

Mrs M Lane

Blakesley House Nursing Home

Inspection report

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11 November 2020

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Ratings

Overall rating for this service	Inspected but not rated
Is the service safe?	Inspected but not rated

Summary of findings

Overall summary

Blakesley House Nursing Home is a residential care home providing accommodation and nursing care for up to 22. At the time of our inspection there were 13 people living at the home.

The provider did not always follow good infection prevention and control guidelines to protect people from the risk of harm. We issued urgent conditions telling the provider to make immediate improvements to keep people safe.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Further information is in the detailed findings below.

Inspected but not rated

Blakesley House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

As part of CQC's response to care homes with outbreaks of coronavirus, we are conducting reviews to ensure that the Infection Prevention and Control practice was safe and the service was compliant with IPC measures. This was a targeted inspection looking at the IPC practices the provider had in place.

This inspection took place on 11 November 2020 and was unannounced.

Is the service safe?

Our findings

S5 How well are people protected by the prevention and control of infection?

- People were at risk because the provider did not consistently apply safe infection prevention and control practices to manage risks to people's health and safety.
- Staff disposed of some people's clinical waste into bin bags kept in people's bedrooms. The bags were not secured into a bin frame with a lid to contain the waste safely. For example, the clinical waste bag in the room of a person who had tested positive for COVID-19 was hanging by its opening on the corner of a piece of furniture.
- The provider used a metal trolley on one floor as a personal protective equipment (PPE) 'station'. A station is meant to be a place for staff to easily access all the PPE they needed to support people safely, such as gloves, masks and aprons. A clinical waste bag with material in it was hanging by its opening from the corner of the trolley. These issues meant there were not safe clinical waste management practices in place to keep people safe.
- We saw there were only boxes of gloves for staff on the trolley PPE 'station'. The provider stored PPE aprons for staff in a cupboard on this floor. We found aprons unboxed on the floor of this dusty cupboard, next to a water storage tank. These issues indicated the provider had not ensured the safe storage of PPE and availability of this to staff.
- The provider was not able to demonstrate that it had checked staff always used PPE appropriately or that staff were competent to do so.
- A clinical waste bin was stored in the level access shower area in a washroom on the ground floor. The cover for the shower plug hole had been removed and there was waste or dirt on the shower floor that had not been cleaned away. The floor edging of the shower area was unclean and needed repair. This indicated the shower room was not always maintained appropriately to prevent and control the risks of infection.
- The provider had not completed risk management plans to prevent and control the spread of COVID-19 infection to either people using the service or staff or regarding visitors to the service. This meant the provider had not taken all reasonably practicable actions to mitigate the risks of COVID-19 to the health and safety of people receiving care as the provider had not assessed those risks.
- We viewed daily, weekly and monthly cleaning checklists used by staff. These records did not provide assurance that appropriate checks of cleanliness of people's rooms and other areas of the home were taking place to keep people safe.
- A healthcare professional had visited the home six months prior to our inspection and made recommendations for improving infection prevention and control practices. These included the regular and frequent cleaning of surfaces and the use of cleaning products. We found the provider could not demonstrate they had implemented these recommendations to prevent and control the spread of COVID-19.

The provider had not made sure safe infection prevention and control practices were always in place to keep people and staff safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued urgent conditions telling the provider to make immediate improvements to keep people safe.

- We have also signposted the provider to resources to develop their approach.
- We were assured that the provider was accessing testing for people using the service and staff.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not ensure care and treatment was provided in a safe way for service users because they did not always assess the risks to the health and safety of service users receiving care and do all that was reasonably practicable to mitigate such risks Regulation 12(1)

The enforcement action we took:

We served an urgent notice on the provider imposing conditions on their registration to improve their infection prevention and control practices in Blakesley House Nursing Home