Patients' individual likes and preferences were reflected throughout the records. Daily records were kept of how each patient spent their day and the care and support provided by staff.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. The home was warm, clean and comfortable. There were no malodours detected in the home.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible. A fire risk assessment had been completed on 12 January 2021 and there were no recommendations made from this visit.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated and suitably furnished. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices.

Chemicals were identified which had been left unattended and accessible to patients on several occasions during the inspection. These could be harmful to patients if ingested. This was discussed with the manager and identified as an area for improvement.

It was unclear that all uncovered radiators in the home were maintained at a low heat. Uncovered radiators could pose as a burn risk to patients if turned on to a high heat. This was discussed with the manager and identified as an area for improvement.

Systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for patients and staff. Environmental infection prevention and control audits had been conducted monthly.

All visitors to the home had a temperature check and symptom checks when they arrived at the home. They were also required to wear PPE. Visits were by appointment only.

Review of records, observation of practice and discussion with staff confirmed that effective training on IPC measures and the use of PPE had been provided. Signage promoting effective hand hygiene and safe use of PPE was displayed throughout the home. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

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, patients could have a lie in or stay up late to watch TV. Patients confirmed that they could remain in their bedroom or go to a communal room when they requested.

Since the last inspection, the activity coordinator had left the role and the home was actively recruiting for a replacement. Care staff were providing activities in the home, however, care staff also identified challenges with this such as workload pressures. This was discussed with the manager and an area for improvement was identified to review the specific hours allocated to activity provision in the home. During the inspection patients were observed watching movies, listening to music and reading.

Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients. Patients enjoyed outings with family/friends and virtual video calls were also facilitated.

5.2.5 Management and Governance Arrangements

Since the last inspection there has been a change in the management arrangements. Mrs Ann Begley commenced as manager of the home on 5 May 2021 and an application to register with RQIA as the manager of the home had been submitted to RQIA and was in process. Discussion with the deputy manager and staff confirmed that there were good working relationships between staff and management.

Staff were aware of who the person in charge of the home was in the manager's absence. Staff told us that they were aware of their own role in the home and how to raise any concerns or worries about patients, care practices or the environment. Staff confirmed that the management team were approachable and would listen to them when they brought any concerns to their attention.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. Areas audited included wound care, patients' care records, infection control and staff training. The manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to

patients' next of kin, their care manager and to RQIA. An area for improvement in relation to governance and audit for medicines management was identified. (See Section 5.2.6)

It was noted that patients and their relatives were provided with written information on how to raise a concern or complaint about care or any service they received in the home. A complaints file was maintained. We discussed the importance of recording any areas of dissatisfaction expressed as a complaint and discussed further ways of enhancing the recording of complaints. Cards and compliments were kept on file and shared with staff.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. Completed reports were available for review by patients, their representatives, the Trust and RQIA.

Review of staff training records confirmed that all staff had recently completed adult safeguarding training. Staff told us they were confident about reporting any concerns about patients' safety. Staff were aware of who to report their concerns to and who to escalate their concern to if they felt that this was required.

5.2.6 Medicines management

The majority of medicines were supplied in the blister pack system. The audits completed at the inspection indicated that these medicines had been administered as prescribed. However audit discrepancies were observed in the administration of liquid medicines and inhaled medicines. In addition audits could not be completed for some medicines (liquids, eye preparations and creams) as more than one supply was in use. There was evidence that the home's monthly audits had identified areas for improvements and that action plans had been addressed. However, the findings of this inspection indicate that a more robust auditing system was necessary. The registered person must implement a robust audit system which covers all aspects of the management of medicines. Any shortfalls identified should be detailed in an action plan and addressed. An area for improvement was identified.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example at medication reviews and hospital appointments. The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had verified and signed the personal medication records when they were written and updated to provide a check that they were accurate. Obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that nurses do not refer to obsolete directions in error and administer medicines incorrectly to the patient. This was discussed with the deputy manager for immediate action and ongoing vigilance.

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment. A sample of these records was reviewed. Most of the records were found to have been accurately completed. A small number of missed signatures were brought to the attention of the deputy manager for ongoing close

monitoring. In addition it was noted that duplicate records were maintained for insulin, warfarin and fluid intake and that it was sometimes unclear when a weekly medicine was due to be administered. The deputy manager advised that these findings would be discussed with nurses during supervision and monitored through the audit process.

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. The records inspected showed that all medicines were available for administration on the day of inspection. However, there was evidence that two medicines which were prescribed for weekly administration had been out of stock in the previous month and were therefore not administered as prescribed. Nurses had not recognised these omissions as medication related incidents which have the potential to affect the health and well-being of their patients. The manager was requested to investigate these incidents and report the findings to RQIA; incident reports were received on 14 October 2021. Nurses must ensure that patients have a continuous supply of their prescribed medicines. An area for improvement was identified.

Medicines must be stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. However, storage was not tidy and organised to ensure that medicines belonging to each patient could be easily located. In addition, the following observations were made:

- more than one supply of some medicines (including liquids, inhalers, creams and eye preparations) were available on the medicines trolley/medicines refrigerator. This does not facilitate a clear audit trail to provide evidence that medicines are administered correctly
- discontinued and/or out of date eye preparations and creams were available on the trolley
- inhaler spacer devices needed to be cleaned and/or replaced
- disposable receptacles used to administer medicines to patients had been washed and left to drain for reuse.

The storage arrangements for medicines should be reviewed to ensure compliance with infection prevention and control and to facilitate a clear audit trail. An area for improvement was identified.

Thickening agents were stored in the treatment room and in an unlocked cupboard in the dining room. Thickening agents must be stored securely under the direct control of staff. The deputy manager advised that a lock would be fitted on the day of the inspection.

To ensure that medicines requiring cold storage are stored in accordance with the manufacturers' instructions, the refrigerator temperature must be maintained between 2°C and 8°C. Staff should record the temperature daily and then reset the thermometer. A review of the daily records showed that the refrigerator temperature was not monitored daily and that temperatures outside the accepted range had been recorded. The thermometer was reset during the inspection and satisfactory temperatures were observed. The registered person must ensure that the refrigerator temperature is monitored daily, the thermometer is reset and that corrective action is taken if temperatures outside the accepted range are observed. An area for improvement was observed.

With the exception of the medicines highlighted above (eye preparations and creams) appropriate arrangements were in place for the disposal of medicines.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs are recorded in a controlled drug record book. The majority of records had been maintained to the required standard. The date of administration had not been recorded for one supply of BuTec patches. The deputy manager agreed to cross-reference with the medication administration records and discuss with the nurses involved.

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another. The management of medicines for one patient who had recently been admitted to the home was reviewed. A hospital discharge letter had been received and a copy had been forwarded to the patient's GP. The patient's personal medication record had been verified and signed by two nurses and their medicines had been administered as prescribed.

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

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Two patients' records were reviewed; each patient had a pain management care plan and regular pain assessments were carried out by the nursing staff.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and its effect. The management of medicines prescribed on a "when required" basis for distressed reactions was reviewed. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Care plans directing the use of these medicines were in place. Directions for use were clearly recorded on the personal medication records and records of administration were maintained. However, the reason for and outcome of administration had not been recorded on a number of occasions. An area for improvement was identified.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. For the two patients whose records were reviewed, speech and language assessment reports and care plans were in place. Records of prescribing which included the recommended consistency level were maintained. Thickening agents were administered by both nurses and care assistants. Care assistants did not maintain a record of the administration. An area for improvement was identified.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral tube. The management of medicines and nutrition via the enteral route was examined. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and daily water flushes were maintained on both a computerised system and a paper record. Frequent omissions in the paper record were observed. This was discussed with the deputy

manager who advised that the recording system would be reviewed. The deputy manager advised that a reduced daily fluid intake had been agreed with the dietician and that written confirmation of this would be requested.

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that they are supported. Nurses in the home had received a structured induction which included medicines management. Competency had been assessed following induction and annually thereafter. Records of staff training in relation to medicines management and competency assessment were available for inspection. The manager advised that training on the management of medicines had been planned for October 2021 and that the findings of the inspection would be discussed with all nurses for ongoing improvement.

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. Only three medication incidents had been reported to RQIA since the last medicines management inspection. As detailed above nurses had not recognised the omission of medicines due to unavailability as a medication incident which has the potential to affect the health and well-being of their patients. The findings of this inspection indicate that the auditing system is not robust and hence incidents may not be identified. The manager advised that nurses would receive supervision on the identification and reporting of medication related incidents.

6.0 Conclusion

Patients spoke positively on living in the home. They were afforded choice on how to spend their day and staff supported patients with their choices. Staff were knowledgeable in relation to each patient's individual needs and care was provided in a caring and compassionate manner. Patients' bedrooms were personalised with their own belongings and communal living areas were maintained clean and tidy. There was evidence of good working relationships between staff and management.

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

The outcome of this inspection concluded that robust arrangements were not in place for all aspects of medicines management. Areas for improvement were identified regarding the storage of medicines, the availability of medicines, the audit system and record keeping in relation to thickening agents and distressed reactions.

Following the inspection the findings in relation to medicines management were discussed with the senior pharmacist inspector and the registered manager. RQIA decided that a period of time would be given to implement the necessary improvements. A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained in relation to medicines management. Failure to implement and sustain the improvements may lead to enforcement.

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

7.0 Quality Improvement Plan

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, April 2015

	Regulations	Standards
Total number of Areas for Improvement	6	4

Areas for improvement and details of the Quality Improvement Plan from the care inspection on 14 October 2021 were discussed with Mr Cathal O'Neill, Responsible Individual and Ms Emma Carter, Deputy Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Areas for improvement and details of the Quality Improvement Plan from the medicines management inspection on 12 October 2021 were discussed with Ms Ann Begley, Registered Manager (via telephone call) and Ms Emma Carter, Deputy 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 Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that chemicals are not accessible to patients in any area of the home in keeping with COSHH legislation. Ref: 5.2.3
	Response by registered person detailing the actions taken: Staff reminded of their responsilities following inspection. Supervision has been rolled out to relevant staff regarding their roles and responsibilities with regard COSHH Legistion.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person must implement a robust audit system which covers all aspects of the management of medicines. Any shortfalls identified should be detailed in an action plan and addressed. Ref: 5.2.6
	Response by registered person detailing the actions taken: Audit system has been reviewed to ensure oversight of all aspects of the management of medicines. Nursing staff have attended refresher training. In addition a supervision on the roles and responsibilites of medicines is being rolled out to all trained staff, due for completion by the 10.12.2021.

Area for improvement 3 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that patients have a continuous supply of their prescribed medicines. Ref: 5.2.6
	Response by registered person detailing the actions taken: As previously detailed, a supervision is being rolled out with all trained staff, the continuous supply of medicines has been addressed as part of this supervision. A full review of medicines has been completed by Eileen Cranney SHSCT. A further review of residents who do not fall in line with the monthly order has also taken place - to date we have been unable to get the local surgeries to bring the monthly order in line with the rest of the home. A system is now in place to ensure the timely ordering of medicines. Supply of medicines is being monitored through the revised auditing system.
Area for improvement 4 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall review the storage arrangements for medicines to ensure compliance with infection prevention and control (IPC) and to facilitate a clear audit trail. Ref: 5.2.6
	Response by registered person detailing the actions taken: Storage has been revisited with improvements to the organisation of the treatment room area. Treatment room checks in place with compliance being monitored by the Home Manager and / or Deputy Manager.
Area for improvement 5 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that the medicine refrigerator temperature is accurately monitored and recorded each day to ensure that medicines are stored at the manufacturer's recommended temperature. Ref: 5.2.6
	Response by registered person detailing the actions taken: Temperature checks are in place. As previously stated the supervision being rolled out with trained staff addresses this responsibility. Compliance with monitoring and recording the tempearture is being monitored by the Home Manager and / or Deputy Manager.

Area for improvement 6 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that records for the administration of thickening agents are accurately maintained. Ref: 5.2.6
	Response by registered person detailing the actions taken: Recording of the use of thickening agents has been addressed with both trained and care staff. An audit of all residents has taken place to ensure the directions of care plans reflect the current levels required. Staff ensure they record the level of fluids given on the daily records - this is monitored as part of the auditing process.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 12 **Stated:** First time **To be completed by:** 14 November 2021	The registered person shall ensure that all patients in the home have a choice of meal at mealtimes. Ref: 5.2.2
	Response by registered person detailing the actions taken: Residents in the dining area get a choice of meal at point of service. Residents who receive meals in their rooms have menu choice from completed on the day - staff also ensure an alterative is provided at point of service should the resident change their mind.
Area for improvement 2 **Ref**: Standard 44 **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that uncovered radiator temperatures are monitored to ensure that they are maintained at a low heat. Any radiator which is not maintained at a low heat must have a radiator cover in place. Ref: 5.2.3
	Response by registered person detailing the actions taken: A survey of radiators has taken place throughout the home. A risk assessment has been completed to identiry radiators that require covers. Work has commenced to ensure this is completed.

Area for improvement 3 **Ref**: Standard 40 **Stated:** First time **To be completed by:** 14 November 2021	The registered person shall ensure that the hours allocated to the provision of activities in the home is reviewed to ensure that patients who wish to engage are provided with meaningful activities. Ref: 5.2.4
	Response by registered person detailing the actions taken: On going recruitment has been taking place for an activities worker, 2 people were appointed in recent months but unfortunatley did not take up post. Following further recruitment a further person has been appointed to the role and is taking up post from the 07.12.2021. When staffing allows care staff to provide activities to the resident. On a day to day basis staff aim to provide social activity to the residenst as part of the daily routine, for example in the lounge areas.
Area for improvement 4 **Ref**: Standard 18 **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that when medicines are administered for the management of distressed reactions the reason for and outcome is recorded. Ref: 5.2.6
	Response by registered person detailing the actions taken: On review of records there were good records evident for the managemetn of distressed reactions on the Goldcrest system. However not consistently will all trained staff - a training need was identified and the required training has commenced roll out, all due to be completed by the 08.12.2021. Compliance with this recording will be monitored by the Home Manager and Deputy Manager.

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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