Inspection Report
28 January 2021

Blair House Care Home

Type of Home: Nursing Home
Address: 107 Dakota Avenue, Newtownards, BT23 4QX
Tel No: 028 9182 4450
Inspector: Rachel Lloyd

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 this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a nursing home which is registered to provide care for up to 53 patients.

2.0 Service details

Organisation/Registered Provider: Amore (Watton) Limited **Responsible Individual:** Mrs Nicola Cooper	**Registered Manager and date registered:** Mrs Vera Ribeiro 22 January 2020
Person in charge at the time of inspection: Mrs Vera Ribeiro	**Number of registered places:** 53 A maximum of 28 patients accommodated within category NH-I and accommodated within a designated unit.
Categories of care: Nursing (NH): I – old age not falling within any other category DE – dementia	**Total number of patients in the nursing home on the day of this inspection:** 40

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 28 January 2021 from 10.00 to 14.40.

Short notice of the inspection was provided to the manager the afternoon before the inspection in order to ensure that arrangements could be made to safely facilitate the inspection.

This inspection focused on medicines management within the home. The inspection also assessed progress with one area for improvement identified at the last care inspection.

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

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration
- medicine receipt and disposal
- controlled drugs
- care plans related to medicines management
- governance and audit
- staff training and competency
- medicine storage temperatures
- employment records

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	*2	1

*The total number of areas for improvement includes one area for improvement which has been carried forward for review at the next care inspection. Two new areas for improvement were identified.

Findings of the inspection were discussed with Mrs Vera Ribeiro, Registered Manager, and the Interim Operations Manager, as part of the inspection process and can be found in the main body of the report.

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

5.0 What has this home done to meet any areas for improvement identified at the last care inspection (16 July 2020) and last medicines management inspection (10 June 2019)?

All areas for improvement identified at the last medicines management inspection were assessed as met at the care inspection dated 18 February 2020.

Areas for improvement from the last care inspection		
Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 17(1) **Stated:** First time	The registered person shall ensure that the manager monitors the recording of nursing care provided to patients during the early morning routine to ensure that the previous improvements made with recording are sustained and embedded into practice. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.**	**Carried forward to the next inspection**
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 38.3 **Stated:** Second time	The registered manager shall ensure that: • explanations are recorded for any gaps in employment • information regarding the candidates' reasons for leaving previous employment for all positions where candidates have worked with children or vulnerable adults are recorded. **Action taken as confirmed during the inspection**: A review of three staff recruitment files evidenced no unexplained gaps in employment. However, on application forms completed on line the reason for leaving previous employment where candidates had worked with children or vulnerable adults was still being recorded as "resignation" without a reason, due to the format of the form. The findings from this inspection were discussed with senior management in RQIA and it was agreed that this is an issue that requires a corporate wide response by Amore (Watton) Limited, to ensure that the improvement is made across all of their registered nursing homes in Northern Ireland. In the interim, until the corporate form is amended, the manager agreed to discuss and record the specific reason for any candidate leaving previous	**Partially Met**

	employment, where candidates had worked with children or vulnerable adults, as part of their local recruitment process. For this reason this area for improvement was assessed as partially met and was not stated for a third time.	

6.0 What people told us about this home?

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

We met with the registered manager, the interim operations manager and four registered nurses on duty. Staff stated they were very satisfied with how the home was managed and how they were supported in their role. They also said that they had the appropriate training to look after patients and meet their needs. They were knowledgeable regarding individual patients and the management of their medicines.

Feedback methods included a poster to enable staff to provide feedback online and paper questionnaires which were provided to the registered manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no questionnaires had been received by RQIA and no staff feedback had been received online.

7.0 Inspection Findings

7.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs will change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, the pharmacist or during a hospital admission.

Patients in the home were registered with a local GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were mostly accurate and up to date. A couple of discrepancies were highlighted to staff for immediate attention. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to provide a double check that they are accurate. Obsolete personal medication records had been cancelled and archived.

Copies of patients' prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription. This is good practice.

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

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Directions for use were recorded on personal medication records and care plans directing the use of these medicines were available. Records of administration were recorded. However, the reason for and outcome of administration were not recorded. This should be recorded on every occasion and a consistent format of recording should be in in place. An area for improvement was identified.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered as prescribed and when required.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

We reviewed the management of thickening agents and nutritional supplements for three patients. A speech and language assessment report and care plan was in place. Records of prescribing which included the recommended consistency level were maintained. Records of administration by nursing staff were maintained. No record of administration was maintained when administration of thickening agents was undertaken by care staff. An area for improvement was identified regarding delegated tasks (see also section 7.3).

7.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

The records inspected showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and well organised so that medicines belonging to each patient could be easily located. Medicines were observed to be stored at the manufacturers' recommended temperatures and controlled drugs were stored in controlled drugs cabinets as required.

It was agreed that spacer devices for use with inhaled medicines would be stored covered and labelled with the patients name for infection prevention and control purposes.

The disposal arrangements for medicines were reviewed. Discontinued medicines were returned to a waste management company. Controlled drugs were denatured prior to disposal as required.

7.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs, when medicines are administered to a patient. A sample of these records was reviewed. These records were found to have been fully and accurately completed. Completed records were filed in a way that facilitated retrieval. Staff were reminded that a second member of staff should verify the accuracy of any handwritten additions to MARS on every occasion, it was clear that this was the expected practice. Where administration of topical medicines or thickening agents was delegated to care staff, an accurate record of administration was not maintained. An area for improvement was identified.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs were recorded in a controlled drug record book. Balances were checked at each handover of responsibility.

Management and staff audited medicine administration on a regular basis within the home. The areas for improvement identified had been highlighted for action. Running stock balances were maintained for a number of medicines and the date of opening was recorded on all medicines to

facilitate audit. The audits completed during this inspection showed that medicines had been administered as prescribed.

7.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

We reviewed the management of medicines for three recently admitted/readmitted patients. Hospital discharge letters had been received and a copy had been forwarded to the patients' GPs. The patients' personal medication records had been verified and checked by two nurses. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

7.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident.

The audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported.

The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

7.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter.

Records of staff training and competency in relation to medicines management were available for inspection.

8.0 Evaluation of Inspection

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

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan and include maintaining records of administration by care staff as a delegated task, and recording the reason for and outcome of the administration of medicines prescribed for use on a 'when required' basis for distressed reactions.

Whilst we identified areas for improvement, we can conclude that overall, the patients were being administered their medicines as prescribed.

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

9.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Vera Ribeiro, Registered Manager, and the Interim Operations 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.

9.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

9.2 Actions to be taken by the home

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 the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref**: Regulation 17(1) **Stated:** First time **To be completed by:** Ongoing from the date of the inspection	The registered person shall ensure that the manager monitors the recording of nursing care provided to patients during the early morning routine to ensure that the previous improvements made with recording are sustained and embedded into practice. Ref: 5.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** Ongoing from the date of the inspection	The registered person shall ensure that accurate records of administration are maintained when this task is delegated, including the administration of prescribed topical medicines and thickening agents. Ref: 7.1 &7.3
	Response by registered person detailing the actions taken: Prescribed topical medicines and thickening agents are now recorded on T MARs and food additives record. Registered Nurses monitor the recording on a daily basis and Home Manager completes ad hoc checks through the monthly medication quality walk round. Group supervisions have been carried out with care staff to ensure all staff responsible for completing the appropriate forms following administration and or application.

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 18.6 **Stated:** First time **To be completed by:** Ongoing from the date of the inspection	The registered person shall ensure that the reason for and outcome of the administration of medicines, prescribed for use ‘when required’ for the management of distressed reactions, is recorded on every occasion. Ref: 7.1
	Response by registered person detailing the actions taken: For all residents prescribed "when required medication" for the management of distressed reactions a care plan is in place and outcome recorded. The staff following adminstration of "when required medication" record the outcomes at the back of the MARR sheet also. Recording triggers and outcomes of medication adminsitered. This is reviewed by the Home Manager through the monthly medication quality walk round.

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

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