Blair House Care Home
RQIA ID: 11104
107 Dakota Avenue
Newtownards
BT23 4QX

Inspector: Dermot Walsh
Inspection ID: IN021768

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Unannounced Care Inspection
of
Blair House Care Home

24 February 2016

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 24 February 2016 from 10.15 to 17.30.

The focus of this inspection was continence management which was underpinned by selected criteria from:

Standard 4: Individualised Care and Support; Standard 6: Privacy, Dignity and Personal Care; Standard 21: Health care and Standard 39: Staff Training and Development of the DHSSPSNI Care Standards for Nursing Homes (2015).

Overall on the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Please also refer to sections 5.2 and 6.2 of this report.

For the purposes of this report, the term 'patients' will be used to described those living in Blair House which provides both nursing and residential care.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 7 September 2016.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	*7

*The total number of recommendations includes three recommendations stated for the second time.

The details of the Quality Improvement Plan (QIP) within this report were discussed with the Registered Manager, Caron Conroy, and the Deputy Manager, Cathy Lacey, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Priory Ltd. Caroline Denny	**Registered Manager:** Caron Conroy
Person in Charge of the Home at the Time of Inspection: Caron Conroy	**Date Manager Registered:** 3 December 2014
Categories of Care: RC-DE, NH-DE, NH-I	**Number of Registered Places:** 81
Number of Patients Accommodated on Day of Inspection: 78	**Weekly Tariff at Time of Inspection:** £475 - £675

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the selected criteria from the following standards have been met:

Standard 4: **Individualised Care and Support, criterion 8**
Standard 6: **Privacy, Dignity and Personal Care, criteria 1, 3, 4, 8 and 15**
Standard 21: **Health Care, criteria 6, 7 and 11**
Standard 39: **Staff Training and Development, criterion 4**

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with the registered manager
- discussion with patients
- discussion with patient representatives
- discussion with staff
- review of a selection of records
- observation during a tour of the premises
- evaluation and feedback

The inspector met with 25 patients, four patient representatives, seven care staff, three ancillary staff members and three registered nursing staff.

Prior to inspection the following records were analysed:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report

The following records were examined during the inspection:

- a sample of staff duty rotas
- staff training records
- five care records
- selection of personal care records
- a selection of policies and procedures
- incident and accident records
- complaints records
- care record audits
- infection control audits

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 7 September 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection dated 7 September 2015

Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref:** Standard 32.1 **Stated:** First time	The refurbishment plan and timeline for commencement and completion should be submitted to RQIA when returning the Quality Improvement Plan.	**Met**
	Action taken as confirmed during the inspection: During a tour of the premises, the submitted refurbishment plan was observed to be close to completion. Four remaining identified rooms were in the process of being refurbished.	

Recommendation 2 **Ref:** Standard 44 Criteria (3) (11) **Stated:** First time	The registered person should ensure that the function of rooms within the home are not inhibited due to inappropriate storage. Rooms should only be used for their designated purpose.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and observation during a tour of the premises evidenced all rooms were being used for the function which they were registered. Storage in rooms did not inhibit the use of the room.	
Recommendation 3 **Ref:** Standard 32 **Stated:** First time	The registered person should ensure that a protocol for timely access to any specialist equipment or drugs is developed. A system to implement the protocol should confirm that all relevant staff have read the document with evidence of staff signature and date.	**Not Met**
	Action taken as confirmed during the inspection: A protocol had not been developed for timely access to any specialised equipment or drugs.	
Recommendation 4 **Ref:** Standard 46 Criteria (1) (2) **Stated:** First time	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection.	**Partially Met**
	Action taken as confirmed during the inspection: Evidence of infection control audits having been conducted on a monthly basis were available on inspection. An additional audit using 'A Good Practice Audit Tool' was completed on 7 February 2016 following an outbreak of Noro Virus. However, during a tour of the premises, areas identified on the previous inspection were also evident on this inspection. Please see Section 5.4.2 for further clarification.	

Recommendation 5 **Ref:** Standard 4 Criteria (9) **Stated:** First time	The registered person should ensure that supplementary care records are completed in full, in a timely manner and a system is put in place to monitor this.	**Partially Met**
	Action taken as confirmed during the inspection: Evidence of documentation audits having been conducted were available on inspection. However, a review of five patients' supplementary care records evidenced omissions of data and/or non-completion of records. Please see section 5.3 for further clarification.	

Areas for Improvement

A protocol should be developed to ensure timely access to specialist equipment and/or drugs.

A more robust system of ensuring best practice compliance with infection prevention and control should be developed.

Supplementary patient records should be completed in full and in a timely manner.

Number of Requirements:	**0**	**Number of Recommendations:**	**3**

5.3 Continence Management

Is Care Safe? (Quality of Life)

Policies and procedures dated February 2014 were in place to guide staff regarding the management of continence.

Best practice guidance on continence care was available in the home for staff to consult from the Royal College of Nursing (RCN) and National Institute for Health and Clinical Excellence (NICE).

These included:

- Improving Continence Care for Patients (RCN)
- Management of Lower Bowel Dysfunction (RCN)
- Catheter Care (RCN)
- Urinary Incontinence (NICE)

Discussion with staff and the registered manager and a review of training records sent to RQIA post inspection confirmed that 14 staff had received recent training in continence management and two further training sessions had been identified to take place in March 2016.

Staff were knowledgeable about the important aspects of continence care including the importance of dignity, privacy and respect as well as skincare, hydration and reporting of any concerns.

Discussion with the registered manager and information sent to RQIA post inspection confirmed there were three registered nurses trained and assessed as competent in urinary catheterisation.

Observation during the inspection and discussion with staff evidenced that there were adequate stocks of continence products available in the nursing home. However, staff during discussion commented that they felt the current cleaning agent to promote hygiene was not 'adequate'. This was discussed with the registered manager who provided an assurance that they would consult with staff and investigate the comments.

A continence link nurse had been identified for the home and training was in the process of being sourced for the link nurse to attend.

Is Care Effective? (Quality of Management)

Review of five patients' care records evidenced that a continence assessment was in place for each patient. This assessment clearly identified the patient's continence needs. A care plan was in place to direct the care to adequately meet the continence needs of the patients. However, the specific type of continence product the patient required was not recorded in three of five assessments and care plans reviewed. A recommendation was made.

Bowel management records reviewed for five patients were not recorded consistently to make reference to the Bristol Stool Chart. The patient's normal Bristol Stool Score should be recorded on admission within the bowel assessment and thereafter within bowel management records. A previous recommendation made with respect to completion of supplementary care records has been stated for the second time.

There was evidence in within four care records reviewed that Braden risk assessments and Malnutrition Universal Screening Tool (MUST) risk assessments had been reviewed consistently on a monthly basis.

Four continence care plans had been reviewed and updated on a monthly basis or more often as deemed appropriate. The promotion of continence, skin care, fluid requirements and patients' dignity were addressed in the care plans inspected.

Fluid targets had been identified within the patient care records and any shortfall of these targets was clearly recorded to include actions taken to address the shortfall.

There was not a clear record of regular skin checks being carried out on four of the five patients reviewed. One patient, who required, did not have a repositioning chart completed. This was discussed with the registered manager and an assurance was given that they would review recording of skin checks and ensure any patient requiring a repositioning chart, would have one recorded. As previously stated a previous recommendation made with respect to completion of supplementary care records has been stated for the second time.

Records reviewed evidenced that urinalysis was undertaken as required and patients were referred to their GPs appropriately.

Is Care Compassionate? (Quality of Care)

The gender of the carer/s providing intimate care was discussed with the patient/representatives on admission and a record of the agreement was recorded in the patients care plan.

During the inspection, staff were noted to treat the patients with dignity and respect. Good relationships were very evident between patients and staff. Staff were observed to respond to patients' requests promptly. Patients confirmed that they were happy in the home and that staff were kind and attentive.

Patients who could not verbally communicate appeared well presented and displayed no signs of distress. The patients appeared comfortable in their surroundings.

Areas for Improvement

It is recommended the specific continence products required to meet the continence needs of the patient should be identified in the continence assessment and care plan.

As previously stated in section 5.2, it is recommended supplementary patient records should be completed in full and in a timely manner. Bristol stool score should be recorded on admission and thereafter within bowel management records. Patient care records should reflect the condition of the patients' skin at the time of checking.

Number of Requirements:	**0**	**Number of Recommendations:**	**1**

5.4 Additional Areas Examined

5.4.1 Consultation with Patients, Representatives and Staff

During the inspection process, 25 patients, four patient representatives, seven care staff, three ancillary staff member and three registered nursing staff were spoken with to ascertain their personal view of life in Blair House. The feedback from the patients, representatives and staff indicated that safe, effective and compassionate care was being delivered in Blair House.

Some patients' comments received are detailed below:
'It's alright here.'
'It's like a hotel here.'
'It's very nice. The company is very good.'
'I like it here.'

Some representative comments received are detailed below:
'First impressions are very good. I'm very impressed.'
'I like the interaction between staff and patients.'
'I like the atmosphere but am a bit concerned that their teeth have gone missing twice.'
'I would like to see more activities.'

The view from staff during conversations was that they took pride in delivering safe, effective and compassionate care to patients.

Some staff comments received are detailed below:
'It's a nice place to work.'
'It has its ups and downs.'
'It's grand here.'
'I enjoy it.'
'It's all right.'
'It's fine here. They're a great bunch.'

5.4.2 Infection Prevention and Control and the Environment

A tour of the home confirmed that rooms and communal areas were generally clean and spacious. However, a range of issues were identified within the homes which were not managed in accordance with infection prevention and control guidelines:

- inappropriate storage in identified rooms
- noticeboards used are unable to be effectively cleaned
- unlaminated signage
- pull cords used with no plastic covering
- uncovered bin in use in communal area

The above issues were discussed with the registered manager on the day of inspection. An assurance was provided by the registered manager that these areas would be addressed with staff to prevent recurrence. A previous recommendation was made in the last care inspection that management systems are put in place to ensure compliance with best practice in infection prevention and control. This recommendation will be stated for a second time.

During a tour of the premises a malodour was detected in an identified room. The inspector revisited the identified room one hour following the initial detection and the malodour remained present. This was discussed with the registered manager and a requirement was made to ensure appropriate management of malodours within the home.

5.4.3 Safe and Healthy Working Practices

During the tour of the premises a fire door leading to a kitchen area in an identified dining area was observed to be held open with a chair. This was discussed with staff working in the area. Meals were being served from a Baine Marie. Due to the heat of the surface on the Baine Marie and the close locality to the patients in the dining area, staff felt it was safer to locate and serve food from the Baine Marie in the kitchen. They felt locating the Baine Marie in the dining area would create a greater risk to patient safety. However, to transfer food from the kitchen to the dining area required the adjoining door to remain open as staff carrying trays could not safely open the door. This was discussed with the registered manager and it was agreed a safe way to manage this situation would be through the insertion of a magnetic lock which would hold the door open and automatically close the door in the event of the fire alarm sounding. A recommendation was made for a timely insertion of a magnetic lock to the identified door to ensure patient and staff safety.

5.4.4 Working in Partnership

On the day of inspection, community dieticians from the South Eastern Health and Social Care Trust were present in the home reviewing all patients' weights and MUST scores. The dieticians had contacted the registered manager to see if the home could be involved in a new model to manage malnutrition in care homes. The model is called the PAAT model (Prevent, Anticipate, Avoid and Treat). It involves the pre-mentioned patient data uploaded to a virtual database. Every month the home would submit patients' weight and MUST score to the dieticians who in turn would review the data and feedback individual plans of care to the registered manager. This was noted as a commendable practice.

5.4.5 Documentation

A review of five patient care records did not evidence involvement with the patient or patients' representatives during the care planning process. A recommendation was made.

One care plan review identified a wound which required management. However, this was not reflected within the patient's daily evaluations. There was no linked wound assessment, care plan or wound charts relating to the identified wound. A requirement was made to ensure any wound requiring management has an assessment and plan of care in place to meet the need of the patient and any change to the plan of care must be reflected within the patients' wound assessment and care plan.

Entries had been made in an identified care record with no evidence of the author's signature or date of the entry. A wound photograph was also present within the care record with no evidence of date or time when the photograph had been taken. A recommendation has been made.

5.4.6 Activities

Blair House now employs two activities persons to fulfil activity needs. New patients are assessed as part of their admission to determine their activity needs. Service user input is utilised when developing activity programmes. An activities board is maintained at reception and in each unit. A day has been set aside each week to facilitate a virtual cruise where a different country is visited each week. An outline of a cruise ship has been attached to a wall in an identified area and flags of the country will be displayed. Music, decoration, food and dress will also reflect the country visited. This was noted as commendable. A weekly Amore newsletter is published each week and a Blair House newsletter is published each month to reflect activities from the previous month and upcoming activities.

Areas for Improvement

It is required that malodours are managed within the home.

It is recommended that a magnetic lock is applied to the identified kitchen door to promote safe and healthy working practice.

It is recommended that patients/representatives are involved in the assessment, care planning and evaluation of care processes.

It is required that wound management is recorded within legislative requirements, minimum standards and professional guidance.

It is recommended that all entries, including pictorial, made to patient care records are signed and dated appropriately by the person making the entry.

Number of Requirements:	2	Number of Recommendations:	3

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager, Caron Conroy, and the deputy manager, Cathy Lacey, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained in this report do not absolve the registered provider/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 18 (2)(j) **Stated:** First time **To be Completed by:** 30 April 2016	The registered person must ensure that malodours are managed within the home. **Ref: Section 5.4.2**
	Response by Registered Person(s) Detailing the Actions Taken: New floor has been requested and should be fitted by the 30th April 2016. I will confirm that this has been completed via Email for confirmation.
Requirement 2 **Ref**: Regulation 19(1)(a) Schedule 3 (1)(a)(b) (3)(K) **Stated:** First time **To be Completed by:** 30 April 2016	The registered person must ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. **Ref: Section 5.4.5**
	Response by Registered Person(s) Detailing the Actions Taken: Record keeping training is in process of being arranged I will confirm date by E mail. All staff nurses have recieved supervisions in relation to accurate wound care documentation. Any resident with a wound care file will have their file audited by the Deputy Manager and or the Home Manager.
Recommendations	
Recommendation 1 **Ref:** Standard 32 **Stated:** Second time **To be Completed by:** 30 April 2016	The registered person should ensure that a protocol for timely access to any specialist equipment or drugs is developed. A system to implement the protocol should confirm that all relevant staff have read the document with evidence of staff signature and date. **Section: 5.2, 5.4.2**
	Response by Registered Person(s) Detailing the Actions Taken: A protocal is in process of being developed. The local Trust are assisting with the formualtion of a protacol as it includes access to their rapid resposnse and palilative care teams. A copy will be forwarded once fully completed and approved.

Recommendation 2 **Ref:** Standard 46 Criteria (1) (2) **Stated:** Second time	The registered person should ensure that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection. **Section: 5.2**
To be Completed by: 30 April 2016	**Response by Registered Person(s) Detailing the Actions Taken:** Nurse pull cords are currently being repaced with washable pvc cords for infection control. Cork notice boards are being removed as discussed and replaced with white washable boards. All non laminated signage is being reomved and replaced with laminted signage.
Recommendation 3 **Ref:** Standard 4 Criteria (9) **Stated:** Second time	The registered person should ensure that supplementary care records are completed in full, in a timely manner and a system is put in place to monitor this. **Section: 5.2**
To be Completed by: 30 April 2016	**Response by Registered Person(s) Detailing the Actions Taken:** A daily Manager walk around sheet has been in place, again staff will attend the documentaiton training, and supervison will be given again in relation to the completion of supplementary records, to all staff who complete these.
Recommendation 4 **Ref:** Standard 4 Criteria (1) (7) **Stated:** First time	It is recommended that patients' continence assessments and care plans are fully completed to include the specific continence products required by the patient. **Ref: Section 5.3**
To be Completed by: 31 May 2016	**Response by Registered Person(s) Detailing the Actions Taken:** Staff have commenced the process of updating continence assessments, to include the specific continence products required by each individual resident.
Recommendation 5 **Ref**: Standard 47 **Stated:** First time	The registered person should ensure a magnetic lock is applied to the identified kitchen door to facilitate safe and healthy working practices within the home. **Ref: Section 5.4.3**
To be Completed by: 30 April 2016	**Response by Registered Person(s) Detailing the Actions Taken:** This device has been ordered and will be fited by the 30TH April 2016

Recommendation 6 **Ref:** Standard 4 Criteria (5) (6) (11) **Stated:** First time **To be Completed by:** 30 April 2016	It is recommended that care records should evidence patients and/or their representatives' involvement in the assessment; planning and evaluation of the patients' care to meet their needs. If involvement is not possible, then the reason why should be clearly documented within the patient's care record. **Ref: Section 5.4.5**
	Response by Registered Person(s) Detailing the Actions Taken: Staff have commenced the process of encouraging relatives and patients to sign to evidence care plan involvement of resdients and next of kin.
Recommendation 7 **Ref**: Standard 37 **Stated:** First time **To be Completed by:** 30 April 2016	The registered person should ensure that staff date and sign any record they create in accordance with best practice and professional guidance. **Ref: Section 5.4.5**
	Response by Registered Person(s) Detailing the Actions Taken: Staff will attend care plan and documentation training and recieve supervision in reation to the documentation. Records will be audited and cheCKED by the Deputy Manager/ and or Home Manager to ensure consistant approach.

Registered Manager Completing QIP	Caron Conroy	**Date Completed**	05/04/2016
Registered Person Approving QIP	Caroline Denny	**Date Approved**	08/04/2016
RQIA Inspector Assessing Response	Dermot Walsh	**Date Approved**	11/04/2016

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address