Regal Care Trading Ltd

Blair House

Inspection report

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Date of inspection visit:
09 July 2018
10 July 2018

Date of publication:
10 September 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Blair House on 9 and 10 July 2018. The first day of the inspection was unannounced. We previously carried out inspections at Blair House. At our inspection in September 2015 we found the provider was in breach of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the premises had not been well maintained and the provider had not ensured systems and processes were in place to assess, monitor and improve the quality and safety of the service provided. The service was rated requires improvement. We inspected again in November 2016 where we found further breaches of regulations in relation to risks to people's safety, people did not receive care that reflected their needs and choices. Staff had not received the training and support they needed to look after people and systems and processes were not in place to assess, monitor and improve the quality and safety of the service provided. The service was rated inadequate and placed into special measures.

We further inspected in July 2017 where we found significant improvements had been made and the provider was meeting the regulations. The service was removed from special measures. However, we found improvements were needed to ensure people's meal choices were always supported and food was well presented. We also found that improvements that had been made in relation to management oversight of Blair House needed time to be maintained and managed to ensure it was fully embedded into everyday practice. The home was rated requires improvement to reflect this.

Before the inspection we had been made aware of concerns related to the management of the home. We undertook this unannounced comprehensive inspection to look at these concerns and all aspects of the service. We found some improvements had been made in relation to people's food choices, however we identified further areas where improvement was required.

Blair House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Blair House provides accommodation and personal care for up to 29 people in one adapted building. At the time of the inspection there were 11 people living there. People living at the home were older people some of whom were living with a dementia type illness or mental ill health. People had a range of needs associated with old age and their health.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a quality assurance system in place, and this was well organised. However, this had not identified all the shortfalls we found. People's records did not fully reflect the care they required and received.

Although there were a range of activities, improvements were needed to ensure people were able to access a variety of meaningful activities throughout the day.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. However, mental capacity assessments and best interest decisions were not in place for everyone who needed them.

Staff had the training however competency assessments had not been completed to demonstrate staff had the knowledge and skills they needed.

Staff knew people well. They demonstrated a good understanding of their needs and choices. People were treated with kindness, respect and understanding. They were supported to make decisions and choices throughout the day and their privacy and dignity were respected.

Accidents and incidents were managed safely. Staff understood their responsibility in recording and reporting incidents. There were systems in place to safeguard people from the risks of abuse and discrimination.

Risks were well managed. Risk assessments were in place and staff had a good understanding of the risks associated with the people they looked after.

There were enough staff to meet people's needs. Systems were in place to ensure medicines were ordered, stored, administered and disposed of safely.

People were given choice about what they wanted to eat and drink, and nutritional assessments had been completed. Peoples health and well-being needs were met. They were supported to have access to healthcare services when they needed them.

A complaints procedure was in place and complaints were responded to appropriately.

There was an open culture at the home. All staff were striving to improve and develop the service.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Systems were in place to ensure accidents and incidents were managed safely.

Staff understood the procedures to safeguard people from the risk of abuse.

Risk assessments were in place and staff had a good understanding of the risks associated with the people they looked after.

There were enough staff to meet people's needs.

Systems were in place to ensure medicines were ordered, stored, administered and disposed of safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had training however competency assessments had not been completed to demonstrate staff had the knowledge and skills they needed.

People were given choice about what they wanted to eat and drink.

The registered manager and staff had a good understanding of Mental Capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS). However, mental capacity assessments and best interest decisions were not in place for everyone who needed them.

Peoples health and well-being needs were met.

Is the service caring?

Good

The service was caring.

Staff knew people well. They treated them with kindness and

understanding.

People were supported to make decisions and choices throughout the day.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were needed to ensure people were able to access a variety of meaningful activities.

People received care that met their individual needs and choices. Staff had a good understanding of the care and support people needed.

A complaints procedure was in place and complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a quality assurance system in place, and this was well organised. However, this had not identified all the shortfalls we found. People's records did not fully reflect the care they required and received.

There was an open culture at the home. All staff were striving to improve and develop the service.

Blair House

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 10 July 2018. The first day of the inspection was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included three staff recruitment files, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information regarding the upkeep of the premises.

We also looked at four care plans and risk assessments along with other relevant documentation to support our findings. This included 'pathway tracking' people living at the home. This is when we check that the care detailed in individual plans matches the experience of the person receiving care. It is an important part of our inspection, as it allows us to capture information about a sample of people receiving care.

During the inspection, we spoke with ten people who lived at the home, two visitors, and 13 staff members, this included the registered manager and provider. We also spoke with two health and social care professionals who visited the service.

We spent time observing people in areas throughout the home and were able to see the interactions between people and staff. We used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who lived at the home. We watched how people were being supported by staff in communal areas. This included the lunchtime meals.

Good

Is the service safe?

Our findings

People told us they felt safe living at Blair House. One person told us, "I like it here I get all my tablets regularly." People were supported to receive their medicines as prescribed in a way that suited them as an individual. Medicines were ordered, administered, stored and disposed of safely.

Some people had been prescribed 'as required' (PRN) medicines. People took these when they needed them, for example, if they were in pain. One person said, "They (staff) give me all my tablets when I need them." Protocols were in place for these medicines and to inform staff about when and why the person may need them. However, these did not all contain the level of detail staff may need. One person had been prescribed a medicine that could be given if the person became agitated. There was no information about when the person may need this and what signs staff should look out for . Staff were able to give us detailed information about when the medicine was needed. This helped ensure people received their medicines consistently. An audit by the provider had identified this needed to be addressed.

Medicine administration records (MAR) were well completed. They showed the medicines people had been prescribed and when they should be taken. MAR's included people's photographs, and any allergies. Medicines were given to people individually and staff signed the MAR after the medicine had been taken.

All staff received medicine training, however only those who had been assessed as competent administered medicines. If night staff were not able to give medicines the senior member of staff from the late shift worked extra time to ensure people received their medicines safely. If people required medicines during the night, staff would contact the person on call who would come in and administer the medicine.

Before the inspection, concerns had been raised with us about the deployment, competency and skills of staff who worked at the weekend. The registered manager told us this had been addressed. The deputy manager now worked one day at the weekend and a senior care worker on the other day. The registered manager told us they were always available for advice.

There were enough care staff working at the home to support people safely. There were three care staff working during the day and two at night. There was a cook each day, a laundry assistant for five mornings and maintenance staff for four days a week. The registered manager worked at the home five days a week, and was available for staff to contact at any time. On occasions agency staff were used to support people. The registered manager told us, as far as possible, regular agency staff were used.

People and staff told us there were enough staff working at the home. One staff member said, "There is enough of us, at the moment it's nice, we have time to spend talking with people." Throughout the day, including mealtimes, staff attended to people in a timely way and supported them at their own pace.

Before the inspection, concerns had been raised about the recording and reporting of accidents and incidents. We found there was a system in place for reporting and staff understood their individual responsibilities. Following an accident, incident or fall, action was taken and recorded to ensure people's

safety. This included a description of the incident, what action had been taken immediately and any follow up actions to prevent a reoccurrence. This was recorded by care staff on their hand-held electronic devices and on an incident form. Staff told us, if an accident or incident occurred they would attend to the person. If necessary, they would contact an appropriate healthcare professional and they would also inform the registered manager. Information from incidents was analysed to identify any themes or trends.

Staff received regular safeguarding training and could tell us what actions they would take if they believed someone was at risk of harm or discrimination. They told us they would report their concerns to the most senior person on duty, and could always contact the registered manager. They told us if they were concerned they were able to contact head office and contact numbers for the local safeguarding team were displayed on the noticeboard. Where concerns had been raised these had been reported to the local safeguarding team.

Information from safeguarding concerns and incidents was shared with staff. This helped to ensure they were aware of what had happened, any changes to people's support needs or changes to their work. For example, following a recent safeguarding concern where one person may not have received all the personal care they needed staff were being encouraged to include detailed information when they supported people with personal care, rather than just recording the person had received personal care.

The provider had identified, before the inspection, improvements were needed to ensure people were protected, as far as possible, by a safe recruitment practice. We found some staff members had references missing and one staff member did not have a full employment history. These issues were addressed during the inspection. Each member of staff had a disclosure and barring check (DBS,) before employment started, to ensure they were safe to work at the home.

The registered manager told us there were enough care staff working at the home however they were short of domestic staff and were currently recruiting. The shortage of housekeeping staff meant the home had not be cleaned thoroughly each day. The registered manager told us there was currently some reliance on care staff to cover domestic shifts. On the second day of the inspection a member of care staff worked a domestic shift and the home was cleaned. The provider and registered manager had identified this was an area that needed to be improved and were working to address the issue.

There was an infection control policy and other related policies in place. Protective Personal Equipment (PPE) such as aprons and gloves were available and used during the inspection. Hand-washing facilities were available throughout the home. The laundry had appropriate systems and equipment to clean soiled washing.

People's safety was maintained and a range of risks assessments were in place. Risk assessments were used to identify and reduce risks. These included pressure areas, mobility and falls. Risks assessments showed what the risks were and what measures were in place to reduce these. Staff were aware of the risks associated with supporting people and they responded to these appropriately. Staff reminded people to use their walking aids, when people went out staff made sure they had contact details with them.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Personal emergency evacuation plans (PEEPs) were in place to ensure staff and emergency services are aware of people's individual needs in the event of an emergency evacuation. Regular fire checks took place and this included fire drills for staff. There were servicing contracts, for example gas, electrical appliances and water temperature and the lift and moving and handling equipment. There was ongoing maintenance and a maintenance program. The registered manager and maintenance staff were aware of

areas where improvements were needed. They told us they were unable to address issues in one bedroom as the person became distressed if disturbed. They explained how this maintenance work would take place in the future.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in July 2017 we found improvements were needed to ensure people's meal choices were always supported. At this inspection we found these improvements had been made and people's meal choices were supported.

Staff knew people well and told us how they supported people. One visitor told us their relative's health and well-being had improved since they moved into the home. Despite this we found areas that needed to be improved.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. There were some mental capacity assessments in place and these related to people moving into the home. However, there were no other, decision specific, mental capacity assessments. Some people were reluctant to receive personal care and staff told us this was provided in the person's best interest. There was no evidence of how decisions had been made in people's best interest, if any discussions had taken place or who was involved. Care plans did not include details of where people lacked capacity and how they made decisions.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications had been submitted for people who did not have capacity and were under constant supervision. Copies of the applications and authorisations were available to staff. There were five DoLS authorisations in place. Care plans informed staff if there was a DoLS and the care plan for one person included details of why the DoLS had been granted. However, this had not been recorded for other people. We identified this as an area that needs to be improved.

Despite these concerns we observed staff asking people's consent and offering them choices throughout the day. One person told us, "They always ask for my consent." Staff demonstrated a good understanding and told us, "Everybody can make choices."

There was an on-going training program to help ensure staff received the training and support they needed to enable them to meet people's needs. Staff who were new to the service completed an induction which included an introduction to the home and time shadowing other staff. This allowed them to get to know people and understanding their care and support needs. They told us they were supported during this time and gained knowledge of how to support people. Staff who were new to care completed the care certificate. This is a set of 15 standards that health and social care workers follow. It helps to ensure staff who are new

to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

Before the inspection concerns had been raised that staff did not have the skills and competencies they needed. At the inspection we found staff received training. However, except for medicines, staff competencies were not routinely assessed. There was no system in place to ensure agency staff had the necessary skills to and competencies to look after people. We raised this with the provider and registered manager as an area that needs to be improved to ensure each staff member has the knowledge and skills they need to support people effectively.

Following the inspection, the registered manager sent us details of competency assessments that would be completed for regular staff in the future.

Some people were living with mental ill health, although staff supported people appropriately they had not received any training to support their understanding of people's needs. We identified this as an area that needs to be improved.

Training was delivered in line with current legislation, standards and evidence based-guidance and there was best practice guidance available for staff. Training included safeguarding, moving and handling, infection control, dementia and equality and diversity. The registered manager told us staff also received training that was specific to people's individual needs this included epilepsy and diabetes. However, this information was not made available to us. There was a training matrix which demonstrated what training staff had received and when training updates were required. We saw that training was ongoing.

The registered manager told us she regularly worked with staff and observed them whilst completing her duties. She told us if she identified any areas of concern these would be addressed through supervision. Staff received regular supervision and this included a tick chart which demonstrated whether the staff member had the knowledge and skills to provide specific areas of care. For example, supporting people to eat and drink. One form showed the staff member required more support with providing personal care to people in bed. The registered manager told us the staff member had highlighted this area themselves and the staff member would be working with other staff to develop their skills and confidence. This information had not been recorded to demonstrate the staff member's needs, support given and outcome. We raised this with the provider and registered manager as an area that needs to be improved.

People's nutritional needs were met. Nutritional assessments were in place to help identify people who were at risk of dehydration or malnutrition. People were provided with a choice of meals, drinks and snacks throughout the day. People told us they enjoyed their meals and the food provided. They told us the food was "good." One person said, "They give us plenty of cakes and tea."

Some people had difficulty in swallowing and required thickened fluids. Staff were aware of this and told us how they prepared these drinks. There was information within people's care plans. The cook and staff understood people's dietary needs such as specialist diets related to their health needs and individual likes and dislikes. People were weighed regularly and this helped to identify if people were at risk of malnutrition. If people had lost weight or required professional support the GP was contacted for advice. Where people had been referred to a dietician or speech and language therapist their advice was followed. Where staff had identified people may not be eating or drinking enough, food and fluid charts were completed to allow staff to monitor people's intake.

The menu was on display and this was also displayed in a pictorial format. Staff supported people in their

choices of meal, and explained to them what was available. People were able to eat their meals where they chose and most people ate in the dining room. Tables were set with napkins, placemats and condiments. A selection of cold drinks and water were available throughout the day. We saw people helping themselves to these throughout the inspection. People required minimal support with their meals however staff were available throughout.

People received the help and support they needed to maintain good health and receive on-going healthcare support. When there was a change in people's health they were referred to see the GP or other appropriate professional. Discussions with staff and records seen confirmed staff regularly liaised with a wide variety of health care professionals. This included the GP and district nurse. Staff were attentive to changes in people's health needs and responded to them in a timely and appropriate way. Healthcare professionals told us referrals made were appropriate and staff ensured people received appropriate support in a timely way. One healthcare professional told us, "This is a good home. They are very good at calling us when people are unwell." Another healthcare professional told us how staff supported them to provide the care for one person. This helped ensure the person received support from staff they were familiar with.

People's individual needs were met through the design of the premises. Blair House was an old building which had been adapted over the years. There were two lounges and a conservatory and people could choose where to spend their time. There was a passenger lift which provided people with access to all floors of the home. There were adapted bathrooms and toilets to support people. People were able to move freely around the home as they wished. There was outside space which had been recently paved. There was some seating and tables and the registered manager told us that new garden furniture had been ordered.

Good

Is the service caring?

Our findings

People and visitors told us staff were kind and caring. One person said about staff, "They are all caring," and a visitor told us, "I feel they are very caring." Staff demonstrated a caring approach to people. One staff member told us, "I really care about these people, like they are my family."

People chose how they wanted to spend their day. Interactions and conversations between staff and people were friendly, positive and kind. There was appropriate laughter and banter. Staff spoke with people as they went about their daily tasks. There was a relaxed and calm atmosphere at the home. People were supported by staff who knew them well. Staff had a good understanding of what was important to people, their needs, likes and choices. They were able to tell us about the people they looked after and their personal histories. They spoke about people's individual care needs and preferences for example, what time they liked to get up, what they liked to do during the day and food and drink preferences.

People were treated with kindness and respect and their dignity was maintained. Staff changed their approach to meet each person's needs and preferences. Staff attended to people promptly when they needed assistance. People were supported to maintain their own personal hygiene and wear clothes of their own choice. They were well presented in clothes that suited their own style. Where appropriate, staff reminded people about dressing appropriately to suit the weather, but people's choices were respected. People were supported to maintain their continence in a discreet manner, and were prompted and offered opportunities to use the bathroom throughout the day. This also helped to promote people's independence.

Staff were observant of people and aware of their needs when they were anxious or distressed. They spent time with people to help identify their concern and supported them appropriately. They provided reassurance to people who were anxious. One staff member told us about a person who may become distressed if their environment was too noisy of busy. They told us they would support the person to a quieter area of the home. One person liked to spend time alone, and did not engage in many conversations. We saw staff regularly speak with the person to ensure they were alright. Staff respected the person's right to privacy but regularly checked on their welfare.

Peoples' equality and diversity was respected. They were supported by staff to maintain their personal relationships with people who were important to them. Visitors, were welcome at the home and staff understood the importance of involving family and friends in people's care. People had developed their own friendship groups at the home. We observed people spending time together, watching television, talking and eating meals.

The registered manager recognised some people needed additional support to be involved in their care and had arranged for the person to be supported by an advocate. There was also information available if other people felt they required more support. An advocate is someone who can offer support to enable a person to express their views, access information and advice, explore their choices and options and promote their rights.

People's privacy was maintained and their confidentiality was respected. Those who wished to spent time in their rooms and were supported to do so. People's bedrooms were personalised, as far as possible, in a way that suited each person. This included their own possessions such as personal photographs and mementos. People were supported to have privacy in their bedrooms.

Care plans were stored securely on the computer which was protected by a password. Other paper records were securely stored. Only staff with appropriate authority were able to access them.

Requires Improvement

Is the service responsive?

Our findings

People told us staff understood their needs and supported them appropriately. A handover was used to ensure key information on people's needs were shared and discussed at each staff handover. This ensured staff had up to date and accurate information on people in order to meet their changing needs. Visiting professionals told us they were confident that staff met people's needs. However, we found an area that needed to be improved.

People told us they had opportunities to take part in a range of activities they enjoyed. One person said, "We do lots here, I get my nails done and I do music and movement." Another person told us, "I get involved with the exercise class, we get an entertainer and I get my nails done." Another person told us they liked to play their records in their bedroom. However, we found there were occasions when people did not appear to have enough to do. Care plans did not reflect what opportunities people had been given to take part in a range of activities that reflected their individual interests. Although it was clear people enjoyed watching television there was nothing to ensure they were given opportunities to take part in a variety of meaningful activities throughout the day. Supporting people to take part in a choice of meaningful activities, helps them to maintain good physical and mental health. Staff told us one person had previously enjoyed cooking but this did not happen now. Another staff member told us a person liked cars and although staff chatted to the person about their interest, no other activities had been developed to enable this person to enjoy their interest. There were no activity care plans to guide staff about how to support people to maintain their hobbies and interests. The registered manager told us they were trying to recruit an activity co-ordinator to improve this part of the service. This had also been identified within the PIR. We discussed this with the provider and registered manager as an area that needed to be improved.

Despite this, we did observe occasions where some meaningful activities took place. One staff member told us one person enjoyed playing dominoes and we saw this happening. During the inspection, people were watching the RAF Centenary celebrations on the television. It was clear that people were enjoying themselves. Staff sat with them and engaged in appropriate conversations whilst not interrupting people's viewing. For example, people and staff were discussing which military service members of the Royal Family had served in. We asked one person if they were enjoying the ceremony and they told us, "Yes, it's traditional isn't it." One person remained in bed due to their declining health, staff ensured this person had music, which they enjoyed, playing in their room.

People who were able went out. During the inspection we saw people who were able going out. One person went out with their family, another person took a bus ride to a nearby town. Another person told us, "I am able to go out by myself or the staff also can come with me to support me, to the bank and stuff."

Before people moved into the home the registered manager or deputy manager completed an assessment to ensure people's needs could be met at the home, and would fit in with the group of people already living at Blair House. Information from the assessment was then used to develop care plans and risk assessments when people moved into the home. These were regularly reviewed. Care plans included information about people's needs in relation to personal care, communication, mobility, pressure area risks, nutrition and

health. Staff knew people really well and were able to tell us about the care and support they needed. We saw people received support that reflected their needs and choices. Where people required support in relation to their mobility, skin integrity and pressure areas this was provided appropriately.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Although staff had not received AIS training they understood the importance of communicating with people in a way that met their individual needs. Communication was seen to be appropriate and meet people's needs. Care plans contained information, for example one person required staff to speak in short, simple sentences. There was information about whether people needed glasses or hearing aids and whether people chose to use these.

There was a complaint's policy and records showed complaints raised were responded to and addressed appropriately. If a complaint was made, where appropriate, this was discussed with the staff, to aid learning and prevent a reoccurrence. People told us they had no complaints but knew how to make one if they did. One person said, "If I have a problem it's taken care of," another stated, "I would go to (registered manager) they would sort it."

As far as possible people were supported to remain at the home until the end of their lives. At the time of the inspection one person was receiving end of life care. We saw the staff were proactive in ensuring the person received all the care and support they needed. They ensured the person was comfortable and staff spent time with them. A visiting healthcare professional told us staff were providing caring, appropriate care and support for this person. Records for this person showed discussions had taken place with their family and healthcare professionals to ensure the appropriate support, equipment and medicines were in place. The registered manager told us, end of life care plans would be developed with people as and when people wished to take part in discussions.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in July 2017 we found improvements were needed in relation to the management oversight of Blair House. Improvements needed time to be maintained and managed to ensure it was fully embedded into everyday practice. At this inspection we found some improvements had been maintained, however, further areas needed to be improved.

There was an audit system in place however, this had not identified some of the shortfalls we found. It had been identified through the audit system that PRN protocols were not always in place. However, it had not been identified that guidance for body creams did not include all the relevant information. Some people had been prescribed body creams. There were body maps in place so that staff knew where the cream should be applied. However, the medicine administration records (MAR), cream charts and cream container stated some cream should be applied, "as directed" and no further information was provided. Staff told us when and why these creams were applied. They told us these creams were used for moisturising people's skin if it was dry and to use as a barrier protection if people were living with continence concerns. Creams that had been prescribed for a medical reason such as an infection had appropriate guidance. Therefore, there was no impact on the care people received.

The lack of care plans for meaningful activities, mental capacity assessments and best interest discussions had not been identified. Although the provider was currently working to address the shortage of housekeeping staff they had not identified areas of the home where further cleaning was needed and this included a slight odour in the communal lounges.

Care plans did not always include all the information staff may need to support people. This had not been identified through the audit system. There was limited information about how people who lacked, or had variable capacity made decisions and choices.

Some people were living with health-related conditions such as epilepsy and diabetes. The care plans did not contain all the relevant information. For example, the diabetes care plan contained information about the expected blood sugar levels and what action should be taken if it went above a certain level. However, there was no guidance about what action should be taken if the blood sugar levels were low. One care plan for a person living with epilepsy did not contain guidance about how to keep the person safe following a seizure. Some people had been assessed as needing sensor mats by their beds as they were at risk of falls. These mats were in place however; this information had not been recorded in people's care plans. One person had a pressure relieving air mattress. The registered manager told us this was set in accordance with the person's weight and they checked it daily. There was no information about what the correct setting was or how staff would check this in the registered manager's absence. This lack of records did not impact on people because staff knew them well and understood their care and support needs. However, there is a risk people may not receive care that is appropriate or consistent.

Since our last inspection the provider had changed the electronic care planning system. The registered manager identified that this change may have contributed to some shortfalls within the care plans, for

example where and how to record mental capacity assessments. Where people had daily charts for position changes or food and fluid charts these were well completed. However, there was some confusion as some staff were also recording this on the computerised records.

The registered manager told us it had been identified that information staff recorded on their hand-held electronic devices did not fully reflect the care and support people had received in relation to their personal care. Staff were being supported to write additional information rather than tick a box to show personal care had been provided. We saw work had started and some people's daily notes were starting to reflect this improvement. However, positive interactions we had observed with people such as conversations and playing dominoes had not been recorded. Therefore, the daily notes did not fully reflect all the care and support people received.

The audit system had not identified that staff had not received mental health training and competencies for care staff and agency staff were not in place. This meant the provider could not be sure staff had the knowledge and skills to support people appropriately.

The registered manager had always received informal support from the registered manager of a nearby home, owned by the same provider. Following recent concerns this support was now on a formal basis. This included daily visits where the supporting manager completed a series of checks, including a tour of the home and discussions with people and staff. They were also available for support at any time. The registered manager told us they felt supported by this arrangement. The registered manager told us they could contact a senior manager within the organisation if they needed further support. However, there was no formal arrangement for the registered manager to receive supervision, for the provider to identify areas where further training or development may be needed. There was no arrangement to identify the registered manager's skills and confidence. The registered manager told us they had received one formal supervision during 2018.

These above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these concerns we found aspects of the service were well-led.

There was an audit system which included three monthly provider audits. Areas for improvement were identified and addressed. The registered manager worked at the home five days a week. She was visible around the home and staff were able to contact her at any time when she was not working. People and staff spoke highly of the registered manager. One person said, "(Registered manager) is an excellent manager." Another person told us the registered manager was, "Very chatty." A visiting healthcare professional said, "(Registered manager) is really supportive." Staff also spoke highly of the registered manager. They told us they could contact her at any time if they had any concerns. One staff member added, "And I do, even 3am." Another staff member said, "There's good morale, we can go to the manager or deputy at any time." All staff told us they enjoyed working at Blair House.

The registered manager and identified areas that needed to be improved and developed. They had identified that the pre-admission assessment form did not include all the questions they needed. Therefore, they had developed a new one which helped identify people's needs before they moved into the home. Following a recent safeguarding concern, the registered manager had identified areas for improvement and these had started to be implemented. It had also been identified that staff who worked as senior care staff had not received any specific training. The registered manager told us that a training plan was being developed to address this issue.

Staff were updated about changes at the home through regular meetings and during handover. Minutes from meetings showed that recent concerns had been discussed with staff and used to improve practice. Resident meetings were held to discuss ideas people may have, this included meals and activities. A recent meeting had discussed an open day held at the home which people had enjoyed. There were opportunities for people and staff to give feedback and discuss issues at these meetings.

The registered manager had recently completed the diploma in management and social care. They were aware of best practice guidance and this was printed off for staff to read. The registered manager attended register manager forum's to further enable them to keep up to date with on-going changes in health and social care.

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 17 HSCA RA Regulations 2014 Good governance The provider had not assured appropriate systems and processes were in place to fully assess, monitor, and improve the quality and safety of the service provided. The provider had not maintained accurate and complete records for each service user. 17(1)(2)(a)(c)(f)

The enforcement action we took:

Warning notice