Inspection Report

3 & 4 October 2022

Croagh Patrick Care Home

Type of Service: Nursing Home
Address: Miller Hill, 235 Millisle Road, Donaghadee, BT21 0LN
Tel No: 028 9188 8383

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1.0 Service information

Organisation: Beaumont Care Homes Limited **Responsible Individual:** Mrs Carol Cousins	**Registered Manager:** Ms Karen Blair– not registered
Person in charge at the time of inspection: Ms Jennifer Hogan – Deputy Manager	**Number of registered places:** 67
Categories of care: Nursing Home (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 TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 52
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 67 patients. Patients' bedrooms, communal lounges and dining rooms are located over both floors of the home. Patients have access to a large garden with patios and seating areas.	

2.0 Inspection summary

An unannounced inspection took place on 3 October 2022 from 9.30 am to 4.40 pm and on 4 October 2022 from 9.15 am to 3.45 pm. The inspection was carried out by a care inspector.

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

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Staff said that staffing levels were not always satisfactory and morale was low at times but teamwork was good within their respective areas and the manager was approachable.

The outcome of the inspection evidenced that patients looked well cared for. Patients did not raise any concerns regarding staffing levels. Staff members were seen to be responsive to

requests for assistance and to treat patients with respect and kindness. However, staffing pressures were identified due to a continued need for the use of bank and agency staff to ensure that shifts were covered. The deputy manager confirmed that staff recruitment was ongoing and agency staff members were block booked if possible for consistency.

Areas requiring improvement identified during the inspection are discussed in the main body of the report.

The findings of this report will provide the 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.

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 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 and how staff went about their work was observed.

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 Jennifer Hogan, Deputy Manager, at the conclusion of the inspection. Ms Hogan was supported by Michelle MacMillan, Registered Manager of another home in the Beaumont group, during the inspection.

4.0 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they were satisfied that there were enough staff to help them, the home was kept clean and tidy and they felt well looked after. Comments made by patients included "I am in the right place and am well looked after here", "it is going okay, the staff are all very nice", "it is one big happy family", "you just have to ask and it is sorted" and "when I ring the buzzer the staff come brave and quick".

Staff said that, while shifts were usually covered, there was a continued reliance on agency staff. Staff acknowledged that it was positive shifts were covered but as agency staff members were less familiar with patients and the daily routine this put additional strains on existing staff who were trying to ensure there was as little impact on the patients as possible. Staff said that the manager was approachable and listened to their concerns. Comments made by staff included "we help each other out", "teamwork is good", "Karen (the manager) is very approachable, we can go to her with anything", "staffing levels are not great and some agency staff members are not great", "morale can be low" and "it can be much pressurised".

Relatives said that they were satisfied with the care provided, found staff to be kind and helpful and thought communication was effective. Comments made by relatives included "staff are lovely, no issues there and the home is clean and tidy", "staff are being very helpful, no issues so far", "staff are good at lifting the phone", "staff are genuinely caring", "staff are quick to pick up on things or any changes" and "we know they are short staffed but it doesn't show".

A record of compliments received about the home was kept and shared with the staff team, this is good practice.

No completed questionnaires or responses to the staff survey were received following the inspection.

Comments made by patients, staff and relatives were brought to the attention of the deputy manager for information and action if required.

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 29 September 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref: Regulation 19 (3) (b)** **Stated: First time**	The registered person shall ensure that records are at all times available for inspection in the home by any person authorised by the RQIA and that the person in charge of the home is able to access these records.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

Area for improvement 2 **Ref: Regulation 13 (7)** **Stated: First time**	The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk of spread of infection.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 3 **Ref: Regulation 30** **Stated: First time**	The registered person shall ensure that RQIA is made aware of any notifiable event without delay.	**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 39** **Stated: Second time**	The registered person shall ensure that all employed staff receives 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.	
Area for improvement 2 **Ref: Standard 35** **Stated: First time**	The registered person shall ensure that a robust system is developed and implemented which ensures effective managerial oversight in relation to staff registration with the NMC / NISCC.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

Area for improvement 3 **Ref:** Standard 39 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that a robust system is developed and implemented which ensures effective managerial oversight of nurse competency and capability assessments. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met.	**Met**
Area for improvement 4 **Ref: Standard 41** **Stated: First time**	The registered person shall ensure that the duty rota accurately reflects the name of the nurse in charge of the home in the manager's absence at all times. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met.	**Met**
Area for improvement 5 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure that a daily menu is on display in a suitable format and in an appropriate location, showing what is available each mealtime. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met.	**Met**
Area for improvement 6 **Ref**: Standard 37 **Stated:** First time	The registered person shall ensure that any record retained in the home which details patient information is stored safely and in accordance with DHSSP policy, procedures and guidance and best practice standards. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was not met. See Section 5.2.2 for more details. This area for improvement will be stated for the second time.	**Not met**

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to protect patients.

Review of records provided assurances that staff registrations with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC) were effectively monitored on at least a monthly basis.

There were systems in place to ensure staff were trained and supported to do their job. An overview of staff compliance with mandatory training was maintained and staff members were reminded when training as due. Review of training records confirmed that all staff had completed training in relation to DOLS.

There was a system in place to monitor and oversee nurse competency and capability assessments. Review of the records of the assessments evidenced that the majority of nurses had completed a nurse in charge competency assessment; a small number were outstanding and had been identified as requiring action to complete.

Medication competency assessments were overdue for all nurses and for the care home assistant practitioner (CHAP). An area for improvement was identified.

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

The deputy manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. The deputy manager also confirmed that efforts were made to cover shifts using bank and/or agency staff as necessary with block bookings arranged for consistency where possible.

Staff said that the morning routine was particularly affected by the experience and skill mix of staff on duty. It was observed that the morning routine took a considerable amount of time to complete; staff members were obviously kept busy but it was positive that they were not seen to rush the patients. On day one of the inspection it was noted that a nurse was still administering morning medications at 11.15 am. Patients had been provided with assistance to meet their personal care needs but several were only finishing breakfast when the mid-morning snack was being served.

Review of the current duty rota also identified an unplanned shortage of domestic staff. The deputy manager confirmed that recruitment was ongoing for staff within all departments but there had been limited success to date. It was confirmed that senior managers within the group had been alerted to the difficulties in recruiting staff and the continued reliance on agency staff.

Staff said there was good teamwork within their respective teams but care staff said that some nurses were reluctant to provide assistance with patients' personal care needs. Nursing staff said that they did not have capacity to provide this assistance, especially in the mornings, as they had alternative duties, such as medication administration, to deliver.

Satisfactory staffing levels, skill mix and experience should be maintained within all departments to ensure the needs of patients can be met consistently, effectively and in a timely manner. An area for improvement was identified.

Comments made by staff regarding staffing levels and teamwork were brought to the attention of the deputy manager for information and action. The deputy manager said that they were aware morale was low and discussed the efforts that were being made to improve morale and working relationships.

5.2.2 Care Delivery and Record Keeping

Staff confirmed that they met for a handover at the beginning of each shift to discuss any changes in the needs of the patients.

Staff were seen to respect patients' privacy, they knocked on doors before entering bedrooms and bathrooms and offered personal care to patients discreetly.

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. Care plans included any advice or recommendations made by other healthcare professionals.

There was evidence of consultation with patients and their relatives, if this was appropriate, in the records reviewed. Patients' individual likes and preferences were reflected throughout the records.

Where a patient was assessed as being at risk of falling, measures to reduce this risk were put in place with equipment such as crash mats in use. Care records reviewed reflected that appropriate action was taken in the event of a fall.

At times some patients may be required to use equipment that can be considered to be restrictive such as bed rails and alarm mats. It was established that safe systems were in place to manage this aspect of care.

Patients who are less able to mobilise were assisted by staff to mobilise or change their position regularly. However, care plans did not include details of individual patients' assessed needs regarding, for example, the use of pressure relieving mattresses or the recommended frequency of repositioning. An area for improvement was identified.

Review of a sample of wound care records evidenced that care plans had been developed detailing the type and frequency of wound dressing but there were gaps in the recording of wound care. Discussion with staff and observation of wound dressings provided assurances that dressings were changed as required but there was a lack of consistency in recording the dressing change. An area for improvement was identified.

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 from simple encouragement through to full assistance from staff. The mealtime was a pleasant and unhurried experience. Staff members were observed to provide patients with the appropriate level of support required during the meal time.

Staff told us how they were made aware of patients' nutritional needs to ensure they were provided with the right consistency of diet and the required assistance. However, there was no information readily available for staff in the dining rooms or on the heated trolley regarding patients and their recommended consistency of diet or menu choice. Staff said that they would always let new or agency staff members know which meal patients should be served but agreed that this was not a robust enough system and could lead to errors.

There was a choice of meals offered, the food was attractively presented, smelled appetising and portions were generous. However, the food being served differed from the planned menu for the day which was on display in the dining rooms. This was discussed with the chef who explained that changes had been made due to a lack of availability of ingredients. The chef said he did not consistently keep a record of changes made to the planned menu. An area for improvement was identified regarding the mealtime experience.

Patients were complimentary about the food provided in the home and confirmed that there was always an alternative choice available.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain.

Up to date records were kept of what patients had to eat and drink daily and when they were repositioned but it was observed that the front pages of the record booklets were not consistently completed with the required details; an area for improvement was identified.

While care records including care plans and nursing notes were held confidentially it was observed that patients' daily care records were not; these records were seen to be located in unlocked and/or at times unsupervised rooms during the inspection. This area for improvement was not met and has been stated for the second time.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was observed to be warm, clean and fresh smelling. Fire exits and corridors were observed to be clear of clutter and obstruction. Patients' bedrooms were personalised with items that were important to them such as family photos, cushions, ornaments, pictures and plants. Dining rooms were clean, tidy and attractively decorated.

There were several lounges throughout the home but it was noted that one had no suitable seating at all and others had limited seating available. Flooring in the ground floor visitor's toilet was damaged. The carpet on the stairs nearest to the ground floor reception area showed signs of wear and tear. Supplies and equipment were stored in inappropriate areas of the home resulting in identified areas being cluttered. An area for improvement was identified.

A number of patients' specialist chairs and wheelchairs were observed to need more effective cleaning. This was brought to the attention of staff and action was taken to effectively clean the identified equipment during the inspection. Equipment cleaning records reviewed were not up to date.

Staff should recognise that equipment may also need to be cleaned at unscheduled times and should take appropriate action to maintain equipment in a good clean condition. An area for improvement was identified.

As previously mentioned it was noted that there was an unplanned shortage of domestic staff in the home. This was discussed with the deputy manager who said that existing issues with domestic staffing had been exacerbated by a sudden resignation; it was confirmed that efforts were made to provide cover with bank or agency staff and recruitment for suitable staff was ongoing. Domestic staff said that they had discussed the ongoing staffing issues with the manager. Domestic staff also said that they worked well as a team but it was difficult to maintain the required standards when their department was consistently short staffed. Staffing levels in all departments of the home was identified as an area for improvement within Section 5.2.1.

Review of records confirmed that training on infection prevention and control (IPC) measures and the use of personal protective equipment (PPE) had been provided. However, staff use of masks in some areas of the home was not consistent or in keeping with the current guidance. This was brought to the attention of the deputy manager for information and appropriate action. On day two of the inspection the deputy manager confirmed that staff had been reminded of their responsibilities around mask wearing and that this would be closely monitored going forward.

There were sufficient supplies of PPE throughout the home. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance when they were attending to patients. Review of records evidenced that staff use of PPE and hand hygiene was inconsistently monitored. It was determined that the home's current monthly monitoring report included improving the frequency of hand hygiene and PPE audits as a required action; progress in this area this will be reviewed at the next care inspection.

Patients said that they were satisfied the home was kept clean and tidy; no concerns were raised by patients or relatives about the environment.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. The atmosphere throughout the home was warm, welcoming and friendly, music was playing or TV's were on and patients were seen to be relaxed and content in their surroundings.

It was observed that staff offered choices to patients throughout the day which included, for example, food and drink options and where and how they wished to spend their time.

Staff were seen to effectively communicate with patients and to speak to them in a friendly and caring manner. It was obvious that staff members were busy but they were observed to provide patients with assistance in a timely manner.

The patient activity lead (PAL) discussed the importance of consultation with patients and/or their relatives to determine individual interests and hobbies in order to help with activity planning in the home. Feedback was sought on the activities provided to evaluate how enjoyable or suitable patients found these.

Patients' views and opinions on the meals and other aspects of the running of the home were also sought in order to help drive improvement and ensure that patients had a positive experience.

The current activity schedule included one to one and group activities in order to help meet patients' cultural, social and spiritual needs. Patients were offered an opportunity to watch movies, take part in quizzes and do jigsaw puzzles. Church services were planned on a weekly basis. A hairdresser came into the home regularly. Outside entertainers providing opportunities for new experiences such as 'circus skills' were regularly booked. A generational scheme was about to commence with volunteers from the local youth forum.

The PAL said that it was important to recognise that, while some patients just needed a bit of encouragement to join in, not all patients enjoyed group and/or planned activities. Each day the PAL made an effort to call in with all the patients to say hello, deliver newspapers and let them know what was planned for the day. Patients who preferred one to one room visits would have these scheduled.

Staff recognised the importance of visits from relatives and said it was really positive that relatives, volunteers groups and entertainers could all visit the home again.

Birthdays and holidays were celebrated. Souvenir photo albums of recent parties, including the summer BBQ and the Queen's Jubilee celebrations, had been commissioned and were on display.

Patients said they were satisfied with the type and variety of activities provided in the home.

5.2.5 Management and Governance Arrangements

There has been a change in the management of the home since the last inspection. Ms Karen Blair has been the manager in the home since 20 April 2022. Ms Blair was in the process of submitting an application to RQIA to be registered as the manager of Croagh Patrick Care Home.

Staff members 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. Staff meetings were held and a record of these was maintained.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

Relatives spoken with said that they knew how to report any concerns and that they were confident these would be sorted out. There was a system in place to manage complaints. The deputy manager said that the outcome of complaints was shared with staff and was seen as an opportunity to for the team to learn and improve.

It was established that there was 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.

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 in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed.

Staff commented positively about the manager; they said she was approachable, listened to them and had taken their concerns regarding staffing, teamwork and the skill mix seriously. One member of staff said that the manager "was a breath of fresh air" and very supportive.

6.0 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).

	Regulations	Standards
Total number of Areas for Improvement	4	5*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Jennifer Hogan, Deputy Manager, and, Michelle MacMillan, Registered Manager (of another home in the group), 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 20(1)(a) **Stated:** First time	The registered person shall ensure that all nurses and the CHAP undertake medicine competency assessments as per the home's planned annual medication competency schedule. Ref: 5.2.1
To be completed by: With immediate effect	**Response by registered person detailing the actions taken:** The CHAP medicine competency has been completed. The remaining 4 competencies will be completed by Friday 17th December 2022.Compliance will continue to be monitored through the completion of the Reg 29 Audit.

Area for improvement 2 **Ref:** Regulation 20 (1)(a) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that satisfactory staffing levels are maintained in all departments of the home. Planned staffing levels should include suitably experienced staff and an adequate skill mix in order to ensure that patients' needs can be met effectively, consistently and in a timely manner. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Home Manager has been actively recruiting with the bespoke Care Asssitant rate applicable to Croagh Patrick Care Home and 3 new Care Assistant staff have commenced employment and a further 2 care staff appointed are undergoing pre- employment checks. The Recruitment Team are aware of all vacancies and have been internally and externally advertised. The Clinical Lead post for First Floor has been advertised and the interview process is to be concluded. Vacant RN posts are currently advertised. The International recruitment team are aware of vacancies but there is no date for pre-registration nurses as yet. Posts are being back filled with block booked and ad hoc Flexibank and agency RNs. All other vacant ancillary posts continue to be advertised and during the recruitment process all attempts are being made to cover with overtime at the new enhanced rate and agency when available. CHESS Dependency tool is a life document when is continually reviewed and updated at least on a monthly basis if there are no changes in between. Staffing is currently in line with the indicative staffing levels. Absenteeism is being robustly managed through Beaumont Policy. Croagh Patrick is part of the Managing Director and Operations Director focused action group for Recruitment and Agency Reduction Strategy and this is reviewed on a weekly basis. Staffing is kept under review as part of the Regulation 29 Report.

Area for improvement 3 **Ref:** Regulation 12 (1) (a)(b)(c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that care plans developed to manage the prevention of pressure damage include details of the recommended use of pressure relieving mattresses/cushions and/or the recommended frequency of repositioning for individual patients. Ref: 5.2.2
	Response by registered person detailing the actions taken: Body maps were completed for all residents on 15th October 2022. All Braden scores have been reviewed and updated. All Residents with a Braden score of 18 or less have a careplan in place which includes details of any recommended pressure relieving mattresses or cushions and or the recommended frequency of repositioning. These careplans have been reviewed by the Beaumont Care Quality Manager and any deficits have been addressed. Care-planning will be monitored through Beaumont Care care-plan auditing by the Home Manager or designated other and through the Regulation 29 Report.
Area for improvement 4 **Ref:** Regulation 27 (2) (d)(g)(l) **Stated:** First time **To be completed by:** 28 February 2023	The registered person shall ensure that: • sufficient numbers of suitable chairs are available in communal lounges • flooring is replaced in the ground floor visitor's toilet • stair carpets are maintained in good condition and/or replaced as necessary to reduce the risk of trips and slips • supplies and equipment are stored in appropriate areas of the home. Ref: 5.2.3
	Response by registered person detailing the actions taken: A quote has been requested for 18 chairs and will be approved through the capex system. A quote for the visitors toilet has been requested and will be approved through the capex process. The staircases have been reviewed and no slip or trip risks have been identifed at present.The stair carpet does not match the current corridor carpet. A quote for the stair carpet has been requested and will be considered through the capex process. The Home is identifying an alternative storage space for the storage of testing equipment boxes and if an alternative cannot be found a variation proposal will be submitted for room repurposing to create additional storage space.

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 37 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that any record retained in the home which details patient information is stored safely and in accordance with DHSSP policy, procedures and guidance and best practice standards. Ref: 5.1 & 5.2.2
	Response by registered person detailing the actions taken: All resident supplementary documentation is now being held in the residents individual rooms and the remainder are retained in nurses office. This will be monitored through the Home Manager Daily walkabout completion to ensure it is embedded into practice and compliance will be monitored through the Regulation 29 Report.
Area for improvement 2 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that records relating to wound care are completed consistently and contemporaneously. Ref: 5.2.2
	Response by registered person detailing the actions taken: All wound care documentation is being reviewed by the Beaumont Care Quality Manager on 28th November and 6th December 2022 and any deficits found are being addressed. The Home Manager will check the compliance of wound care recording during Daily walkabout completion and sign the RN diary daily ensuring wound care planned for that day has been addressed and recorded onto the wound analysis form and the careplan evaluation. The Home Manager will complete a monthly wound care TRaCa on each resident with a wound. The monthly Home Manager wound analysis has been updated with all current wounds. The repositioning supplementary booklet front covers have been completed by cross referencing to risk assessment and care plan and laminating the front page. The supplementary documentation relating to pressure area prevention is now held in residents' bedrooms. RNs are quality assuring the completion of repositioning supplementary documentation. SEHSCT TVN Wound Assessment and Management will be conducted on a proposed date of 9th December 2022. Compliance will also be monitored by the Regulation 29 Report.

Area for improvement 3 **Ref:** Standard 12 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that: • there is a suitable system in place to ensure that patients are provided with the correct consistency of diet • any variations to the planned menu are consistently recorded and available for review • the menu on display for patients is updated if changes are made. Ref: 5.2.2
	Response by registered person detailing the actions taken: **Dietary sheets for each resident have been updated, cross referenced and a copy in file to the kitchen. A quick guide for ease of review has been typed and laminated for each dining room and trolley. This will be checked and updated every Sunday by the night duty RN.** **SEHSCT SLT has been supporting the Home on 21st November, 28th and 29th November and have reviewed all resident documentation known to SLT. They have provided feedback in relation to the correlation of SLT recommendations across all documentation. RN staff are working through this feedback to ensure correlation is achieved. The Beaumont Care Nutritional Audit will be conducted by the Care Quality Manager to evidence the compliance. The Home Manager will monitor all changes to SLT recommedations and ensure documentation is updated. This will be reviewed by the Regulation 29 Report** **The daily menu is now also displayed on a blackboard in each Dining room. This is updated daily and is the responsibilty of the kitchen staff. Any changes to the planned menu are recorded on the blackboard for the Residents knowledge, recorded in the Kitchen diary and recorded by the Home Manager on the Daily walkabout. This will further be monitored by the Regulation 29 Report.**

Area for improvement 4 **Ref:** Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all required patient details are completed on the supplemental record booklets in use for individual patients. Ref: 5.2.2
	Response by registered person detailing the actions taken: **Supplementary booklets front covers have been completed by cross referencing to the risk assessments and care plans and laminating the front page. All supplementary documentation is now held in residents bedrooms.** **This will be monitored by the Home Manager's Daily walkabout** **Compliance will also be monitored by the Regulation 29 Report.**
Area for improvement 5 **Ref:** Standard 45 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that equipment cleaning records are kept up to date and that equipment is cleaned according to the schedule and/or also when required. Ref: 5.2.3
	Response by registered person detailing the actions taken: **Cleaning records are now retained in the residents rooms and equipment schedules are being put in place.** **Supervision with staff will be ongoing to ensure this is embedded into practice.** **This will be monitored by Home Manager on the Daily walkabout completion and compliance will be monitored by the Regulation 29 Report**

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

The Regulation and Quality Improvement Authority

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