Blair House Care Home Limited

Blair House Care Home

Inspection report

18 Roe Lane
Southport
PR9 9DR
Tel: 01704 500123

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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?	Good
Is the service well-led?	Requires improvement

Overall summary

This unannounced inspection of Blair House Care Home took place on 21 September 2015.

Blair House provides nursing and personal care for people who have mental health needs. It is registered to provide 41 places. The home is a large detached property set in a residential setting fairly close to Southport Town Centre.

A registered manager was not in post. A manager had been appointed and commenced in post and they had applied to the Care Quality Commission (CQC) as the registered manager and this application was in process. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered person's have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People living at Blair House told us they felt the home was a safe place to live.

Staff we spoke with had a good understanding of safeguarding and how to report concerns and policies were in place to guide staff.

There were processes in place to maintain the safety of the building and equipment within it, such as risks assessments and servicing of equipment.

Summary of findings

Care files we viewed showed that people had had risks assessed in relation to their mental and physical health to ensure their safety and wellbeing.

Our observations showed us that there were adequate numbers of staff on duty to meet people's needs.

Records we viewed showed that appropriate checks had been completed to ensure prospective staff were suitable to work with vulnerable people.

A medicine policy was in place to ensure staff followed principles of safe administration of medicines. Regular audits were completed to ensure risks regarding the management of medicines were minimised.

People living at Blair House were supported by the staff and external health care professionals to maintain their health and wellbeing. Our observations showed us that staff responded timely and appropriately to changes in people's physical health.

Staff felt well supported in their role and had completed an induction on commencement of their post. Staff felt this induction was sufficient to ensure they could meet people's needs.

Records showed that supervision was irregular and not all staff had completed mandatory training to ensure they had the knowledge and skills to meet the needs of people living in the home. We made a recommendation in the main body of the report about this.

Staff we spoke with had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, though not all staff were aware of the individual agreements in place to protect people's safety and wellbeing.

People were involved in the development of their plans of care and people we spoke with told us their needs were being met.

We observed that staff sought consent from people prior to providing support. Capacity assessments had been completed for those people who may not have been able to consent to their care.

People told us the meals in Blair House were very good and there was always a choice. Records showed that people's preferences were recorded and their nutritional needs had been assessed.

People we spoke with told us staff were kind and caring and treated them with respect. Our observations showed us staff protected people's privacy and dignity.

Processes were in place to seek feedback from people living in the home, for instance through regular meetings and quality assurance surveys.

Care plans we viewed were detailed, individual to the person and reflected people's needs and preferences.

People told us there were a variety of activities available, both within the home and within the community. An activities coordinator was employed to support people to maintain their social interests.

A complaints policy was in place and available to people to view. People told us they had not had reason to make a complaint, but were aware of how to raise concerns should they need to. People told us they felt able to raise concerns with staff and were confident that they would be listened to.

We received positive feedback regarding the management of the home. People told us communication was good, that the manager was "Approachable" and staff felt supported by the management team.

Processes were in place to ensure the quality and safety of the service. This included audits covering areas such as medicines, health and safety and accidents.

We found some incidents had occurred which should have been reported to CQC as legally required, but had not been.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Good

People living at Blair House told us they felt the home was a safe place to live and our observations showed us there were adequate numbers of staff to meet people's needs.

Staff we spoke with had a good understanding of safeguarding and how to report concerns and policies were in place to guide staff. Records we viewed showed that appropriate checks had been completed to ensure prospective staff were suitable to work with vulnerable people.

Medicines were administered as prescribed and regular audits were completed to minimise any risks.

There were processes in place to maintain the safety of the building and equipment within it, such as risks assessments and servicing of equipment.

Is the service effective?
The service was not always effective.

Requires improvement

Not all staff had completed mandatory training to ensure they had the knowledge and skills to meet the needs of people living in the home.

Staff had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, though not all staff were aware of the individual agreements in place to protect people's safety and wellbeing.

We observed that staff sought consent from people prior to providing support. Capacity assessments had been completed for those people who may not have been able to consent to their care.

People told us meals were very good and their choices and preferences were considered.

Is the service caring?
The service was caring.

Good

People told us staff were kind and caring in their approach and our observations confirmed this.

People were able to have their views heard regarding the support they received. This was achieved through regular meetings and satisfaction surveys.

People's dignity and privacy was maintained by staff.

Is the service responsive?
The service was responsive.

Good

Summary of findings

People had individual plans of care that reflected their needs and preferences and people had been involved in the development of the plans.

A programme of activities was available to people to support them in maintaining their social interests and hobbies.

A complaints policy was in place and people were aware how to raise concerns.

Is the service well-led?

Requires improvement

The service was not always well led.

Feedback from staff and people living in the home was positive regarding the management of the service.

The quality and safety of the service was monitored, for instance through completion of audits, covering areas such as medicines, health and safety and accidents.

We found some incidents had occurred which should have been reported to CQC as legally required, but had not been.

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

This unannounced inspection took place on 21 September 2015.

The inspection team included an adult social care inspector, a specialist advisor who was a registered mental health nurse and an expert by experience. A specialist advisor is a person who has experience and expertise in health and social care. 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 our inspection we reviewed the information we held about the home. This usually includes a review of the Provider Information Return (PIR). However, we had not requested the provider submit a PIR prior to this inspection. The PIR 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 looked at the notifications the Care Quality Commission (CQC) had received about the service. We contacted the commissioners of the service to obtain their views.

During the inspection we spoke with the manager, seven members of care/nursing staff, 13 people who lived at the home, the maintenance person and the chef.

We looked at the care files for three people living at the home, three staff recruitment files, six medicine administration charts, staff rota's and other records relevant to the quality monitoring of the service. We made general observations, looked around the home, including some bedrooms, bathrooms, the dining rooms and lounges.

Good

Is the service safe?

Our findings

People we spoke with told us they always felt safe living at Blair House, were well looked after and staff we spoke with agreed that people's safety was maintained.

We spoke with staff about safeguarding and they told us they had received safeguarding adults training. They had a good understanding of what constituted abuse and told us they would inform the manager or nurse on duty if they were concerned about a person being mistreated. Safeguarding policies and procedures were available as well as contact details for the Local Authority, should a safeguarding referral need to be made. Records we viewed showed that appropriate safeguarding referrals had been made to the Local Authority as required.

Arrangements were in place for checking the environment to ensure it was safe. This included a health and safety audit of the environment. Risk assessments had been completed to identify potential risks in areas such as the laundry, kitchen, offices, corridors, dining room and bathrooms.

A fire risk assessment had been completed and people who lived at the home had a personal emergency evacuation plan (PEEP). Safety checks of equipment and services such as, fire prevention, hot water, emergency lighting, lift, legionella and gas were undertaken. The electrical certificate expired in August 2015 and the manager told us a company were visiting the following week to complete the annual check of the electrical system. Since the inspection we have been provided with a copy of the new electrical certificate.

The care files we looked at showed staff had completed risk assessments for people, in order to identify risks and put measures in place to reduce those risks. Assessments included individual risks relating to people's mental health conditions, as well as physical risks such as those relating to nutrition. Risk assessments viewed were accurate and reviewed monthly by staff. This meant that people were supported in a way that minimises risk.

We looked at how the home was staffed. People who lived at Blair House and the staff told us that there was enough staff on duty to ensure people received the support they needed. One staff member described the staffing levels as, "Ideal." People told us staff were always available if they required support, both during the day and night.

On the day of the inspection there was a manager, a deputy manager, two nurses, four care staff, one activities co-ordinator and a staff member responsible for monitoring people's weight, blood pressure and other clinical observations. There was also a chef, a kitchen assistant and domestic staff on duty, providing support for 39 people. We looked at the staffing rota and this showed the number of staff available. The staff ratio was consistent and there appeared to be adequate numbers of staff to meet people's needs.

Our observations showed people were supported safely by the staff. People had access to aids to help them walk, for example a walking frame and staff provided the help they needed when mobilising. We saw staff chatting to people in the dining room, lounges and other communal areas throughout the day.

The manager told us they did not use a staffing analysis tool to determine staffing levels, but increased and decreased the staffing numbers based on the needs of people living in the home. Agency staff were used when required but the manager advised us in order to promote continuity, existing staff usually covered any staff sickness or holidays. This meant that people were supported by staff who know them and the support they required.

We looked at how staff were recruited to the home. We saw three personnel files and they all contained evidence of applications forms, references and identification of prospective employees. Disclosure and Barring Service (DBS) checks had also been carried out prior to new members of staff working at the home. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. The appropriate checks were in place to ensure prospective staff were suitable to work with vulnerable people.

We looked at procedures in place to ensure on going monitoring of nurses registration. From the records we viewed, three staff did not have evidence of current registration, though the manager told us the registrations had been renewed. We asked the manager to check the registrations through the national electronic monitoring system and confirm when this was completed. The day after the inspection, the manager provided evidence of all registrations.

Good

Is the service safe?

We looked at how medicines were managed in the home. Medicines were stored in a locked clinic room and administered by registered nurses. There were no competency assessments completed to ensure staff were skilled and knowledgeable to administer medicines safely to people. This was raised with the manager who told us that staff were observed administering medicines as part of a monthly audit process to ensure they remain competent. These observations were not recorded and the manager agreed to review this.

A medicine policy was available which included guidance on safe administration, self-administration, controlled drugs, covert (medicine hidden in food or drinks) administration; though this was not currently being used, steps to take in the event of an error and PRN (as required) medicines. Daily temperature monitoring of the clinic room and medicine fridge were recorded. People had individual medicine care plans within their care files and these were reviewed monthly.

We viewed the lunch time medicines being administered and observed that staff took time with people whilst giving them their medicines and were available to answer any concerns they had. The medication administration records (MARs) we viewed were clear and easy to read and contained a photograph of the person for identification, details of date of birth and any allergies, in line with best practice guidance. A monthly audit was completed, covering areas such as ordering, storage, training and disposal of medicines. Any actions identified were recorded. We were also told the pharmacy that dispensed the medicines completed an audit to ensure there were no interactions between the prescribed medicines for each person. This meant that risks relating to medicine errors were minimised and people received their medicines safely.

Despite refurbishments taking place, we found the home to be clean and this included the laundry room and kitchen. Staff advised us they had plenty of gloves, aprons and hand gel in accordance with good standards of infection control. We saw these in use during the inspection.

Requires improvement

Is the service effective?

Our findings

We looked at three personnel files to establish how staff were inducted into their job role. The files contained an induction covering areas such as health and safety and policies and procedures of the service. Staff who commenced in post after April 2015 had begun completing an induction in line with the newly implemented Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Staff we spoke with told us they felt they had received sufficient induction to their role to enable them to meet people's needs.

We looked at on going staff training and support. The majority of training was provided by an external company and records were held electronically by the company, which the manager could access. The manager also had a training matrix which included training in areas such as fire safety, food hygiene, moving and handling, health and safety, infection control, mental capacity and safeguarding. This matrix only included training completed this year and there was no matrix available for previous years, as previously individual training records were kept for each staff member. This meant that it was difficult to establish when staff had completed training and when it was due to be refreshed. We looked at the individual training records for three staff members. One staff member had not been trained in a number of areas which the service classed as mandatory, such as safeguarding adults, infection control, health and safety, mental capacity and deprivation of liberty safeguards. All three staff had completed training in first aid and managing challenging behaviours, however no staff had completed moving and handling or food hygiene training. There was no formal training provided to staff in relation to mental health conditions or how they may impact on people. This meant that staff may not have the knowledge and skills required to meet the needs of people who use the service. Staff we spoke with told us training had improved and there had been a lot offered recently. The manager told us refresher training was being arranged for all staff in all mandatory areas.

Staff we spoke with felt well supported in their role and able to speak with senior staff or the manager should they have any concerns. The records we viewed showed inconsistency in the recording of this support. Some records showed staff were receiving supervision every few months, whereas other staff received supervision more infrequently. For instance, one staff member received supervision in August 2015, but prior to that was June 2014. The files we viewed showed that staff had not received a regular appraisal of their performance in their role. One staff member last received an appraisal in 2012 and another staff member in 2013. Staff we spoke with agreed that supervision was not always regular, but they felt it was adequate as they could always approach the manager if they needed to discuss an issue. This meant that staff may not be fully supported to carry out their role. The manager agreed to look at how this support is recorded.

Not ensuring staff are appropriately supported to carry out their roles and responsibilities, through training, induction and appraisals, is a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, community mental health team, social worker, optician, dietician and through appointments at local hospitals. One person told us staff support them to attend medical appointments and arrange transport to get there.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS. We observed that the service had a clear policy in place in relation to MCA and DoLS.

The manager had applied for authorisation of Deprivation of Liberty Safeguards (DoLS) for one person living at the home and this had been agreed. Staff we spoke with had a good understanding regarding Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS), though not all were aware of the details of the DoLS in place. The manager agreed to speak with staff to ensure they were aware of the agreements in place to protect the individual's safety and wellbeing.

Requires improvement

Is the service effective?

The manager told us staff sought consent from people and involved them in key decisions around daily life and support. Care files viewed evidenced that people had been consulted about their care and agreed to the support plans in place. When there was a concern that people were unable to make decisions, an assessment of their capacity was completed and decisions made in their best interest, in line with the Mental Capacity Act 2005. Capacity assessments regarding people's ability to consent to their care and treatment were observed within people's care files.

During discussions with staff they told us they always asked for people's consent before providing support and we observed this taking place during the inspection, such as when staff were supporting people with mobility, before entering people's rooms and when assisting people with medicines. A staff member told us they always checked to make sure people were happy for them to provide support and another staff member told us they offer support and wait for people to accept it before providing any care.

Staff told us they do not use restraint within the service. De-escalation techniques are used when people present with behaviours that may challenge and getting to know people as individuals, helps staff to support people effectively.

We observed the lunch time meal. Some people chose to sit together in the dining room and the atmosphere was very relaxed. There was a choice of meal and although people had been asked the previous day which option they would prefer, there were menus displayed on the tables and people received meals they chose. We received positive feedback from people regarding meals. One person told us they were, "Spoilt for choice" and another person told us the food was, "Delicious." People told us they could discuss meals and preferences in the regular residents' meetings. Fresh fruit was available to people to access in the dining room.

Care files we viewed showed that people's nutritional risk was assessed and appropriate support measures implemented, such as regular weight monitoring and referrals made to health professionals such as a dietician and the eating disorder clinic, in order to maintain people's nutritional wellbeing. We observed nutritional information on display for people, advising of the importance of healthy eating and how this could be achieved.

We spoke with the chef and they told us they were kept informed of people dietary requirements by staff. The chef catered for any specialist dietary requirements when needed and ensured one person received their choice of vegetarian diet.

Good

Is the service caring?

Our findings

People we spoke with told us the staff were kind and caring and treated them with respect. One person told us they, “Wouldn't want to be looked after by anyone else” and another person described the staff as, “Truly magical.” We observed interactions between staff and people living in the home to be warm, caring and gentle and staff were attentive in their approach. People were acknowledged by staff when they walked by, enquiring if they would like a drink or to join in with an activity. People living in Blair House seemed relaxed in the company of the staff. The manager told us that the ethos of the service was about, “Quality of life” and that she saw part of her role was to ensure the staff team created a pleasant environment for people to live in.

We observed staff respecting people’s privacy and dignity in various ways throughout the day, such as, knocking on people’s doors before entering room’s and referring to people in their chosen term of address. Personal care activities were carried out in private and we observed staff offering reassurance when supporting people, such as when assisting a person to transfer and mobilise. People were given plenty of time to eat their meals they were not rushed in any way. We observed a staff member supporting a person on an individual basis, offering support and reassurance with the activity being completed. Other staff were observed sitting and chatting with residents about preferences, such as which musical groups they preferred.

Staff we spoke with had a good understanding of people’s needs and preferences. One person told us they were supported by staff to access a local show recently as part of their hobby.

Records showed that people had been involved in the development of care plans and people told us their needs were being met.

People living at the home were able to express their views through monthly residents’ meetings. People told us they enjoyed these meetings as it gave them an opportunity to have their say, for instance on the current redecoration of the home. People felt confident they would be listened to by staff and have their views acted upon. One person told us, “I can speak to any of the staff when I want, they listen to me.”

Although no relatives visited during the inspection, people told us their friends and family were able to visit without restriction. The manager agreed that the home had an open door policy with regards to visitors.

For people who had no family or friends to represent them, contact details for a local advocacy service were available. The manager told us one person was receiving support from an advocate.

Good

Is the service responsive?

Our findings

We asked people whether they were involved in creating their plans of care and how staff involved them in their care, treatment and support. People we spoke with were able to tell us that staff spoke with them about their care and people told us their needs were being met. The care records we viewed showed that people had been involved in developing their plans of care and had signed them to show their involvement and agreement with the plan in place.

Care plans we viewed were detailed, individual to the person and reflected people's needs and preferences, in areas such as physical health, mental health and social functioning. This enabled staff to get to know the person and provide care specific to the individual. Care plans were reviewed by nursing staff each month to ensure they remained accurate and people's health and care needs were updated within the plan of care if there were any changes. Every six months care plans were reviewed by the wider team, including other health professionals when appropriate, such as the community mental health team. Care files included information regarding people's history and preferences in relation to social activities and hobbies. Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs. This was achieved through staff handover and reading the daily report, as well as people's care plans. People we spoke with told us they were happy with the support staff provided to them and that staff knew them well.

People living at Blair House were supported to maintain relationships that matter to them. For instance, people are able to go and stay with relatives for the weekend. This support helps to avoid people becoming socially isolated.

We asked people to tell us about the social aspects of the home and how they spent their day. An activities co-ordinator was employed by the service four days per week and there was a planned schedule of activities on display. The service had a car which was used to support people to access the local community. For instance one person was supported by staff to attend a local air show recently. People told us there were a lot of activities available, such as bingo, art therapy, walks and trips out. We observed a "knit and natter" session taking place, in which people were making blankets for a local charity and an upcoming party was advertised within the home. People told us they enjoyed the activities available and could choose whether or not to participate.

We observed staff responding to people's needs on an individual basis. For instance, during the inspection we observed a person's medical condition deteriorate and staff responded effectively and in a timely manner. Staff ensured the required equipment was available to the person and they contacted the GP to request a visit. This means that the staff were able to maintain the person's health and wellbeing.

There were a variety of ways people living at Blair House could provide feedback on the service they received. These included a suggestion box in the foyer as well as completion of quality assurance surveys. These had last been completed in May 2015 and the overall outcomes were displayed on a poster in the foyer. People told us they enjoyed the monthly residents' meetings as this provided an opportunity to share their views and experiences. We viewed records from these meetings which showed that people's views were recorded and acted upon and covered areas such as meals, complaints, suggestions for activities, policies and procedures of the service and issues relating to infection control. This means that the service has procedures in place to routinely listen to people's views.

People had access to a complaints' procedure and this was displayed in the main entrance of the home. People we spoke with told us they had never had to make a complaint, but knew how to raise concerns should they need to and would be comfortable doing so. People told us they were sure staff would listen to their concerns. We viewed the complaints file which showed that complaints received were responded to appropriately and in accordance with the homes policy.

Requires improvement

Is the service well-led?

Our findings

A manager had commenced in post and made an application to be the registered manager. This application was being processed by us [the Care Quality Commission] at the time of the inspection. We asked people their views of how the home was managed. Feedback from people living at the home and staff was positive. Staff we spoke with all felt able to raise any issues with senior staff and one staff member told us the management team were, "Approachable" and helped them, "Feel at ease, as they are relaxed." Another staff member described the manager as, "Visible." People living at the home all told us the management of the service was good.

During the visit we looked at how the manager and provider ensured the quality and safety of the service provided. We saw that there were a range of audits (checks) completed by the manager to monitor the quality of the care provided and help improve practice. These audits covered areas such as medicines, health and safety, care plans and accidents and incidents. Any identified actions were recorded. The manager told us that staff from the company's head office visited occasionally and offered support and guidance in various areas regarding the service. However there was no system in place to record the findings from these visits. The manager agreed to look at ways of recording future visits and checks made.

We found on inspection that some issues requiring the home to notify the Care Quality Commission (CQC) had not been made. These included notifications regarding allegations of abuse, outcomes of applications regarding deprivation of liberty safeguards, incidents involving the police and incidents resulting in serious injuries to people. The manager was unaware that these notifications were required. They had, however completed other necessary notifications and made appropriate referrals to local safeguarding teams and incidents had been investigated. The manager told us they would ensure such notifications to CQC would be made in the future.

There were systems in place to gather feedback regarding the service, including residents' meetings and quality assurance surveys. The main findings from these surveys were displayed within the home, but the manager told us they had not had access to all of the completed surveys, only the main findings. This meant that the manager was not aware of all feedback received. The manager agreed to discuss this with the provider to ensure the quality assurance processes were effective in providing full feedback to the manager and enabled them to drive forward improvements.

Staff told us they were encouraged to share their views regarding the service. Records we looked at showed that staff meetings were held regularly and staff we spoke with confirmed this. A staff survey had also been completed and the manager told us this was designed to look at ways to raise and maintain staff morale. Staff told us there was an open and fair culture within the service and all staff we spoke with told us they were well supported. Staff described working at the home as, "A breath of fresh air," "Like a family unit" and, "Wonderful."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure staff were appropriately supported to carry out their roles and responsibilities because effective processes were not in place regarding training, induction and appraisals.