Unannounced Care Inspection Report
12 & 13 October 2020

Balmoral View Care Centre

Type of Service: Nursing Home
Address: 5 The Manor, Blacks Road, Dunmurry, BT10 0NB
Tel No: 02890 629 331
Inspectors: Julie Palmer and Catherine Glover

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 nursing home registered to provide nursing care for up to 39 persons within two units, the Suffolk Suite and the Coleman Suite.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager and date registered:** Ruth Murphy – acting no application required
Person in charge at the time of inspection: Adrian Vulpe – deputy manager on 12 October 2020 Ruth Murphy – manager on 13 October 2020	**Number of registered places:** 39 A maximum of 15 patients in category NH-DE to be accommodated in the dementia unit. Category NH-MP for 1 named patient only. There shall be a maximum of 1 named resident receiving residential care in category RC-I.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill. MP – Mental disorder excluding learning disability or dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 37

4.0 Inspection summary

An unannounced care inspection took place on 12 October 2020 from 09.20 to 16.45 hours.

A medicines management inspection took place on 13 October 2020 from 10.30 to 13.30 hours. Short notice of the inspection was provided to the manager on the afternoon before the inspection in order to ensure that arrangements could be made to safely facilitate the inspection in the home.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to prioritise inspections to homes on the basis of risk.

The following areas were examined during the inspection:

- staffing
- personal protective equipment (PPE)
- the environment
- care delivery

- care records
- governance and management arrangements
- medicines management.

Patients spoken with told us that staff were friendly and they felt well looked after; a patient commented that “it’s a lovely place”.

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.

The term ‘patients’ is used to describe those living in Balmoral View which provides both nursing and residential care.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	1

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Adrian Vulpe, Deputy Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with 13 patients and eight staff. Ten questionnaires were also left in the home to obtain feedback from patients and patients’ representatives. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided the manager with ‘Tell us’ cards which were then placed in a prominent position to allow patients and their representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision. No completed questionnaires or staff responses were received within the indicated timeframe.

The following records were examined during the inspection:

- duty rota from 5 to 18 October 2020
- staff training records
- staff supervision schedule
- incident/accident reports
- monthly monitoring reports
- a sample of governance audits/records
- complaints/compliments records
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC)
- two staff recruitment files
- five patients' care records
- COVID-19 information file
- the annual quality report
- RQIA registration certificate
- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drug records
- care plans related to medicines management
- staff training and competency records relating to medicines management.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

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 the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 21 January 2020.

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 17 **Stated:** Second time	The registered person shall ensure the annual quality report compiled reflects upon and reviews the quality of nursing and other services provided in the home	**Met**

	Action taken as confirmed during the inspection: An annual quality report had been compiled; this included a review of the quality of nursing and other services provided in the home.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time	The registered person shall ensure that the reason for, and outcome of, administering "when required" medicines for distressed reactions is recorded.	**Met**
	Action taken as confirmed during the inspection: A small number of patients are prescribed medicines for distressed reactions. Care plans were in place to direct how they should be used. Staff advised that these medicines are rarely required. There are protocols and administration sheets in place on the medicines files to enable/prompt staff to record the reason for and outcome of administration.	

6.2 Inspection findings

6.2.1 Staffing

During the inspection we observed that patients' needs were met promptly by the number and skill mix of staff on duty. No concerns regarding staffing levels were raised by staff during the inspection. Staff told us that teamwork was good and that the management team was supportive and approachable.

Review of two staff recruitment files confirmed that the necessary pre-employment checks were made prior to staff commencing work in the home. A supervision schedule was in place and staff confirmed that they received supervision. There was a system in place to ensure that staff were appropriately registered with the NMC or NISCC. A record of staff meetings was maintained.

Staff confirmed they had received appropriate training to help them meet the needs of patients during the COVID-19 pandemic, for example, training in the use of PPE and infection prevention and control (IPC) measures. Face to face training had also recently been provided regarding adult safeguarding awareness and moving and handling. Staff demonstrated their knowledge around reporting safeguarding or other concerns in the home.

Staff were knowledgeable about the needs of the patients in their care and obviously knew them well. Staff were seen to speak to patients kindly and with respect; there was a pleasant and friendly atmosphere in the home. Staff spoken with commented positively about working in the home; comments included:

- “Teamwork is very good.”
- “We use some agency staff but they have been here before so it works well.”
- “This is the best home I have ever worked in.”
- “Ruth is an excellent manager.”
- “I have enough time to keep up with training.”
- “I can’t say it hasn’t been stressful over the last few months, it has been, but we have good management support and that really helps.”
- “I like working here.”

The manager informed us that patients’ dependencies were regularly reassessed to ensure their needs were effectively met; block booked agency staff were used to cover vacant shifts where necessary. Recruitment was ongoing with an emphasis on recruitment of more female staff at the present time.

6.2.2 Personal Protective Equipment (PPE)

There was a plentiful supply of PPE available; PPE stations were well stocked and signage providing useful information on PPE was placed in appropriate areas throughout the home. Staff told us that they had had sufficient supplies of PPE at all times.

We observed that staff used PPE according to the current regional guidance. Staff were observed to put on and take off their PPE correctly and to carry out hand hygiene at appropriate times.

Staff and residents had a twice daily temperature check; a record of this was maintained. Visiting was currently on hold but a system was in place to ensure that any visitors to the home also had a temperature check recorded.

6.2.3 The environment

We reviewed a selection of bedrooms, bathrooms, lounges, sluice rooms, store rooms, dining rooms and treatment rooms in the home. We observed that the home was clean, tidy and fresh smelling throughout. Corridors and fire exits were clear of clutter and obstruction.

The manager told us that infection prevention and control (IPC) measures had been enhanced throughout the COVID-19 pandemic.

We spoke to the housekeeper who told us that every effort was made to maintain the home in a clean and hygienic condition; frequently touched points were cleaned throughout the day by domestic staff and then later in the evening and overnight by care staff. Deep cleaning was carried out as necessary in addition to the normal cleaning schedule in the home.

Measures had been put in place to maintain social distancing for patients where possible. Seating in the lounges and dining rooms had been arranged in such a way as to allow adequate social distancing.

Patients commented positively about the cleanliness of the home; they told us:

- “The cleaner is second to none; the place is cleaned every day.”
- “They are always cleaning, no problems with that at all.”

The manager told us that costings had been obtained to replace communal bathrooms in the Suffolk Suite; these bathrooms were clean and tidy but did require updating. However, the COVID-19 restrictions will affect these refurbishment plans which may have to be put on hold as a result; this will be kept under review.

We observed that identified equipment required more effective cleaning; an area for improvement was made. Identified radiator covers required repair/repainting, however, we evidenced that this had already been flagged as an action to be undertaken on the home’s most recent monthly monitoring report.

6.2.4 Care delivery

Patients in the home looked well cared for, they were well presented in clean clothes with attention paid to hair and nail care. The atmosphere was calm and relaxed, staff were seen to effectively communicate with patients and to offer them support as required. Patients who were in their rooms had call bells within reach. We observed that staff did not rush patients and took their preferences and wishes into account when providing care and assistance. Staff knowledgeably discussed individual patient’s needs.

Patients who were not able to communicate appeared to be content and settled in the home and in their dealings with staff. Patients who were able to communicate told us that they felt staff listened to them and that there were enough staff to help them. Other comments included:

- “The wee cleaner is lovely; she helps me with my crossword.”
- “I have my call bell if I need anything.”
- “Most of the staff are very friendly.”
- “They need to get on the ball with their activities.”

One patient told us that, very occasionally, they felt there were not enough female staff on duty and that sometimes there were not enough pads. Comments regarding pads were brought to the attention of the manager who assured us that the home had more than adequate supplies of continence products available at all times. The manager also told us that measures were in place to ensure staffing arrangements met the assessed needs and preferences of patients and, as previously mentioned, recruitment was ongoing.

There were two activity therapists employed in the home; the activity programme had been reviewed as a result of COVID-19 restrictions with more emphasis on one to one activities at present. Activity therapists also took on the role of ‘visiting champion’ which involved booking visits, assisting visitors with PPE and assisting patients to the designated visiting area.

The chef told us that there was excellent communication between staff regarding patients’ nutritional needs and dietary requirements. New menus had been introduced three weeks previously, patients views would be sought on these and every effort was made to cater for all tastes, if a patient changed their mind that was no problem.

We observed the serving of lunch in one of the dining rooms and found this to be a pleasant and unhurried experience for patients. Patients were offered a selection of drinks, condiments were available and the menu was on display. Staff were wearing PPE and discreet assistance was offered as required. The food on offer was well presented and smelled appetising. We could see that alternative meals to the menu options were provided to patients who preferred something different. Staff asked patients if they enjoyed their lunch and if they needed anything else. We also observed that fresh fruit, snacks, scones, pancakes and drinks were offered between meals. Patients told us:

- "The food is good and there is plenty of it."
- "The food is really good; John (the chef) gives us plenty of choice."
- "The food is okay here."

6.2.5 Care records

We reviewed the care records for five patients and found that these contained relevant risk assessments and care plans to ensure that patients' daily needs were met. A daily up to date record of care provided was maintained. Risk assessments and care plans in place were informative and evidenced that regular evaluation was undertaken. Care plans contained recommendations from other healthcare professionals such as the dietician, speech and language therapist (SALT) and the tissue viability nurse (TVN) where required.

In the event of a fall we observed that the relevant risk assessments and care plans had been updated and neurological observations were appropriately completed and recorded.

We looked at wound care for two patients. A gap in wound care recording for one patient was discussed with the nurse who assured us that the wound had been redressed as required and we could see that recording was currently up to date. No deficits in wound care recording were identified in the other file reviewed.

Review of the care records for two patients who had recently been admitted to the home evidenced that, whilst assessments had been completed within five days of admission, a photograph of the patients was not available in their care records. An area for improvement was made. We also observed that weight on admission had not been recorded in the appropriate section of the care records for these patients. However, we evidenced that weights had been obtained and were recorded on a separate monthly weight record. This was brought to the attention of staff in order that the care records could be updated.

6.2.6 Governance and management arrangements

Management arrangements had changed since the last inspection and RQIA had been appropriately notified of this. As previously mentioned staff spoken with told us that they felt well supported by the management team in the home.

Discussion with the manager evidenced that there was a system in place to manage complaints. Review of accidents and incident records confirmed that there was a system in place to ensure these were managed appropriately and reported to RQIA in a timely manner. A record of safeguarding referrals was maintained. The manager provided us with an update on progress with an ongoing complaint and also an ongoing safeguarding investigation.

There was a system in place to monitor staff compliance with mandatory training and to indicate what training was due.

Review of audits carried out evidenced that systems were in place to monitor and evaluate the quality of care and other services provided in the home; action plans were developed as required. We also reviewed a sample of monthly monitoring reports completed in respect of the home. The reports were comprehensive, included the views of patients and staff and contained an action plan.

A COVID-19 file was maintained with up to date information; the manager told us that new guidance received was disseminated to staff in the home verbally and was also printed off and left available in the staff room for their attention.

Thank you cards were displayed to ensure all staff were aware of thanks and compliments received; written comments included:

- “Although my stay was short you all cared for me in a loving way.”
- “I am so grateful for everything you have done for me.”
- “A big thank you to all the staff for all your help and support.”
- “You were all very kind.”
- “Thank you for your kindness and help during my time here.”

6.2.7 Medicines management

Personal medication records and associated care plans

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 may 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 and hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. 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 were accurate.

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, self-administration etc.

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

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 for two patients. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral tube. We reviewed the management of medicines and nutrition via the enteral route for one patient. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Staff had received training to manage medicines and nutrition via the enteral route. Records of the training were available for inspection.

Medicine storage and record keeping

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.

In order to reduce footfall in the home we did not review the medicine storage areas during this inspection.

Administration of medicines

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). A sample of these records was reviewed and were found to have been fully and accurately completed. The records were filed once completed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs are recorded in a controlled drug record book. The controlled drugs record book and been fully and accurately completed. The balance of these medicines was checked at each shift change to ensure that all medicines were accounted for.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

Several patients have their medicines administered in food/drinks to assist administration. Care plans detailing how the patients like to take their medicines were in place. It was evident that there had been discussion with the patients' GP and the pharmacist to check the suitability of administering medicines in this way.

Management of medicines on admission/re-admission to the home

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 two patients who had been recently admitted to the home. A hospital discharge letter had been received for one patient and a copy had been forwarded to the patient's GP. The patient's personal medication record had been updated to reflect medication changes which had been initiated during the hospital stay. For the second patient, confirmation of the medicine regime had not been sought at the time of admission. The subsequent prescription confirmed that the details on the personal medication record were correct; however this should be determined at the time of admission with the GP surgery. The manager advised that this would be the usual practice in the home and agreed to reinforce this procedure with the registered nurses.

Medicine related 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.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. 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.

Medicines management training

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. A written record was completed for induction and competency assessments.

Areas of good practice

Areas of good practice were identified regarding staffing, training, teamwork, use of PPE and IPC measures. Additional areas of good practice included treating patients with kindness, the care provided, the food on offer, communication, governance and management arrangements and medicines management.

Areas for improvement

Areas for improvement were identified regarding effective cleaning of equipment between patient use and ensuring that a photograph is available in the care records.

	Regulations	Standards
Total number of areas for improvement	1	1

6.3 Conclusion

Patients were observed to be well cared for, content and settled in the home. The environment was clean and tidy, effective IPC measures were maintained. Staff were observed to treat patients with respect and kindness.

There were robust systems in place for the management of medicines. Records were well completed and effective governance systems were in place. We can conclude that overall the patients were being administered their medicines as prescribed by their GP.

No further information was required for follow up after the inspection.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Adrian Vulpe, Deputy 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

<table>
<tr><td colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 19(1)(a)

Stated: First time

To be completed by:
17 October 2020</td><td>The registered person shall ensure that a recent photograph of the patient is available in the care record.

Ref: 6.2.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
The registered person has obtained a new camera and printer for the purpose of obtaining recent photographs of patients for the care records</td></tr>
<tr><td colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 46

Stated: First time

To be completed by:
With immediate effect</td><td>The registered person shall ensure that equipment is effectively cleaned between patient use and that staff are aware of their responsibilities in this area.

Ref: 6.2.3</td></tr>
<tr><td>Response by registered person detailing the actions taken:
New decontamination schedules have been introduced to identify specific equipment to be cleaned on a daily basis. The registered manager is conducting spot checks of equipment in order to ensure that the schedule is adhered to. All staff have been informed of their responsibilities in this area</td></tr>
</table>

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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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

Assurance, Challenge and Improvement in Health and Social Care