# Unannounced Care Inspection Report
# 26 September 2019

# Melmount Manor Care Centre

**Type of Service: Nursing Home**
**Address: 1 Orchard Road, Strabane BT82 9QR**
**Tel No: 028 7138 3990**
**Inspector: Jane Laird**

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes. 2015.

## 1.0 What we look for


## 2.0 Profile of service

This is a registered nursing home which provides care for up to 69 patients.

## 3.0 Service details

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|---|---|
| **Organisation/Registered Provider:**<br>Larchwood Care Homes (NI) Ltd<br><br>**Responsible Individual:**<br>Christopher Walsh | **Registered Manager and date registered:**<br>Annie Frobisher<br>28 December 2012 |
| **Person in charge at the time of inspection:**<br>Annie Frobisher, registered manager | **Number of registered places:**<br>69<br><br>A maximum of 38 patients in category NH-DE and a maximum of 31 patients in categories NH-I and NH-PH |
| **Categories of care:**<br>Nursing Home (NH)<br>I – Old age not falling within any other category.<br>DE – Dementia.<br>PH – Physical disability other than sensory impairment. | **Number of patients accommodated in the nursing home on the day of this inspection:**<br>68 |

## 4.0 Inspection summary

An unannounced care inspection took place on 26 September 2019 from 10.15 hours to 19.00 hours. The purpose of the inspection was to assess whether the home was delivering safe, effective and compassionate care and if the service was well led.

As a result of the inspection, RQIA were concerned that a number of areas in relation to the quality of care and service delivery within Melmount Manor Care Centre were below the minimum standard expected. A decision was taken to invite the responsible individual to a serious concerns meeting in relation to the general presentation of patients, infection prevention and control (IPC), control of substances hazardous to health (COSHH), risk management and fire safety. Further areas of concern were identified in relation to record keeping, supplementary charts, pressure area care, management of complaints, reporting of notifiable events, quality governance audits and the provision of mandatory training. This meeting took place at RQIA on 7 October 2019.

At this meeting Christopher Walsh, responsible individual, Nuala Greene, managing director and Annie Frobisher, registered manager, acknowledged the deficits identified and provided an action plan as to how these would be addressed by Melmount Manor Care Centre management team. RQIA were provided with the appropriate assurances and the decision was made to take no further enforcement action at this time. RQIA will continue to monitor and review the quality of service provided in Melmount Manor Care Centre and will carry out a further inspection to validate sustained compliance and to drive necessary improvements.

Areas requiring improvement were identified as outlined in the quality improvement plan (QIP). Please refer to section 7.0.

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

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

## 4.1 Inspection outcome

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 7 | 5 |

Details of the Quality Improvement Plan (QIP) were discussed with Annie Frobisher, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action resulted from the findings of this inspection by way of a serious concerns meeting. Following this meeting a decision was made to take no further enforcement action at this time.

## 4.2 Action/enforcement taken following the most recent inspection dated 3 January 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 3 January 2019. No further actions were required to be taken following this inspection.

## 5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, and any other written or verbal information received.

During our inspection we:

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

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

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

The following records were examined during the inspection:

- duty rota for all staff from 16 September 2019 to 29 September 2019
- 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
- five patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits/records
- complaints record
- compliments received
- a sample of monthly monitoring reports for August 2019 and September 2019

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

## 6.0 The inspection

## 6.1 Review of areas for improvement from previous inspection

There were no areas for improvement identified as a result of the last care inspection.

## 6.2 Inspection findings

## 6.3 Is care safe?

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

We arrived at the home at 10.15 hours and were greeted by the manager and staff who were helpful and attentive. Patients were mainly in one of the dining areas or lounges following breakfast or mobilising around the unit as desired, whilst others were either seated in their bedroom or in bed as per their personal preference and/or assessed needs.

Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients, however, staff did comment that staffing levels can be effected by short notice absenteeism and that there was a high turnover of staff making it difficult to carry out their role effectively on occasions.

Comments from staff included;

- “I love it here”
- “Staffing levels have improved”
- “Big turnover of staff”
- “Stressful when short staffed”
- “Feel supported by management”

Staff stated that they were aware of the homes recruitment drive and welcomed the addition of new employees to enhance the availability of cover during short notice absence. We also sought staff opinion on staffing via the online survey. There was no response in the time frame allocated.

Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Melmount Manor Care Centre. We also sought the opinion of patients on staffing via questionnaires. Unfortunately there was no response in the time frame provided.

On review of the duty rota there were adequate staffing levels within the home to meet the needs of the patients. However despite sufficiency of staffing we observed that patients’ needs were not always met by the levels and skill mix of staff on duty. There was poor recognition and delivery of care in regards to identified patients eye/oral care and the personal care of identified patients were observed to be below an acceptable standard and relevant staff were requested to attend to the patients needs by the inspector during the inspection. This was discussed with the manager and identified as an area for improvement.

Records of staff training in mandatory topics were reviewed and evidenced that there was poor compliance across all topics. This was discussed with the manager who stated that the homes trainer was currently unavailable and they were in the process of sourcing another trainer from within the company. During the meeting at RQIA the responsible person provided additional training dates for IPC and moving and handling. This is discussed further in 6.6.

We reviewed staff supervision and annual appraisal records which identified that there was no system in place to easily establish when an employee had received their supervision and/or appraisal and when it was next due. This also applied to the yearly competency and capability assessments for registered nurses. We discussed this concern with the manager who implemented a matrix chart for each of the areas discussed prior to the completion of the inspection and agreed to update the charts with the relevant dates.

There was evidence of poor management of hygiene throughout patient bedrooms, bathrooms, sluice rooms and communal areas. Furniture and patient equipment was observed to be soiled and not decontaminated after use. Continence aids were identified as being left open outside of the packaging throughout the home which risked contamination prior to patient use. The underneath of raised toilet seats, commodes, shower chairs, shower heads, hand paper towel, toilet paper and soap dispensers evidenced that these had not been effectively cleaned following use. Equipment used by patients was not appropriately maintained and could not be effectively cleaned, including over bed tables, identified mattresses and bed frames. Wheelchairs were observed to be unclean and high and low level dusting was poorly maintained. We identified inappropriate storage of patient equipment in an identified sluice room and cupboards within the dining areas and cutlery trays unclean. There was a deficit in the knowledge base of staff in relation to the management of IPC and staff were observed to be non-compliant with the principles of good IPC. Hand washing practices were limited across all grades of staff and the use of alcohol gel was not observed throughout the inspection. As an outcome of the inspection concerns were

identified in regards to the cleanliness of the environment and adherence to best practice in infection prevention and control (IPC). The above deficits were discussed in detail with the manager and identified as an area for improvement. During the meeting at RQIA the responsible individual provided an action plan detailing the actions taken to address the deficits which included a deep clean of the home and patient equipment following the inspection and that equipment had been repaired and/or replaced as necessary.

A malodour was evident in identified patient bedrooms and on examination of the mattresses a number were found to be stained and not fit for purpose. These were replaced during the inspection and a detailed review of all mattresses was scheduled to be undertaken following the inspection. During the meeting the responsible individual confirmed that all identified mattresses were replaced and that ongoing audits have been initiated to ensure that standards are maintained.

We identified a chemical within a spray bottle unsupervised within a communal area of the home which had the potential to be harmful to health if ingested. This was discussed with the registered nurse who removed the chemical and acknowledged the risks associated with this practice. This information was shared with the manager and identified as an area for improvement.

There was poor management of risks for patients. Scissors and other toiletries including denture cleaning tablets and razors were left unsecured in patients' bedrooms within the dementia unit presenting as a potential risk to patients' safety. Patients were observed to be unsupervised within the dementia unit with access to food which had the potential to increase the risk of choking and the door to a linen store was observed unlocked with a staff handbag inside. This was discussed with the manager as an area for improvement. During the meeting at RQIA the responsible individual confirmed that locks had been fitted to vanity units within patients' bedrooms to reduce the risks associated with the above practices and that notices were on display for visitors to speak with the nurse in charge of the unit prior to distributing food items.

A bedroom door was identified as being propped open with a bed side locker. Staff displayed a lack of awareness of the risks associated with this practice throughout the inspection and failed to inform the manager that the magnetic holding device for the door was broken. This was discussed with the manager who requested the maintenance personnel to repair the door. This was identified as an area for improvement due to the risks associated with this type of practice. During the meeting the manager provided dates for fire awareness training and agreed to monitor this during daily walk arounds.

Head injury observations were carried out on patients post fall but not in accordance to the updated NICE guidelines. This was discussed during the meeting at RQIA and the responsible individual provided evidence as to why the home preferred to use different guidelines in line with their current policy. It was recommended that they communicate with the commissioning trust to establish the preferred guidance and observations to be used.

**Areas for improvement**

The following areas were identified for improvement in relation to general presentation of patients, infection prevention and control (IPC), control of substances hazardous to health (COSHH), risk management and fire safety.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 4 | 1 |

**6.4 Is care effective?**

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

We reviewed the management of nutrition, patients' weight, management of infections and wound care for five patients and a number of deficits were identified within care plans to direct the care required. On review of one patient's care records it was identified that there was incorrect grading of a wound and a referral had not been made to the tissue viability nurse (TVN), the commissioning trust, next of kin or RQIA. Care plans for diet and nutrition did not include the dietary type and/or fluid consistency for one identified patient and a referral made by another healthcare professional had not been followed up in several months for another patient in relation to oral care. Risk assessments and care plans were not consistently reviewed on a monthly basis with multiple scoring out throughout identified care records resulting in the original entry not being able to be clearly read. Daily records failed to elaborate on the accurate delivery of care and events on a daily basis and there was no evidence that any communication had been made with the next of kin and/or the commissioning trust regarding any of the above findings. This was discussed with the manager and identified as an area for improvement. The manager acknowledged the above deficits in record keeping and agreed to communicate with relevant staff the importance of communicating effectively with other health care professionals, patient representatives and to document all relevant conversations. Following the inspection the manager submitted a notification to RQIA in relation to the above patients wound and confirmed that all other relevant parties had been informed.

On review of a sample of repositioning records patients were being repositioned as per their care plan on most occasions, however, there were inconsistencies in relation to the recording of the frequency of repositioning on identified recording charts. We further identified that the records for an identified patient in relation to fluid intake over a four day period had inconsistencies in relation to the type of fluid consistency recommended. Two of the charts had no recommended fluid consistency recorded and different consistency types of fluid were identified on the other two charts. This was discussed with the manager to review due to the potential risk to the patient consuming incorrect fluid consistency. The manager acknowledged the shortfalls in the documentation and agreed to review all patients' supplementary charts regarding pressure area care and care plans in relation to dietary/fluid requirements and to communicate with relevant staff to ensure they document accurately the daily events within patients' supplementary charts. This was identified as an area for improvement.

We also reviewed the settings on identified pressure relieving mattresses and on review of the patients care records the care plans regarding pressure care did not contain the recommended setting/type of pressure relieving mattress. This was discussed with the manager who acknowledged the importance of including such information within the patients care plan and agreed to implement this going forward.

Staff confirmed that they were required to attend a handover meeting at the beginning of each shift and demonstrated an awareness of the importance of handover reports in ensuring effective communication. Staff confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

**Areas for improvement**

Areas for improvement were identified in relation to record keeping, supplementary charts and pressure area care.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 1 | 2 |

**6.5 Is care compassionate?**

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

Staff interactions with patients were observed to be compassionate and caring. However, we observed the reaction of staff during an incident where a patient with dementia exited the unit. We observed that staff lacked appropriate skills in how to deescalate the situation and to provide the necessary reassurance to the patient resulting in the manager intervening to resolve the situation. This was discussed with the manager who agreed to arrange appropriate training for staff in relation to supporting patients who have dementia. This is discussed further in 6.6.

Consultation with 15 patients individually, and with others in small groups, confirmed that living in Melmount Manor Care Centre was a positive experience.

Patient comments:

- “Staff are looking after me well”
- “I am doing the best”
- “Happy here. No concerns”
- “Staff are good”
- “The staff are looking after me terrible well”
- “Feel happy. Staff friendly”

Representative’s comments:

- “Staff are very friendly”
- “Fantastic care”
- “Manager very approachable”
- “Very happy with ….. care”
- “The patients are well looked after”

We also sought relatives’ opinion on staffing via questionnaires. There was no response in the time frame provided.

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

Patients' bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences. A virtual dementia train was located within a dayroom of the Dennett unit which included journeys to various locations to enhance patient experience and develop positive memories. The purchase of the train was through fund raising by patient representatives.

We observed the serving of lunch. Lunch commenced at 12.15 hours and a range of drinks were offered to patients. Trays were delivered to patients in their bedroom as per their personal choice. Staff were observed assisting patients with their meal appropriately in an unhurried manner, however, not all staff were wearing aprons during the meal delivery. This was discussed with the manager who agreed to monitor this going forward and address with relevant staff when required.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. On the day of the inspection the activity coordinator was very enthusiastic in her role and patients had participated in a baking activity. There was clear evidence of a relaxed, pleasant and friendly atmosphere between patients and staff and care records contained the social history of the patients and their preferences in relation to activities.

**Areas for improvement**

There were no areas for improvement identified during the inspection within this domain.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 0 | 0 |

**6.6 Is the service well led?**

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

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded.

We reviewed accidents/incidents records in comparison with the notifications submitted by the home to RQIA which verified that records were maintained appropriately, however, as previously discussed in 6.3 a notifiable event had not been submitted to RQIA in accordance with regulation. This was discussed with the manager who submitted the notification retrospectively and an area for improvement was identified.

Review of the home's complaints records evidenced that systems were not in place to ensure complaints were being recorded appropriately. This was discussed during the meeting and new recording charts were initiated and training had been provided to relevant staff. This was identified as an area for improvement which will be reviewed at a future inspection.

Management audits failed to identify deficits in the management of wound care records, pressure area care, non-reporting of a notifiable event, risk management and lack of recorded

communication between staff and patient representatives. We further identified that there were no audits in relation to care records and hand hygiene and during the meeting the responsible individual discussed the homes review of audits to ensure they were more specific to the home. This was identified as an area for improvement.

As discussed in 6.3 and 6.5 concerns were identified during the inspection regarding that lack of training in fire awareness, swallowing difficulties, pressure area care, IPC, Control of Substances Hazardous to Health (COSHH) and dementia to enable staff to effectively carry out their role. On review of the monthly monitoring visits by the responsible individual in July 2019 and August 2019 it was identified that the training statistics were below an acceptable percentage. Despite this having been identified there was no action taken by the manager to address the deficit in a timely manner. This was discussed with the manager and identified as an area for improvement.

**Areas of good practice**

There were examples of good practice found throughout the inspection in relation to maintaining good working relationships.

**Areas for improvement**

The following areas were identified for improvement in relation to management of complaints, reporting of notifiable events, quality improvement and the provision of mandatory training.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 2 | 2 |

## 7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Annie Frobisher, registered 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 Nursing Homes Regulations (Northern Ireland) 2005**

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|---|---|
| **Area for improvement 1**<br><br>**Ref**: Regulation 27<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With Immediate effect | The registered person shall ensure that the environmental and infection prevention and control issues identified during this inspection are urgently addressed and a system is initiated to monitor ongoing compliance.<br><br>Ref: 6.3 |
| | **Response by registered person detailing the actions taken:**<br>Following the inspection a deep clean of the Home was commissioned over a 5 day period. In addition the cleaning records were reviewed and revised to ensure that the housekeeper and Home Manager could more easily review these. Housekeeping hours were reviewed and increased and the duty rota for the Housekeeper was amended to provide more oversight. Decontamination records were reestablished and updated. A further audit of all areas of the Home was completed and reviewed twice over the subsequent month with actions updated as completed. New quipment including showerchairs, commode chairs and mattresses were purchased as required. The Home established new auditing processes including weekly environmental auditing with associated action plans and hand hygiene audits. |
| **Area for improvement 2**<br><br>**Ref:** Regulation 14 (2) (a) (b) and (c)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With Immediate effect | The registered person shall ensure that all chemicals are securely stored in accordance with COSHH legislation, to ensure that patients are protected from hazards to their health.<br><br>Ref: 6.3 |
| | **Response by registered person detailing the actions taken:**<br>In the dementia unit where the risk assessment for access to cosmetic products indicated that residents should be protected from access under sink vanity units had locks installed. In addition the stores within this unit were locked and unncessary prodcucts relocated to resident bedrooms. Domestic staff were reminded of their responsibilities in the safeguarding of cleaning products whilst undertaken duties. |

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| **Area for improvement 3**<br><br>**Ref**: Regulation 27 (4)(b)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With immediate effect | The registered person shall take adequate precautions against the risk of fire to ensure the safety and wellbeing of patients in the home.<br><br>Specific reference to ensuring that fire doors are not propped open.<br><br>Ref: 6.3 |
| | **Response by registered person detailing the actions taken:**<br>The outcome of the inspection was communciated to all staff and staff were encouraged to ensure that all doors were closed when not in use or held open with magnetic or sound activated closure devices. |
| **Area for improvement 4**<br><br>**Ref**: Regulation 27 (2) (t)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With immediate effect | The registered person shall, having regard to the number and needs of the patients, ensure that a risk assessment to manage health and safety is carried out and updated when necessary.<br><br>With specific reference to:<br>• storage of denture cleaning tablets and toiletries including scissors<br>• staff handbags<br><br>Ref: 6.3 |
| | **Response by registered person detailing the actions taken:**<br>In line with Area for Imrpovement 2 the risk assessment for residents in the dementia unit indicated that there was a need for the vanity units under the sinks to be locked. This was duly undertaken in the two weeks post inspection. The communal storage area for linen, which also contains overstock of cosmetic products was also reinforced with a bar and key lock. |

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| **Area for improvement 5**<br><br>**Ref**: Regulation 13 (1) (a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>26 November 2019 | The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals.<br><br>Specific reference to care plans and daily records:<br><br>• care plans must be person centred and relevant to the patients current care needs<br>• any changes or alterations to a patients care plans or care records are made in such a way that the original entry can still be read.<br><br>Ref: 6.4 |
| | **Response by registered person detailing the actions taken:**<br>Staff nurses were reminded of their responsibilities in line with the good guidance stated within the Code of practice from the NMC section 10. The Home Manager is establishing a process for named nurses to review care files within the Home. |
| **Area for improvement 6**<br><br>**Ref:** Regulation 30<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With Immediate effect | The registered person shall give notice to the Regulation and Quality Improvement Authority without delay of any occurrence of a pressure ulcer until further notice.<br><br>Ref: 6.6 |
| | **Response by registered person detailing the actions taken:**<br>Following the inspection the Home Manager reviewed the current guidelines from the RQIA in respect of the notification of events. In particular the appendix 2 reporting grid was reviewed and established within practice. |
| **Area for improvement 7**<br><br>**Ref:** Regulation 20 (1) (c) (iii)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>26 November 2019 | The registered person shall ensure that persons employed to work at the nursing home receive training relevant to their role.<br><br>Ref: 6.6 |
| | **Response by registered person detailing the actions taken:**<br>The Home Manager has instructed training for all staff in the mandatory areas including safeguarding, infection control and emergency care. There has been 4 all day training sessions at time of writing and further training will be provided in December if required. |

| Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015 | |
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| **Area for improvement 1**<br><br>**Ref**: Standard 6<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With Immediate effect | The registered person shall ensure that patients' personal care and grooming needs are regularly assessed and met. This includes (but is not limited to):<br><br>• Patient's finger nails<br>• Facial hair<br>• Footwear<br>• Clothing<br>• Eye/oral care<br><br>Ref: 6.3 |
| | **Response by registered person detailing the actions taken:**<br>The Home Manager and Responsible Individual met with nursing and care staff following the inspection to highlight the findings. Individual residents who have been assessed as self-neglectful or non-compliant with personal care attempts will have care plans generated in consultation with their families to document this. |
| **Area for improvement 2**<br><br>**Ref**: Standard 4<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With Immediate effect | The registered person shall ensure that all nursing interventions are appropriate to the individual patients needs and supported by current evidence and best practice guidelines.<br><br>Specific reference to repositioning and fluid intake recording charts:<br><br>• The frequency of repositioning should be recorded within the repositioning chart to reflect the patients care plan<br>• Dietary type and fluid consistency should be recorded on daily intake charts to direct relevant care.<br><br>Ref: 6.4 |
| | **Response by registered person detailing the actions taken:**<br>Nursing staff were reminded that they must prescribe care in line with the Company "Care Prescription" policy. This includes the need to prescribe repositioning for residents who are risk assesed through the use of the Braden tool. In addition, nursing staff are reminded to document dietry and fluid intake in daily communciation for residents assessed at risk of malnutrition of dehydration. |

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| **Area for improvement 3**<br><br>**Ref**: Standard 23<br><br>**Stated:** First time<br><br>**To be completed by:**<br>26 November 2019 | The registered person shall ensure that there are clear and documented processes for the prevention, detection and treatment of pressure damage.<br><br>With specific reference to ensuring:<br>• the recommended setting/type of pressure relieving mattress are maintained at the correct setting and included in the patients care plan<br>• where the recommended setting has been altered to suit the patients individual preference it is clearly documented within their care plan<br><br>Ref: 6.4 |
| | **Response by registered person detailing the actions taken:**<br>Nursing staff have been supported to understand that the assessment using the Braden tool must result in appropriate plans of care if indicated. Where there are risks identified, nursing staff will document the same in a prescription of care. |
| **Area for improvement 4**<br><br>**Ref**: Standard 35<br><br>**Stated:** First time<br><br>**To be completed by:**<br>26 November 2019 | The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home.<br><br>• Environmental and hand hygiene audits should be sufficiently robust to ensure that any IPC deficits are appropriately identified and actioned<br>• Governance audits in respect of care records should be initiated to ensure care plans and care records are maintained as required<br><br>Ref: 6.6 |
| | **Response by registered person detailing the actions taken:**<br>Following the inspection a full new suite of governance audits was compiled and implemented. These included hand hygiene and a weekly enviornmental audit. In addition, audits of showerchairs, mattresses, commode chairs, waste bins.<br><br>Further the Home Manager has instructed that the management team in the Home will instigate audits on the care files completing 3 care files per unit monthly. This will ensure that all care files are reviewed within the year and actions will be communciated to the Home Manager and the named nurse with a review dates stated. |

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| **Area for improvement 5**<br><br>**Ref**: Standard 16<br><br>**Stated:** First time<br><br>**To be completed by:**<br>26 November 2019 | The registered person shall ensure that all complaints are dealt with promptly and effectively and held within a complaints ledger.<br><br>Ref: 6.6 |
| | **Response by registered person detailing the actions taken:**<br>All staff were provided with training in the definition and response to expressions of dissatisfaction. The Home Manager maintains a register of complaints and feedback and will seek resolution where possible. |

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

The Regulation and Quality Improvement Authority

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