

# Regal Care Trading Ltd

# Blair House

## Inspection report

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### Ratings

#### Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



### Overall summary

Blair House is registered to provide permanent and respite care for up to 29 older people. There were 10 people living at the home at the time of the inspection. Including one person living at the home for a period of respite care. People required a range of help and support in relation to living with dementia, mobility and personal care needs.

Blair House is owned by Regal Care Trading Ltd. Regal Care Trading Ltd had been in administration since 2012 and was taken over by a new provider in April 2015.

The home is a four storey Georgian building. There was a passenger lift at the home, due to the layout of the building, which included some split levels; a chair lift was in place to rooms which could not be accessed by the passenger lift.

This was an unannounced inspection which took place on 8, 9 and 11 September 2015.

Blair House did not have a registered manager. However, the acting manager was in the process of applying to register as manager with CQC. A registered manager is a person who has registered with the Care Quality

# Summary of findings

Commission (CQC) 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.

The acting manager was in day to day charge of the home supported by the registered manager of a nearby sister home. People and staff spoke highly of the acting manager and told us that they felt supported by them and knew that there was always someone available to support them when needed.

The provider had not ensured the home had been properly maintained. The provider had not visited the service to review concerns identified in audits completed by the acting and supporting manager.

There were systems in place to assess the quality of the service. However, when quality and safety issues were identified for example the décor of the home and issues with flooring, the provider had not responded in a timely manner.

The lift was out of order during the inspection, staff and people living at Blair House told us that this had been an on-going issue over many months. There were areas of the building that were in need of repair. This included the flooring in the dining room which could present a trip hazard and areas of redecoration. Due to the fact the lift was currently out of order the dining room was not accessible although people were not currently at risk. The acting manager had implemented safety measures which included moving people to bedrooms accessible without using the lift to minimise the impact on people. People told us they were happy with the measures put in place.

Some areas of documentation needed to be improved this included identifying people's choice and involvement in decisions, for example bathing and showering. We also found documentation for medicines needed to be improved.

The acting manager carried out a programme of supervision and appraisals for staff. However, the managers had not received any formal supervision or support from the provider.

Staff received training which they felt was effective and supported them in providing safe care for people. Robust recruitment checks were completed before staff began work.

Care plans and risk assessments had been completed to ensure people received appropriate care. Care plans identified all health care needs and had been reviewed regularly to ensure information was up to date and relevant.

Staff demonstrated a clear understanding on how to recognise and report abuse. Staff treated people with respect and dignity and involved people in decisions about how they spent their time.

People were encouraged to remain as independent as possible and supported to participate in daily activities.

People were asked for their consent before care was provided and had their privacy and dignity respected.

People's nutritional needs were monitored and reviewed. People had a choice of meals provided and staff knew people's likes and dislikes.

Referrals were made appropriately to outside agencies when required. For example GP appointments, dental appointments and hospital visits.

Fire evacuation procedures needed to be improved to incorporate different staffing levels at night. Personal evacuation procedure information was in place in event of an emergency evacuation. This information had been updated to ensure that people who had moved rooms due to the lift breakdown remained safe in the event of an emergency evacuation.

Feedback was gained from people this included questionnaires and regular meetings with minutes available for people to access.

Notifications had been completed to inform CQC and other outside organisations when events occurred.

We found breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions 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 not consistently safe.

Procedure for 'as required' medicines and documenting medicines needed to be improved.

Fire evacuation procedures needed to be improved to incorporate different staffing levels at night. Personal evacuation procedure information was in place.

People told us they felt safe and staff knew what to do if they suspected anyone was at risk of abuse.

Risk assessments were in place to ensure people's safety was maintained.

All required recruitment checks were completed before staff began work.

Requires improvement



### Is the service effective?

The service was effective.

All staff felt they received effective training to ensure they had the knowledge and skills to meet the needs of people living at the service.

Staff had regular supervision and appraisals.

Management and staff had a good understanding of mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS)

People were supported to eat and drink. Meal choices were provided and people were encouraged to maintain a balanced diet. People's weights were monitored.

Referrals made to outside professionals if required.

Good



### Is the service caring?

The service was caring.

Staff knew people well and displayed kindness and compassion when providing care.

People were involved in day to day decisions and given support when needed.

Staff treated people with patience and dignity.

Good



### Is the service responsive?

The service was not consistently responsive.

Computer and paper records did not always correlate. Some significant information had not been included in daily records.

People's choices in relation to baths and showers was not clear.

Requires improvement



# Summary of findings

Clear information was in place for staff. Care plans had been written for peoples identified care needs and care plans were regularly reviewed and updated.

Daily activities were provided for people to allow them to spend time doing things they enjoyed.

A complaints procedure was in place and displayed in the main entrance area for people to access if needed.

## Is the service well-led?

Blair House was not consistently well-led.

There was no registered manager. However, the acting manager was in the process of applying to CQC to register.

There were systems in place to assess the quality of the service. However, when quality and safety issues were identified the provider had failed to respond in a timely manner.

The provider had not ensured the home had been properly maintained.

The acting manager had implemented a programme of staff, relative and resident meetings.

Staff felt supported by the acting manager and told us that they were always available if needed.

Notifications had been completed to outside agencies when required.

**Requires improvement**



# 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 which took place on 8, 9 and 11 September 2015 and was unannounced.

The last inspection took place on 29 July 2013 where no concerns were identified.

The inspection team consisted of one inspector and an expert by experience who has experience of older people and dementia care services. 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 we looked at information provided by the local authority. We reviewed records held by the CQC including notifications. A notification is information about important events which the provider is required by law to tell us about. We also looked at information we hold about the service including previous reports, safeguarding notifications and investigations, and any other information that has been shared with us.

Before the inspection, the provider completed a Provider Information return (PIR). A 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 used the PIR to help us focus on specific areas of practice during the inspection.

Not everyone living at Blair House was able to tell us about their experiences of living at the home.

We carried out observations in communal areas, looked at care documentation for three people and daily records, risk assessments and associated daily records and charts for other people living in the service. Medicine Administration Records (MAR) charts and medicine records were checked. We read diary entries and handover information completed by staff, policies and procedures, accidents, incidents, quality assurance records, staff, resident and relatives meeting minutes, maintenance and emergency plans. Recruitment files were reviewed for two staff and records of staff training, supervision and appraisals for all staff.

We spoke with seven people using the service and seven staff. This included the acting manager, the registered manager of a sister home who supported the acting manager, care staff, cook, administration staff and other staff members involved in the day to day running of the service.

There were no relatives or personal visitors to the home during our inspection. However, we spoke to a nursing professional who provided a service in the home after the inspection.

# Is the service safe?

## Our findings

Everyone we spoke with told us they felt safe living at Blair House. People's rooms could be kept locked if they wished and people's personal items were kept safely in their rooms. We were told, "I feel very safe here, I am looked after well." "The staff make me feel safe," and, "Yes, I do feel very safe." People felt that staff looked after them very well.

There were policies and procedures for the management of medicines including information for PRN or 'as required' medicines prescribed by people's GPs. PRN guidance was in place in the medicines administration records (MAR) charts for most medicines, however we found one newly prescribed medicine which did not have PRN guidance in place. Staff were documenting when PRN medicines were given, however this was not consistently documented on the rear of MAR charts. The acting manager addressed this during the inspection. This is to ensure that all PRN medicines are given in a clear and consistent way regardless of who is administering them. The acting manager told us people were always asked whether they wanted PRN medicines and that these would only be given when people requested them. Staff were appropriately trained to administer medicines.

Medicines were stored and disposed of appropriately. Medicines were labelled, dated on opening and stored tidily within the cupboard and trolleys. We found one controlled medicine which had not been appropriately documented. This medicine was waiting to be disposed of as the person had passed away. Staff were aware that the medicine should be documented and told us this was an oversight. This was an area that needed to be improved. We observed medicine administration and saw that this was done safely. Due to the lift being out of order the meds trolley was not being stored on the lower ground floor in the medicine room, but locked securely in a bedroom on the ground floor. Medicines were administered from medicine trolleys which were locked when left unattended. Medicines and topical creams were stored appropriately in line with legal requirements. Medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of appropriately.

**We recommend the provider should take into account the National Institute for Health and Care Excellence (NICE) guidance 2014, Managing medicines in care homes.**

Regular maintenance checks had been completed on gas, and electric appliances including annual Portable appliance testing (PAT). Water checks including Legionella testing had been completed within the last 12 months. Equipment used for moving people, including hoists and stand aids had been serviced regularly to ensure they were safe to use.

Staff demonstrated a good knowledge around how to recognise and report safeguarding concerns. The acting manager and senior care staff knew the correct reporting procedure. Staff had access to a member of management on call at all times. This was recorded on the duty rota so staff were always aware who to contact. A safeguarding policy and folder was available for staff to access if needed. A flow chart was displayed in the acting manager's office to remind staff of actions to take. We saw that safeguarding alerts were responded to and referrals completed to outside agencies if appropriate. Staff told us they would raise concerns with the acting or supporting manager and that they had a responsibility to raise concerns directly with the local authority if this was not possible. Staff were clear that their priority was to protect people and ensure they were safe from the risk of abuse.

Individual risks to people due to their health, mobility and care needs were identified and well managed. There were risk assessments in place which supported people to stay safe at Blair House whilst encouraging them to be as independent as possible. For example, falls, use of bed rails, safe environment, road safety and outings. We observed people being supported to stand and walk using walking aids, staff encouraged and talked to people reminding them how to stand straight, get their balance and take their time to ensure they remained safe, whilst allowing them to remain as independent as possible.

Personal emergency evacuation plans (PEEPS) were in place. These had been updated to incorporate that people had moved bedrooms since the lift had become out of order. This information was stored centrally for easy access in the event of an emergency. This meant people's care needs and mobility had been considered in relation to their safe evacuation in the event of an emergency. We spoke to member of staff who was clear about the evacuation procedure to follow. However it was noted that the fire risk assessment needed to be reviewed to incorporate an

## Is the service safe?

accurate number of residents and staffing on duty at night. The acting manager told us they would ensure that evacuation information was updated to include night procedures.

Incidents and accident forms had been completed when required. There had been a low number of incidents, over the past twelve months. There was however analysis completed to ensure that any trends and risks were identified to prevent reoccurrence if possible. The acting manager and staff understood the importance of learning from incidents to facilitate continued improvement within the service.

People were protected as far as possible by a safe recruitment system. Since taking over the running of the home in April 2015 the acting manager had worked to ensure that recruitment files were up to date and included all appropriate information and checks. We looked at two staff recruitment files these included details of relevant checks which had been completed before staff began work. For example, disclosure and barring service (DBS) checks, A DBS check is completed before staff begin work to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. Application forms included information on past employment and relevant references had been sought before people were able to commence employment.

Staff and people living at the home felt that staffing levels were appropriate. A dependency tool was used by the home to identify people's level of care needs. It was noted that one person required a high level of emotional support throughout the day. We looked at their dependency tool and although completed accurately there was no way to include this high level of support requirement in the analysis of need. We discussed this with the acting manager and they told us they would look at adapting the tool to ensure people's emotional care needs could be included.

As there were currently ten people living at the home and most of these spent the day in the communal areas, staff were readily available to provide care and support. One person had been moved to the sister home in close vicinity due to their poor mobility whilst the lift was out of order. Staff we spoke with told us, "It's fine at the moment, obviously as people's needs increase it can impact, and if someone is unwell it can be hard work, but at the moment it is ok." We saw that staff covered for others when they were off sick, this meant that people had continuity of care staff. Staffing levels appeared appropriate and there were staff available to support people and answer bells throughout the inspection.



# Is the service effective?

## Our findings

People told us that they thought staff were, “Very well trained and good at what they do.” Staff felt that they received effective training to support them to meet peoples care needs. They told us that the training received was, “Very good,” and, “There is always training going on and it helps you to do things right.” Staff felt there were further opportunities for professional development. The acting manager told us this included further advanced training in areas including dementia. Staff told us these opportunities made them feel valued as an employee.

Training provided was mostly online, supported by some practical sessions. This included all essential training for staff and further training including medicines for staff who administered medicines. Competency checks took place to ensure staff training had been appropriate before staff were able to administer medicines. Staff told us the training they received enabled them to understand people, for example dementia training had helped them provide appropriate care for people with dementia.

New staff had a period of induction and were supported throughout this time by management and other care staff. The acting manager told us they were using the new Care Certificate Standards induction for new care staff. The Care Certificate sets out the learning outcomes, competences and standards of care that are expected from care workers to ensure they are caring, compassionate and provide quality care. This included getting staff to complete a self-assessment tool to identify areas of further learning, strengths and weaknesses. Staff received regular supervision and appraisals, staff told us that they felt supported by the acting manager. Supervisions were documented and signed by the individual. Ad-hoc supervisions or ‘flash meetings’ also took place when there were areas that needed to be discussed or to support staff when needed. Staff told us that regular supervisions gave them the opportunity to talk to the acting manager about any further training they required or any issues personal or professional they wanted to discuss.

Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what may constitute a deprivation of liberty. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. The Deprivation of Liberty Safeguards concern decisions about

depriving people of their liberty, so that they get the care and treatment they need but there may be a need to restrict their movements in some way in order to be able to do this. The Care Quality Commission has a legal duty to monitor activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person’s best interests and with the least restrictive option to the person’s rights and freedoms. Providers must make an application to the local authority when it is in a person’s best interests to deprive them of their liberty in order to keep them safe from harm. The acting manager understood the principles of DoLS, how to keep people safe from being restricted unlawfully and how to make an application for consideration to deprive a person of their liberty. At the time of the inspection there was one DoLS authorisation in place and further applications had been made. The acting manager had followed correct processes and made referrals appropriately. Staff understood why some people had a DoLS in place and the specific restrictions this placed on them.

People said staff always asked for consent before providing any care. Staff described how they would ask for people’s permission before giving support, and what they would do if someone declined the support offered. We observed staff involving people in decisions and speaking to people to ensure they were involved in how they received care and spent their day. In the lounge we saw that staff ensured people were orientated and involved in all day to day decisions about how they were dressed and how they spent their day. Consent forms were completed in people’s care files to show that they consented to photographs and the use of bed rails.

Referrals had been made to other health professionals when required. This included GPs, community nurses, dentists and chiropodist. The deputy and acting manager contacted outside professionals, for example, one person needed to see the community nurse after a fall and two people had been supported by a member of care staff to attend a dental appointment.

Without exception everyone told us that the food was good. One said, “It’s very lovely, If I get hungry between meals they will also give me something.” Another, “It’s excellent, it’s lovely” “The meals are nice, and we get a choice and can even pick something else we might fancy.” There was a four week rolling menu; this was flexible with



## Is the service effective?

other alternatives provided on request. Due to the lift being out of order the dining room was not being used. Tables were brought into the two lounges to provide seating for people at meal times. Other people chose to sit in comfortable chairs and have their meal. We saw that one person chose to eat alone in a quiet area. Meals were brought to the lounge and served up individually. Meals looked well presented and nutritious. People who required special meals to meet dietary or health needs had these provided, for example if people were diabetic. The cook

knew if people had any allergies and also people's specific likes and dislikes. We saw that chocolate cake made for people had not been made with cream as someone was unable to eat this. Cream was provided for people who wanted it. People's dietary intake was monitored to ensure people received appropriate nutrition. Staff told us they always observed people's eating and drinking and reported any concerns if people appeared unwell or they were not eating as well as normal.

# Is the service caring?

## Our findings

People spoke very highly of staff and told us, “I think they’re lovely.” And “Staff are so patient and caring.”

Staff interacted positively with each other and people living at Blair House. Staff engaged people in conversations which did not relate to care and assisted people to read the newspaper prompting conversation amongst people in the lounge. Two residents who both have dementia were deep in conversation. Staff facilitated this by moving their armchairs around slightly so that they were able to chat face to face. It was clear that this was really positive engagement for them both.

We saw that care staff spent time with people. Due to the small number of people living at the home, most people spent their time in one of the communal areas. There was always at least one staff member in the lounge with people at all times. People responded very warmly when greeted by any of the staff. It was clear that people recognised staff and felt secure and comfortable in their company. Staff showed great patience, for example, one person needed eye drops administered. This person initially refused to allow staff to administer the eye drops. The staff member sat with the person and took the time to explain what the drops were for. The person relaxed and allowed the eye drops to be administered. The same caring and compassionate attitude was shown when assisting people with food and drinks.

Some people told us they liked to sit alone in one of the communal rooms provided. This was their choice and they told us they were happy sitting on their own. We saw that staff checked people who preferred to spend time sitting alone, asking if they needed anything and popping in for a chat when they were passing to check they were ok. People who wished to smoke had access to the rear garden and a seating area was provided.

Staff knew the people they were caring for and were able to tell us about their likes and dislikes.

People were offered choices and involved in all day to day decisions. People told us they chose how they spent their

day. “If you feel like doing anything, you can choose.” People felt that the staff helped them to remain as private and treated them with dignity. Staff knocked on people’s doors before entering the room and spoke to people discretely when talking about their care needs. People were dressed in the way they liked. For example one person’s care plan and initial assessment informed staff that they liked to be dressed in matching tops and trousers and did not like wearing skirts. They also liked to have items including a handbag with them at all times. We saw that this person was dressed in a co-ordinating trouser and top set with matching footwear, and had their bag and a few personal items with them in the lounge. They told us they liked to have their hair styled regularly and we saw that they had their hair done that day by the visiting hairdresser.

The acting manager and one further staff member were dignity champions and had carried out further training. The home had a dignity day every February to promote improvements in dignity and care. The acting manager told us the aim of dignity champions is to attend further training and share this with staff to ensure that dignity is an area that staff consider at all times when providing care.

There were no visitors during the inspection and staff told us that a number of the people living at Blair House did not have regular visitors although this was encouraged. Staff said they spent time with people as they felt it was important that people felt valued. One told us, “I treat people like they are family, they may not have any real family, or they may not be able to visit so we make sure they don’t feel lonely.” And, “I treat people how I would treat my own grandparents or parents. People should be treated with respect and dignity at all times.”

People had access to call bells and we saw that people received assistance in a timely manner when they used the call bell to alert staff that they needed assistance.

We discussed advocacy services with the acting manager. They told us that they were in the process of contacting an advisory service to obtain an advocate for someone living at the service who they felt would benefit from this support. This had been done with the agreement of the individual.

# Is the service responsive?

## Our findings

People told us that they felt that the home met their needs. People felt listened to, and told us. “The staff do what you ask, they are here for me.”

Daily notes were completed on an iPod system. This is a hand-held digital device on which staff recorded care and support people had received. This information was then stored on the main computer. Some paper documentation was also being used to document personal care, baths, showers, food and fluid intake. Some information was being documented on both the computer system and on paper charts. However, this information did not always correlate. We saw these charts had not been fully completed, for example, paper documentation identified gaps when people had not received baths or showers, whereas information on the computer showed this had taken place more frequently, but the information was not always the same. This meant that it was difficult to get a clear picture regarding personalised care provided for people.

People’s choice and involvement in decisions was not always clear from care planning, assessments and daily records. For example, information regarding people’s choices in relation to baths and showers had not been clearly recorded to show whether people had been offered a choice or had declined. People told us they had a choice of baths or showers. However, this was not clear from documentation that people had been offered choice and whether they refused. The acting manager was aware that this information needed to be clearer and felt this was due to staff documenting care on the computer and again on paper. This was an area the acting manager had identified as needing to be simplified.

People may be put at risk if documentation is not always complete and accurate. Accident and incident forms had been completed for example when a person had fallen in their room, but this information was not always documented in the daily records or on the handover form used at the end of every shift. We highlighted this with the acting manager as an area for improvement.

Care plans were in place for all identified care needs. This included information for specific health related conditions

including, dementia and diabetes. These were clear and up to date. Diabetes information provided support to staff on how to recognise and respond if the person became unwell due to their diabetes.

Care reviews had taken place monthly or more frequently if people’s care and support needs changed. Where reviews had taken place changes had been noted and the appropriate information recorded to update the care plan. Care files also included a précis of people’s needs at the front of the file. This meant that staff had quickly accessible information available to ensure they knew people’s care needs. Staff were regularly updated about changes in people’s needs at handover, in meetings and throughout the day.

We spoke to someone who had recently arrived at Blair House for a period of respite. They told us they felt involved in decisions and discussed their needs and requirements before they moved in. We saw that they had clear information in their care plan including a full pre admission assessment completed. This included detailed information around their health and dietary needs, how they liked to spend their time and the help they required. Documentation also informed staff areas of care where this individual remained fully independent.

Where people may not be able to fully participate in care planning decisions we saw when possible their relatives or representatives had been involved. This included consent forms for the use of specific equipment. When people moved into the home relatives and next of kin had been asked how involved they would like to be in the care planning process. Visitors were welcomed at the home and encouraged to participate and be involved with their loved ones care when possible.

People had the opportunity to share their views and give feedback during regular resident and relatives meetings. We saw minutes from meetings detailed discussions and actions taken. Minutes were displayed in the entrance hall for people to read and an analysis of findings and actions had been included. We saw that these included feedback from people over the last two months regarding issues with the lift. However, all other areas of feedback had been positive.

A complaints policy and procedure was in place and displayed in the entrance area. Copies were also given to people as part of the information given on admission.

## Is the service responsive?

People told us that they would be happy to raise concerns and would speak to staff or management if they needed to. There were no on-going complaints at the time of the inspection. The acting manager understood the importance of ensuring even informal concerns were documented to ensure all actions taken by the service were clear and robust.

The acting manager told us that there was a designated activities employee who worked at the home. However, they were not working during the inspection. All staff provided support for people to enable them to interact and participate in daily activities. Although there was an activities schedule displayed, we were told and saw that this was flexible depending on what people wanted to do. Due to the small number of people living at Blair House staff were able to assist people in a number of different pastimes. These included reading the newspaper with people, listening to music and dancing in the lounge, flower making and games. There were also visiting entertainers each week. This included musicians, singers, pat a dog services. A hairdresser had their own hairdressing room and people enjoyed the experience of 'going to the

hairdresser'. People went out with staff when possible. One person told us how much she liked to go with the staff and pay for the papers at the local shop. Another told us they sometimes liked to go for a walk. For people who did not wish to participate in group activities we saw that they had quiet areas to sit and read or watch the television, or they could spend time in their room if they chose.

An activities folder was in place for each person. This had information about people's lives, hobbies and backgrounds. Staff documented what activities people had participated in each day and whether they had enjoyed them. Staff told us people often suggested different things to do and they incorporated this into the week's activities if possible. The atmosphere in the home was lively and people did not appear to be bored. The staff were aware to observe people to ensure they did not become socially isolated. For people who were unable to participate in formal activities due to their dementia, staff were seen to provide alternative activities. Staff were seen to sit with people, hold their hand and talk to them to ensure they felt included and valued.

# Is the service well-led?

## Our findings

There was no registered manager at the time of the inspection. The previous manager had left in April 2015 and removed their registration shortly before the inspection. The acting manager was being supported by the registered manager from a sister home and had previously worked at the sister home as a deputy manager. The acting manager told us that they were in the process of applying to become registered manager with CQC.

People and staff spoke highly of the acting manager and the positive changes they had implemented since starting work at Blair House.

Despite this positive feedback we found that areas of the home had not been well maintained to ensure the safety of people. We found an area of flooring in the dining room which needed to be replaced to prevent people from being at risk of trips and falls. Despite annual servicing last completed in July 2015, the lift had had been subject to repeated breakdowns over previous months. Engineers had visited the home, however, breakdowns still occurred and at the time of the inspection the lift was out of order. Other areas of the home had been identified by the acting manager as in need of redecoration. They had devised a maintenance plan detailing the order of priority for completion of these tasks. The acting manager had been on annual leave and in their absence work had commenced on redecorating empty bedrooms. The acting manager had returned to work on the morning of the inspection and along with the registered manager from a sister home accompanied the inspector on a tour of the building. It was acknowledged by both the acting and supporting manager that the redecoration completed had not been done to an appropriate standard, or in the order of priority.

The acting and supporting manager had identified concerns with regards to the dining room flooring and passenger lift in audits completed over the previous months. However, these issues had not been addressed by the provider in a timely manner. Immediate action had been taken by the acting manager to minimise the impact of the broken lift and to ensure people could be looked after safely. This had included moving people unable to safely access the stairs to bedrooms more adjacent to the ground floor and blocking the lift to ensure no one attempted to use it. The dining room floor had tape

applied to the area which needed replacing and the dining room was not being used whilst the lift was out of order as it was located on the lower ground floor. People we spoke with told us that although annoying, the lack of a lift had not impacted on their care, and, "Staff were making the best of it with a smile." However, they felt that this had been something that had happened a lot and, "Really needed to be sorted properly."

These issues meant that the provider had not ensured all premises and equipment was properly maintained. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 201.

There was a system of auditing in place. The majority of audits were completed by the acting manager. The acting manager had identified areas for improvement in a number of audits completed. These included audits completed on a rotation so that each area was audited every three months, for example, health and safety, infection control, dignity, and environmental checks.

Care documentation had been audited in August 2015. This had included ensuring care plans were up to date and reviewed appropriately. Daily documentation including the completion of charts had been identified as needing to be improved but this had not been done in the short timescale since the audit had been completed. The acting manager told us about a number of planned changes to how daily care was documented; however these were yet to be implemented.

Since the new provider had taken over in April 2015 there were no documented visits or audits completed by the provider to identify any areas of concern.

A provider audit had been completed by the supporting registered manager of a sister home on two occasions. Both of these audits had identified the areas of improvement found during the inspection. Including the on-going issues with the passenger lift and flooring problems in the dining room. We were told that these audits had been sent to the provider but the acting manager had not received any feedback with regards to the areas identified. The acting and supporting manager told us they were not aware of any financial budget in place to support the improvements identified.

The acting manager attended staff meetings to insure they had a good working relationship with all staff and to ensure staff were aware of their responsibilities whilst working at

## Is the service well-led?

the home. By completing daily 'walk arounds' and audits, they were fully aware of the people, staff, redecoration and improvements required to the building and had devised a maintenance schedule including order of priority and dates for completion. Some redecoration had been done, however this was painting of one or two walls in some bedrooms and this had not been completed to a high standard. No evidence was seen to show the provider had inspected the home to identify and address any issues.

Environmental audits completed by a maintenance employee had not identified areas over the past two months that were found during the inspection. This included areas of flooring which needed replacing, furniture in need of repair in bedrooms including bedside cabinets with missing handles or broken doors. This also gave incorrect information which stated that oxygen was safely stored within the building when there was no oxygen stored at the home.

The acting manager and supporting manager were aware of areas that needed to be improved and had taken all the actions they could to prevent people's safety being compromised and to improve the overall experience for people living at Blair House. We asked the acting manager what support and supervision they received from the provider. They told us that they could contact the organisations operations manager or newly appointed nominated individual. However, they had not received any formal supervision by the provider since taking over as acting manager. The support they received had been from the registered manager of the sister home who they could contact at any time. This did not demonstrate the provider had an overview of what was happening at the home or ensured the acting manager was supported with a system of regular supervision.

The provider did not have systems in place to assess, monitor or improve the quality of services provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager worked at the home most days and had a good knowledge and understanding of people, their needs and choices. They promoted an open inclusive culture and told us the focus of the service was to ensure people received person centred care which supported them to maintain independence and dignity at all times. They strove to ensure the service was open and transparent and welcomed comments and suggestions from people and staff to take the service forward and make continued improvements.

Regular surveys had taken place to ensure that people had the opportunity to share their views of Blair House. Staff, resident and relatives meetings took place regularly.

Policies and procedures were available for staff however, these were not well organised and it was difficult to locate individual policies. The acting manager told us the organisational policies were updated regularly by the head office and any amendments or changes sent through to them. These were also available online if staff wished to access them. The acting manager acknowledged that policies needed to be sorted out and a copy made available for staff to allow them to access them freely. This was something that had been identified as needing to be completed in the near future. This was an area that needed to be improved.

Staff were aware of the whistleblowing policy and told us that they felt they could raise concerns with any of the management. A safeguarding folder including the safeguarding policy was accessible for staff.

All of the registration requirements were met and the acting manager ensured that notifications were sent to us when required.

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

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**The provider did not have systems in place to assess, monitor or improve the quality of service provided.**

17 (2)(a)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

**The provider had not ensured all premises and equipment was properly maintained.**

15(1)(c)(e)