Unannounced Care Inspection Report
12 April 2017

Blair Lodge

Type of service: Residential care home
Address: 32 Bryansburn Road, Bangor, BT20 3SB
Tel No: 028 9146 0733
Inspector: Patricia Galbraith

1.0 Summary

An unannounced inspection of Blair Lodge took place on 12 April 2017 from 10.15 to 13.30. The inspection was undertaken in response to an anonymous complaint received by RQIA. It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the registered providers and the commissioners of care. However, if RQIA is notified of a potential breach of regulations or minimum standards, it will review the matter and take appropriate action as required; this may include an inspection of the home.

The inspector for the home, Patricia Galbraith was accompanied by Ruth Greer, inspector, residential care team.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Rosemary Clarke, registered 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.

1.2 Actions/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Blair Lodge/Helen Armstrong	**Registered manager:** Rosemary Clarke
Person in charge of the home at the time of inspection: Rosemary Clarke	**Date manager registered:** 01 February 2016
Categories of care: MP - Mental disorder excluding learning disability or dementia MP (E) - Mental disorder excluding learning disability or dementia – over 65 years LD - Learning Disability LD (E) - Learning disability – over 65 years	**Number of registered places:** 29

3.0 Methods/processes

Prior to inspection we analysed the following records: information sent to RQIA, accidents and incidents register received at RQIA since the last inspection.

During the inspection, in addition to the registered manager, the inspectors met with the behavioural co coordinator and four care staff.

The following records were examined during the inspection:

- Staff duty rota in relation to sufficient staff on duty trained in Management of Actual or Potential Aggression (MAPA)
- Two residents' care files
- Accident/incident/notifiable events register
- Policies and procedure for as required medication and whistle blowing

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection on 26 January 2017

The most recent inspection of the home was an unannounced care inspection.

4.2 Review of requirements and recommendations from the last care inspection on 26 January 2017

There were no requirements of recommendations made as a result of the last care inspection.

4.3 Inspection findings

An anonymous complaint was received at RQIA on 21 March 2017. The complainant raised the following issues:

- Insufficient qualified staff on duty who were trained in the use of MAPA.
- The alleged mismanagement of one identified incident involving a member of staff and a resident had not been investigated appropriately
- As and when required medication had been withheld from one resident
- Staff were told not to report any concerns to outside agencies
- A resident had been left in the care home's car for long period of time

On the day of inspection the registered manager confirmed the staffing levels for the home and that these were subject to regular review to ensure the assessed needs of the residents were met. No concerns were raised regarding staffing levels during discussion with staff.

A review of the duty roster confirmed that it accurately reflected the staff working within the home and confirmed there was a sufficient amount of qualified staff to ensure MAPA procedures, if required, could be followed appropriately. Records showed on each occasion when MAPA was used a debrief session was conducted afterwards to discuss the incident and disseminate any learning among staff. Where a review of an incident showed that additional training was required this had been provided.

The complaint alleged that one incident had been dealt with inappropriately. The registered manager confirmed she was aware of the identified incident. The registered manager and registered provider had completed an investigation and written documentation examined by the inspectors confirmed that appropriate action had been taken as a result of the home's findings.

The complaint also alleged that as and when medication had been withheld from a resident. Inspectors spoke at length with the behavioural coordinator who was knowledgeable about the resident and their individual care needs. Records showed that there was a comprehensive behavioural management plan in place devised by the specialist behaviour management team from the trust. A representative from the trust met with staff in the home each month to ensure the resident's care needs had been updated and reviewed as necessary. Records showed as and when required medication had been administered as prescribed. A review of the as and when required medication policy found it had been followed appropriately.

The complaint further alleged that staff had been told by the registered manager not to report concerns to outside agencies. Inspectors spoke with four care staff all of whom confirmed that they would speak to the registered manager at any time about any concerns they had. They also confirmed that they were aware of the home's whistleblowing policy and procedure and would report to relevant agencies if they needed to. Staff gave examples of where they had approached management in regard to a range of issues. The inspectors reviewed the whistle blowing policy and procedure which was found to be in date and was accessible to staff.

The complaint alleged that a resident had been left in the home's car for a long period of time. The registered manager reported that the resident, at times, liked to spend time sitting in the home's car when parked outside the building. The resident's plan of care was reviewed and it accurately reflected that the resident liked to spend time in the car. Care notes showed that staff had observed and frequently checked the resident when this had been requested.

Conclusion

Discussion with the registered manager, staff and review of documentation concluded that there was no evidence to substantiate the allegations made by the complainant to RQIA on 21 March 2017.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards.

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