Blair House Care Home Limited

Blair House Care Home

Inspection report

18 Roe Lane
Southport
Merseyside
PR9 9DR

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13 November 2018
23 November 2018
12 December 2018

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was unannounced and took place over three separate dates, 13 November 2018, 18 November 2018 and 12 December 2018.

Blair House is a residential 'care home' which provides accommodation and personal care for up to 41 people, including people living with complex mental health conditions. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement.

The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.
The home is a large detached property set in a residential setting fairly close to Southport Town Centre. A the time of the inspection there were 40 people living at the home.

A registered manager was in post.

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.

The home was last inspected in December 2016. The home was rated as good overall. We found during this inspection a breach of legal requirement, and the home is now rated as 'requires improvement' overall.

Risk assessments were in place for people who lived at the home and the majority of risks were well assessed and reviewed regularly. However, we did see that one person's risk assessment did not contain enough information for staff to follow to keep the person safe. There is an ongoing police investigation in relation to this incident which will not be reported upon.

There were quality assurance procedures in place which checked service provision however, they were not always effective. We saw that quality assurance systems were mostly robust. We did see however, that some of the processes with regards to service provision, such as the risk assessments required further improvements.

Everyone we spoke with told us that they felt safe living at Blair House.

A medicines inspector looked at how medicines were managed in the home. We looked at storage, records and administration and found that medicines were managed safely.

Medicine audits demonstrated that changes and learning took place to improve procedures and staff confirmed this. There was a good culture for reporting errors and we saw evidence of analysis and changes

made to improve the service.

Staff were able to describe how they ensured people were kept safe from harm or abuse. Staff discussed the actions they would take to report actual or potential abuse, which included reporting to the registered provider or registered manager, the local authority or the police.

Staff were recruited safely to enable them to work with vulnerable people. We saw that each staff member had been subject to a Disclosure and Barring service (DBS) check.

Staff rotas and our conversations with staff evidenced that there was mostly enough staff employed to work at the service and on shift to support people appropriately. Some staff had worked at the home for a number of years. There was however, some use of agency staff in the home, which some people said they did not like. We saw that the registered manager was trying to decrease their usage of agency staff, which had been successful in the last months.

The home was clean and tidy. There were hand washing facilities and hand sanitizers found throughout the home. Personal protective equipment (PPE) was available and we staff using these when they served people's food.

The training matrix and examination of staff training certificates showed that all mandatory training was in date, and had been completed by staff. We saw that specialised training was taking place to support people living with complex mental health conditions. The registered manager informed us during our inspection, that more training had been arranged for the staff.

Staff we spoke with confirmed they received regular supervision and appraisal. The induction process for staff who had no previous experience of working in health and social care settings was aligned to the principles of the Care Certificate.

People were appropriately assessed prior to being admitted to the home. The initial assessment process focused on people's needs and choices while taking into account the type of treatment and support they required.

The service was working within the principles of the Mental Capacity Act (MCA). Additionally, we checked to see whether the conditions identified in the authorisations to deprive a person of their liberty were being met.

The service was actively encouraging people to partake in decisions around their own care by presenting information in different formats to support people's understanding.

People we spoke with told is they enjoyed the food.

People were supported to access medical care when they needed it. Each person's care plan contained a record of professional's visits. These were completed by staff following each appointment people attended, including the reason for the appointment and the outcome.

The home was decorated to a pleasant standard with further plans on-going. There was directional signage and notice boards in place with activities and upcoming events so people knew what was going on each day at Blair House.

Staff we spoke with described how they protected people's privacy during personal care.

Our observations at lunch time showed that people were being treated with compassion and dignity.

All of the staff we spoke with told us they enjoyed working at Blair House and liked spending time with the people who lived there.

Care plans were signed by people who were able to do so. For people who were not able to sign their own care plans we saw this had been done via a best interest processes.

There was information provided for people with regards to the local advocacy agency.

Consideration had been given to different formats and communication methods people may require. There was some information made available in accessible formats in line with the accessible information standard.

The care records that we viewed were sufficiently detailed regarding peoples likes and dislikes and contained person-centred information. We saw that people were getting the care and support which was right for them and specific to their assessed needs. People were referred to dieticians and the Speech And Language Therapy (SALT) team when needed. .

The service was respecting and encouraging people's diverse needs and human rights.

The service had a complaints procedure clearly displayed in the communal areas of the home. This was also available in easy read and pictorial format.

There was a full and varied programme of activities at the home. There were numerous photos which were full of recent activities people had partook in. Days out were often arranged, and people partook in in- house activities.

There was end of life training programme for the staff; this ensured that people received dignified support at the end stages of their life. and
There was a registered manager in post who had been at the service for over 18 months.

All of the staff we spoke with said they enjoyed working at the home and the culture was friendly and homely. We observed this over the course of the three days we were at Blair House.

The registered manager had a good working relationship with the Local Authority and hospitals to support planned discharges for people into Blair House.

Feedback forms had been gathered from people who lived at the home, we reviewed a sample of these forms and they contained very positive comment and compliments about the service in general.

Team meeting and resident meetings were regularly taking place. We saw a sample of minutes from these. Agenda items such as the menus and activities were discussed.

We saw that the CQC had been notified appropriately of incidents and events which occurred at the service, as legally required by law. The rating for the last inspection was clearly displayed in the communal area of the home and on the registered providers webpage.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

More robust information was required in risk assessments to ensure staff could support people safely.

People said they felt safe living at Blair House.

Staff recruitment was safe, and pre-employment checks were completed on potential new staff members.

Is the service effective?

Good

The service was effective.

The staff had the correct training to reflect their roles; this was evidenced in the training matrix.

Staff received regular supervision and annual appraisals.

People were supported to eat and drink appropriately.

The service worked in accordance with the principles of the Mental Capacity Act and associated legislation.

Is the service caring?

Good

The service was caring.

We observed kind and familiar interactions between people who lived at the home and the staff who supported them.

Staff were able to demonstrate a good knowledge of the people they supported.

There was advocacy information available for people who wished to access this service.

Is the service responsive?

Good

The service was responsive.

People were receiving care which was person centred.

Complaints were dealt with in line with the registered providers complaints process.

People were supported to have a dignified and pain free death.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were audits (checks) taking place on service provision such as health and safety checks. Some audits, such as risk assessments were not robust enough.

People spoke positively about the registered provider and the registered manager and said they were approachable.

The ratings from the last inspection were displayed within the home and on the webpage.

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 checked 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.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. We also received a large number of notifications in relation to medication errors. We spent time checking and auditing medication records to ensure that the registered provider had taken action when sustained concerns were found.

We wanted to ensure that people were not at any risk and their safety and well-being was being appropriately responded to and risk assessed.

Before our inspection visit, we reviewed the information we held about Blair House. This included looking at the notifications we received from the registered provider about any incidents that may have impacted on the health, safety and welfare of people who used the service. We also looked at the Provider Information Return (PIR). This form asks the registered provider to give some key information about the service, what the service does well and what improvements they plan to make. Additionally, we approached local stakeholders for feedback about the service. We also approached the Local Authority for some feedback about the home. We did not receive any other feedback in relation to the home other than the incident we had already been made aware of. We used this information to help us populate our 'planning tool' which determines how the inspection should be carried out.

We found no evidence to suggest other people who lived at the service were subject to harm or risk as a result of this incident. We will continue communicate with Merseyside police and the local authority safeguarding team as the investigation progresses.

This inspection took place on 13 November 2018 which was unannounced,23 November 2018 and 12 December 2018 and was announced.

The inspection team consisted of three adult social care inspectors, a pharmacy inspector and an 'Expert by Experience'. An Expert by experience is someone who has experience of using a particular service. In this instance, the Expert by experience had experience of mental health services.

During our inspection we spoke with registered manager four people who used the service and five staff. We also looked at the care plans for four people and a range of documentation, including medication audits and associated documentation. We looked around the building, including the communal areas, and with permission, some people's bedrooms.

Requires Improvement

Is the service safe?

Our findings

Risk assessments were in place for people who lived at the home and the majority of risks were well managed and reviewed regularly. For example one person was at risk of smoking related injuries. The person had a risk assessment in place which contained details of how to support the person to smoke in appropriate areas of the home. Another person had a risk assessment in place around storing food in their room. Staff had a procedure to follow in order to help the person maintain a safe environment, and actions included permission to check the person's room weekly for items of food that may be inappropriately stored.

However, we did see that one person's risk assessments did not contain enough information for staff to follow to keep the person safe. There is an ongoing incident in relation to this person which we cannot report further on due to an ongoing police investigation.

This is a breach of regulation 12 of the health and social care act 2008 Regulated Activities regulations 2014.

Everyone we spoke with told us that they felt safe living at Blair House. Comments included. "There is always two staff", "Feel safe when they [staff] assist me", "Staff have had training" and "I feel safe living at Blair House."

A medicines inspector looked at how medicines were managed in the home. We looked at storage, records and administration and found that medicines were managed safely.

Medicines were stored securely in a dedicated treatment room and access was restricted to authorised staff. Room and fridge temperatures were recorded regularly and records showed that medicines were kept at the correct recommended temperature. This is important as it storing medications at the incorrect temperature can affect their ability to work effectively.

Staff gave medicines in a kind and patient way and signed the medication administration records (MARs) after the person had taken their medicine. Medicines that should be given at specific times to be effective were given at the right times. Staff knew people well and understood their needs and preferences. We spoke with one person who told us their privacy was always maintained and staff were prompt with medicines and applied creams when they were due.

Records were clear and there was evidence that stock checks were being completed. We checked a sample of medicine stocks and these were correct. There were no gaps in records indicating that people were receiving medicines as prescribed. Dates had been recorded on medicines with a shortened expiry once opened ensuring they were safe to use.

We looked at six MARs in detail. All people had photographs to help identify them and records included person centred details, such as how people liked to take their medicines, as well as essential information to keep people safe. Additional records were kept for specific medicines, such as antibiotics and insulin that

helped staff safely manage medicines. We saw assessments had been carried out for people who managed their own medicines and a secure system was in place for people who left the home on social leave.

Medicine audits demonstrated that changes and learning took place to improve procedures and staff confirmed this. There was a good culture for reporting errors and we saw evidence of analysis and changes made to improve the service.

Staff were able to describe how they ensured people were kept safe from harm or abuse. Other than the ongoing incident, there were no recent safeguarding concerns at the home which were under investigation. Staff discussed the actions they would take to report actual or potential abuse, which included reporting to the registered provider or registered manager, the local authority or the police. Staff we spoke with also said they would whistleblow to CQC if they felt the need to and understood their role with regards to this. Staff also attended training in safeguarding as part of their induction process and completed regular training refreshers.

Staff were recruited safely to enable them to work with vulnerable people. We saw that each staff member had been subject to a Disclosure and Barring Service (DBS) check. A DBS check is a check performed by potential new employers to enable them to make safer recruitment decisions. There were also at least two references for each staff member we viewed, which covered their employment history. Relevant identification had been obtained by the registered provider and copies of medical questionnaires were also kept in the staff members files.

Staff rotas and our conversations with staff evidenced that there was mostly enough staff employed to work at the service and on shift to support people appropriately. Some staff had worked at the home for a number of years. There was however, some use of agency staff in the home, which some people said they did not like. We saw that the registered manager was trying to decrease their usage of agency staff, which had been successful in the last months.

We asked about the process for inducting agency staff to the service, and how they were made aware of important information about the people that lived there. We saw during day one of our inspection there was limited information in place for agency staff, which did not give enough explanation about the people who lived at the home. We fed this back to the registered manager during day one of our inspection. When we returned for day two of the inspection, we saw that the registered manager had introduced new profile information with regards to each person, which was more in depth.

The home was clean and tidy. There were hand washing facilities and hand sanitizer available around the home. Personal protective equipment (PPE) was available and we saw staff using these when they served people's food.
There were checks taking place on the environment, such as the gas, electricity and water. We spot check some of these certificates to ensure they were in date.

There were Personal Evacuation Plans (PEEPs) in place for people who lived at the home, which took into account how each person would require supporting if they were to be evacuated from Blair House.

Incidents and accidents were well documented and the registered manager was completing a 'trend' analysis when re-occurring incidents occurred. For example, one person was falling more than usual, and the analysis showed this was linked to their medication. The registered manager took action to resolve this and this was communicated to the relevant health and social care professionals.

Good

Is the service effective?

Our findings

People we spoke with said that staff had the right skills to support them. One person we spoke with said, "I always get good advice off the staff."

The training matrix and examination of staff training certificates showed that all mandatory training was in date, and had been completed by staff. Training took place in a range of subjects including moving and handling, safeguarding, first aid, health and safety and mental capacity and deprivation of liberty safeguards (DoLS). We saw that specialised training was taking place to support people living with complex mental health conditions. The registered manager informed us during our inspection, that more training had been arranged for the staff. This was due to a recent incident occurring. The registered manager had identified that more knowledge was needed in this area, so had arranged more bespoke training.

Staff we spoke with confirmed they received regular supervision and appraisal. Appraisals and supervisions are scheduled to ensure staff receive one to one time with their line managers to reflect on good practice and discuss additional support needs in the workplace. The induction process for staff who had no previous experience of working in health and social care settings was aligned to the principles of the Care Certificate. The Care Certificate is a 12-week programme designed to help newly appointed staff working within the health and social care sector develop their skills within the role. This can then be signed off by a senior colleague when completed. In addition, the registered provider had their own induction which all staff were required to complete. This included discussions around polices such as whistleblowing, safeguarding and equality and diversity. All staff who had been working at the home for more than six months had been enrolled onto the relevant National Vocational Qualification (NVQ).

We saw that people were assessed prior to them being admitted to the home. The initial assessment process focused on people's needs and choices while taking into account the type of treatment and support they required. This had been transferred and incorporated into the person's care plan. For example, one person's independence was important them, and it was documented in their care plan to ensure this person had access to the community when they wanted it.

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 decision's and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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 had the appropriate legal authority and were being met.

The service was working within the principles of the MCA. The registered manager was knowledgeable about

the MCA and DoLS and knew the CQC needed to be notified when the outcome of any applications was known. We saw that some people had conditions stipulated on their DoLS authorisations and these conditions were subject to continuous checking.

The service was actively encouraging people to partake in decisions around their own care by presenting information in different formats to support people's understanding. We saw that 'best interest processes' were being followed for people who had limited capacity and understanding of complex decision making. The need for 'best interest' processes were clearly identified in people's care plans. The service had documentation in place which encouraged people to be involved in the decision-making process in a way that they understood. For example, we saw one person required restrictions around their cigarettes. There was risk assessment in place which the person had been involved in and this had been explained to them.

Most people we spoke with told us they enjoyed the food. One person we spoke with said "The food is ok. If I don't like anything they will do something else." We observed this at lunch time as one person did not want what was offered on the menu. People said they could have a snack if they wanted to. People who were subject to specialised diets and meal plans had these in place and the kitchen staff and chef were aware of this.

People were supported to access medical care when they needed it. Each person's care plan contained a log of professional's visits. These were completed by staff following each appointment people attended, including the reason for the appointment and the outcome.

The home was decorated to a pleasant standard with further plans on-going. There was directional signage and notice boards in place with activities and upcoming events so people knew what was going on each day at Blair House.

Good

Is the service caring?

Our findings

Everyone we spoke with spoke positively about the staff. Comments included, "The best thing about Blair House is the people, but mainly the staff", "Everyone is friendly", "Food is excellent. Can always get something you like" and "I can go out on my own, but I sometimes go to Asda with staff."

Staff we spoke with described how they protected people's privacy during personal care. This included closing doors and windows and covering people up with towels and blankets. One staff member discussed the importance of not discussing people's personal information in communal areas, as it would be breaking their confidentiality.

Our observations at lunch time showed that people were being treated with compassion,dignity and respect. When we walked around the home at various parts of the day, we saw that people's bedroom doors were closed when they were being supported with personal care, and staff were addressing people respectfully. We also observed staff talking to people discreetly, respectfully and offering help and reassurance. This was well received by people.

All of the staff we spoke with told us they enjoyed working at Blair House and liked spending time with the people who lived there.

Care plans were signed by people who were able to do so. For people who were not able to sign their own care plans we saw this had been done via a best interest processes. People who were able to had also signed consent forms within their plan of care to say they agreed with the plan, and have given permission for their records to be shared with appropriate professionals.

There was information provided for people with regards to the local advocacy agency. Advocacy agencies help support people to make desicions when they have no next of kin who are available to do this. At the time of our inspection there was no one making use of this service.

Consideration had been given to different formats and communication methods people may require. There was some information made available in accessible formats in line with the accessible information standard. For example, large print or easy read versions of the service users guide was available for people to request if they required.

Good

Is the service responsive?

Our findings

The care records that we viewed were sufficiently detailed and contained person-centred information. 'Person centred' means care which is based around the needs of the person and not the organisation. In one record we viewed there was a good level of detail about; family history, life history, medical history, likes and dislikes. This helped staff to get to know the person and provide individualised care which was responsive to the person's needs. One care record relating to a person with complex healthcare needs provided detailed guidance for staff, but also focussed on their personal preferences. For example, we saw that one person liked to spend time alone in their room, however, this person was at risk of social isolation, so staff had a specific strategy for engaging with this person whilst ensuing their right to privacy was respected.

We saw that people were getting the care and support which was right for them and specific to their assessed needs. For example, people who were at risk of weight loss or malnutrition were weighed regularly and where there had been a recorded weight loss the appropriate referrals had been made to dieticians. We saw that one person had been put on a regime which required them to be weighed weekly and their weight to be monitored. We checked the persons records and saw they were being weighed, and their weight was consistent. We saw people who were on specific medications and depo injections had regular blood tests in line with guidance from the Community Practice Nurses (CPN's) and consultant psychiatrists.

The service was respecting and encouraging people's diverse needs and human rights. We saw how one person was supported with their cultural and religious choices, in this case, attending church was important to the person.

We checked the process for logging and responding to complaints. The service had a complaints procedure clearly displayed in the communal areas of the home. This was also available in easy read and pictorial format. We viewed a sample of recent complaints. We saw from looking at these records that the complaint had been documented, responded to and analysed for future learning. Each complaint had a summary of the action taken to resolve the complaint.

There was a full and varied programme of activities at the home. There were numerous photo albums which were full of recent activities people had partook in. Days out were often arranged, and people partook in in house activities. People told us they enjoyed the activities and they partook in them.

There was end of life training programme for the staff to complete. This helped to ensure that people received dignified, respectful and compassionate care at the end stages of their life.

Requires Improvement

Is the service well-led?

Our findings

There were quality assurance procedures in place which checked service provision. We saw that quality assurance systems were mostly robust. Areas such as care planning and assessments were checked each month by the quality assurance manager. The audit tool the service had in place was aligned to CQC's Safe, Effective, Caring, Responsive and Well-Led domains.

We saw that some improvements, such as medication documentation had been highlighted in this audit as requiring further improvement, this was action planned and assigned to the appropriate person to implement. We did see however, that some of the processes with regards to service provision, such as the risk assessments with regards to the incident referred to in the safe section of this report required further improvements.

There was a registered manager in post who had been at the service for over 18 months. We received positive comments with regards to the registered manager, and their level of professionalism. One person we spoke with on the first day of our inspection said "'[Manager] is great. They give me little tasks to do sometimes, and I feel like I am really helping out."

All of the staff we spoke with said they enjoyed working at the home and the culture was friendly and homely. We observed this over the course of the three days we were at Blair House.

We asked the registered manger about lessons learned and if they had improved any practices since they had been in post. The manager had changed the approach to medication management due to an increase a few months earlier of medication errors at the service. Our CQC medicines pharmacist confirmed that medication practices had clearly improved in the last few weeks.

The registered manager developed good working relationship with the Local Authority and local hospitals. This meant that people received a smooth transition from hospital when being admitted into Blair House.

Feedback forms had recently been gathered from people who lived at the home, we reviewed a sample of these forms and they contained very positive comment and compliments about the service in general. Comments included, 'Very happy' and 'I like living here.'

Team meeting and resident meetings were regularly taking place often, and we saw a sample if minutes from these. Agenda items such as the menus and activities were discussed.

The registered provider had policies and guidance for staff regarding safeguarding, whistle blowing, dignity, independence, respect, equality and safety. Staff were aware of these policies and their roles and responsibilities within them. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance.

We saw that the Care Quality Commission had been notified appropriately of incidents and events which

occur at the service, as legally required by law. The rating for the last inspection was clearly displayed in the communal area of the home and on the registered providers webpage.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Some information within risk assessment was not detailed enough to help keep people safe.