Regal Care Trading Ltd

Blair House

Inspection report

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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

Summary of findings

Overall summary

Blair House provides residential care for up to 29 older people. People required a range of help and support in relation to living with memory loss, dementia and personal care needs. Most people were independently mobile, some with the use of mobility equipment and required support and prompting from staff. There were nine people living at the home at the time of the inspection. The provider had made a decision after the inspection in November 2016 not to admit people to the service until improvements had been made. This was no longer in place and people had moved in for periods of respite. However, the provider and registered manager told us people had been reluctant to move into Blair House due to further improvements needed to the environment and the enforcement action taken by CQC.

Blair House was inspected in November 2016. A number of breaches were identified and it was rated as inadequate. The Care Quality Commission (CQC) took enforcement action and the service was placed into special measures. Special Measures means a service will be kept under review and if needed could be escalated to urgent enforcement action. CQC issued three Warning Notices after the inspection in respect of safe care and treatment, premises and equipment and good governance. We also found two further breaches in relation to a lack of person centred care and failing to ensure sufficient numbers of appropriately trained and competent staff were in place at all times.

This inspection took place on 24 July 2017 and was a full comprehensive inspection to check the provider had made suitable improvements to ensure they had met regulatory requirements. We found that appropriate actions had been taken and issues had been addressed. The provider was now meeting the regulations and the service no longer required to be in special measures.

Blair House had a registered manager. A registered manager is a person who has registered with the Care Quality 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 registered manager was in day to day charge of the home, supported by the nominated individual working on behalf of the provider.

People told us they enjoyed the meals and people's weights were monitored. People did not have their choice supported at supper time. Pureed meals were not presented in an appetising way.

Systems to assess and monitor the service provided had been significantly improved. These had been implemented and continued over recent months which demonstrated that improvements had become part of the day to day systems within the home, these now needed to be maintained. This included auditing, provider oversight and an open transparent culture within the home. People spoke positively of the improvements which had taken place. Staff felt supported and people's views had been sought and responded to.

We found significant improvements to the care documentation and records. Staff had access to relevant information about people; this meant they knew people and their care needs well. People received care which was assessed, planned and reviewed regularly to ensure their needs were met and to reflect their preferences. Individual and environmental risk assessments were in place when risks to people's safety had been identified. When accidents, incidents or falls occurred clear systems were in place to record and respond appropriately. Referrals were made to other health professionals if needed.

Staff had an understanding of recognising and reporting abuse. Staff had received training and information was available to ensure they understood their responsibility. The registered manager was aware of what was required to be reported and kept a record of when this had taken place. Improvements had been made to ensure people's dignity and privacy were maintained at all times and care records were stored safely.

There was on-going maintenance and servicing of all areas of the home, including water systems, gas and electrical equipment. Fire safety checks had taken place and information was recorded regarding evacuation and emergency procedures.

There were systems in place to manage people's medicines safely. Medicines were stored safely and documentation completed accurately regarding prescribed medicines and when they were given.

Recruitment processes were in place, these included checks which took place before people began work at Blair House. Recruitment was on-going. The registered manager worked some care shifts to support care staff and to carry out observations around care provision. New staff had a period of induction. There was an on-going programme of training and supervision for staff.

Mental Capacity Act 2005 (MCA) assessments were completed as required and in line with legal requirements. Staff had attended MCA and Deprivation of Liberty Safeguards (DoLS) training. People were supported to spend their time how they wished, with guidance and prompting provided when needed. People felt involved in choices about how they spent their time, staff were aware that people should be involved in all day to day decisions.

Staff communicated with people in a caring and supportive manner. Staff knew people well and people were treated with respect and dignity. There was a varied activity schedule. People engaged actively in activities and told us they enjoyed them. There was a complaints policy and procedure. People told us they would raise concerns if needed.

Many improvements had taken place since the last inspection and the warning notices and breaches of regulations had been met. At the next inspection we will check to make sure the improvements are embedded and sustained. This is because there are currently nine of a possible 29 people at the home and we will need to see that as people are admitted the improvements continue, which is why the rating is requires improvement despite no breaches having been identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Blair House was safe and was meeting the legal requirements that were previously in breach.

Individual and environmental risk assessments were in place when risks to people's safety had been identified. A robust system was in place for responding to and recording accidents and incidents.

There was on-going maintenance and servicing of equipment. Fire safety checks had taken place.

There were systems in place to manage people's medicines safely.

Staff had an understanding of recognising and reporting abuse.

There were enough staff to meet people's needs.

The provider had safe recruitment processes, appropriate checks took place before people began work at Blair House.

Is the service effective?

Requires Improvement

Blair House was not consistently effective.

Meal choices were not supported at supper time. Pureed meals had not been presented in a way to ensure they looked appetising and offered a variety of flavours.

People told us they enjoyed the meals and were supported to stay healthy.

Staff induction, training and supervision programmes were taking place.

Mental Capacity Act 2005 (MCA) assessments were completed as required and in line with legal requirements. Staff had attended MCA and Deprivation of Liberty Safeguards (DoLS) training.

Peoples weights were monitored, referrals were made to other health professionals if needed.

Is the service caring?

Good

Blair House was caring.

Improvements had been made to ensure peoples dignity and privacy were maintained at all times.

Staff communicated with people in a caring and supportive manner. Staff knew people well and people were treated with respect and dignity.

Peoples were supported to spend their time how they wished. Guidance and prompting were provided when needed.

Records were kept securely. People had access to advocacy services if required.

Is the service responsive?

Good

Blair House was responsive.

People received care which was assessed, planned and reviewed to ensure their needs were met and to reflect their preferences.

Staff had access to relevant information about people; this meant they knew people and their care needs well.

There was a varied activity schedule. People engaged actively in activities and told us they enjoyed them.

There was a complaints policy and procedure. People told us they would raise concerns if needed.

Is the service well-led?

Requires Improvement

Blair House was meeting the legal requirements that were previously in breach.

Systems in place to assess and monitor the service provided needed time to embed to ensure they were maintained as numbers of people living at Blair House increased.

There was a registered manager in post, supported by the provider.

People spoke positively of the improvements which had taken place. Staff felt supported and people's views had been sought and responded to.

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 was an unannounced inspection which took place on 24 July 2017. The inspection team consisted of one inspector and an expert by experience in older people's care and mental health. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the home, including previous inspection reports and the action plan sent to CQC after the previous inspection. We also looked at the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at information which had been shared with us by the local authority and quality monitoring team and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We observed the care which was delivered in communal areas and spent time talking to staff and people who live at Blair House. We were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us. During the inspection we spoke with eight people to find out their views and experiences of the services provided at the home. We also spoke with the nominated individual working on behalf of the provider, registered manager, care staff, cook and one relative. We received feedback prior to the inspection from health professionals who have visited the service.

We reviewed records at the home; these included two staff files including staff recruitment, training and supervision records. We looked at daily records, computerised care plans and other information completed by staff, policies and procedures, accidents, incidents, quality assurance records, meeting minutes, maintenance and emergency plans.

We looked at two people's care plans and risk assessments in-depth and a further three care plans to follow up on specific areas of care provided. This is an important part of our inspection, as it allowed us to capture

information about a sample of people receiving care.

Good

Is the service safe?

Our findings

At the last inspection in November 2016, the provider was in breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people's safety had not been assessed and supported, including management of pressure areas, medicine processes were not safe. We identified risks due to a lack of fire safety measures and unsafe storage of items in the building.

The provider submitted an action plan that detailed how they would meet the legal requirements. At this inspection we found systems in place to ensure people were kept safe had significantly improved. Changes had been implemented and continued over recent months which demonstrated these improvements had become fully embedded into practice. The provider was now meeting this regulation.

Everyone we spoke with told us they felt safe living at Blair House. Telling us, "They are very good, all of them, I don't need much help.", "They are always around if you need anything.", "I just know I can tell I'm safe, if I feel unwell or need anything, she will always look after me" and, "Oh there are always new staff here, it does not affect me they still look after me well, same as the others." A relative told us, "Very safe here, she is very happy."

At the inspection in November 2016, the provider was in breach of Regulations 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Serious concerns were identified with regards to the maintenance of the building and cleanliness around the home. This included monitoring of fire safety throughout the building, safe water temperatures and other environmental risks in relation to cleanliness. The provider submitted an action plan that detailed how they would meet the legal requirements. At this inspection we found the provider was meeting this regulation.

New systems had been introduced and maintained over previous months by the registered manager and provider. Documentation and regular checks had been completed to ensure that appropriate maintenance and monitoring had been completed. An annual list was seen which identified when maintenance and system checks were due and completed.

Appropriate levels of cleanliness were seen in communal areas, bathrooms and bedrooms. The storage of items had been addressed in the laundry and basement areas. Fire safety risks had been assessed and reviewed. A fire risk assessment action plan had been completed to show how areas identified had been addressed. Fire safety documentation also included Personal Emergency Evacuation Plans (PEEPs) for people living at Blair House and evacuation plans in the event of an emergency. This meant that risks to people's safety were being identified and assessed to help maintain a safe environment.

The nominated individual and registered manager told us there was a five year business plan which included on-going refurbishment of people's rooms. Further plans were in discussion to continue improvements to the general environment. This included changing the laundry area and some external refurbishment. We discussed some on-going work required to ensure the garden was suitably and regularly maintained to make it a more inviting area. The registered manager had included this within their five year

plan.

We previously found that medicine procedures were not safe. Improvements were needed to the safe storage and documentation of medicines. At this inspection we found people received their medicines in a safe and consistent manner. People told us they felt supported to take their medicines correctly. Medicines were stored safely within a locked trolley in the medicine room. Medicines were taken to the communal lounge/dining room a medicine trolley which was locked when left unaccompanied. We looked at medicine administration records (MAR) charts. We found that these had been accurately completed. Medicine audits were completed and the pharmacy providing medicines to the home had carried out an audit of medicines with no actions identified. 'As required' or 'PRN' medicines prescribed by a GP to be taken when needed were documented on MAR charts. PRN protocols were seen and staff had documented when and why these had been given. We saw that when a person told staff they had a headache. Staff asked them if they needed any pain relief and a prescribed PRN medication was then given to the person.

At the inspection in November 2016 we found that people were not safe due to a lack of documentation and information about their health and care needs. At this inspection we found that systems had been introduced to ensure that risks to people were identified, reviewed and managed in a safe and consistent manner. Risk assessments had been completed for identified health needs, including, risk of falls, moving and handling, behaviours, smoking, mental capacity, psychological risks and those associated with specific health conditions. The registered manager told us that pressure area management would be included within care plans if someone was identified as at risk. Risk assessments were individualised and had been reviewed and updated regularly over previous months. Information was detailed, for example, a moving and handling risk assessment identified that the person did not require any equipment but included relevant information that the person shuffled when walking. Staff had access to this information to ensure that they had the information and guidance to provide safe appropriate care to people at all times. No-one currently required the use of lifting hoists, although some did require support and guidance when standing and mobilising around the home.

Previously we found that newly appointed staff were working unsupervised and did not have adequate experience, training or awareness people's needs to ensure their safety and individual health and welfare needs were met. At this inspection we found information was recorded within peoples' care plans to ensure staff were well informed and understood peoples care needs. There were enough staff on duty to support and respond to people's needs promptly. Staff told us that staffing levels were appropriate. The registered manager said recruitment was on-going and when required, for example, due to holidays or sickness they would cover the senior carer role as this gave them the opportunity to observe how peoples' care was provided.

At the inspection in November 2016, we found that the response to accidents and incidents was not consistent. Not all incidents had been appropriately recorded and responded to. At this inspection we found that a new robust recording system had been implemented and embedded into practice. When incidents occurred staff completed an accident/incident form and body map to record injuries if needed. This was then reviewed by the registered manager who logged the incident and ensured that appropriate actions had been followed. For example, regular checks after a suspected head injury, contacting other health professionals or reporting incidents to the local authority and CQC. A falls tracker was also in place which included the time/shift the fall occurred and other relevant information to enable this to be cross referenced. Information was checked and signed to show management oversight. All information had been logged consistently over previous months with a monthly analysis form which had been used to identify any trends or themes. We were able to track an incident recorded within a person's daily records on the computer care planning system and follow a clear audit trail of how this had been responded to and actions

followed. These meant injuries, accidents and falls were responded to, to help keep people safe.

People were protected, as far as possible, by a safe recruitment system. Appropriate checks were undertaken, including references and criminal records checks with the Disclosure and Barring Service (DBS). Staff did not start working until satisfactory checks had taken place this included two references including one professional reference from the most recent employer or other appropriate person. There were copies of other relevant documentation including interview records, identification and job descriptions in staff files. Staff files had been audited to ensure that information was up to date and maintained.

People were protected from the risk of harm from abuse. The registered manager was aware when safeguarding issues needed to be reported. We discussed that this included unexplained bruises or injuries to ensure that people's safety was maintained. Staff were aware of the safeguarding policy and procedure. Information about recognising and reporting concerns was displayed in staff areas.

Requires Improvement

Is the service effective?

Our findings

At our inspection in November 2016 we found the provider had been in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not know people's needs and lacked confidence. The provider had not taken appropriate steps to ensure new staff had received an appropriate induction, guidance and training before working independently within the home. Staff had not completed training to ensure they had the appropriate skills and knowledge to provide peoples' care. Training records showed that some staff were out of date or had not completed necessary training before working unsupervised.

The Provider submitted an action plan detailing how they would meet their legal requirements. At this inspecting we found Improvements had been made and the provider was now meeting this regulation.

At our inspection in November 2016 we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Mental capacity assessments (MCA) had not been completed. Decisions made regarding peoples' care did not identify how decisions had been made and who had been involved. Staff were not aware who had a Deprivation of Liberty Safeguard (DoLS) authorisation in place. When DoLS decisions had been authorised or applications made, documentation had not been updated to ensure all information was available for staff. This led to people's safety being compromised.

The Provider submitted an action plan detailing how they would meet this regulation. At this inspection we found Improvements had been made and the provider was now meeting the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported and had the training they needed to meet people's needs. Training records had been updated and gave a clear picture of training attended and booked. When staff training was out of date this was highlighted and steps taken to ensure this was addressed in a timely manner. The registered manager had a clear rationale and explanation for the minimal out of date training shown on the training records, for example due to staff sickness or absence. The registered manager was aware of the need to take action if staff failed to attend training when arranged. Staff were provided with amongst others, safeguarding, dementia, moving and handling, MCA and DoLS and challenging behaviour training. Despite all the training being provided we saw that some staff, although experienced and trained, lacked confidence interacting with people. We discussed this with the registered manager who told us they were aware of those staff who may need further support.

At this inspection we found structured inductions were now organised to ensure all staff felt supported and competent to undertake their role within the service. New staff completed a period of induction, this included introduction to the home, policies and procedures, shadowing staff members, supervision and training. We spoke to one member of staff who had recently returned to Blair House, they told us they felt appropriately supported and trained to meet people's needs. The registered manager delegated some of the induction programme to other senior care staff. We discussed that it would be beneficial for the

registered manager to have final oversight of the induction programme and carry out competencies to enable them to assess new staff were appropriately trained and competent to work unsupervised. The registered manager told us they would add this to the induction programme immediately to continually improve. We saw that a supervision and appraisal schedule was on-going to provide staff with one to one support. The supervision schedule showed some supervision included spot checks and observations to check skills and competencies of staff. Supervisions were scheduled approximately every two months. Staff told us that if they had any issues or concerns they could speak to the manager at any time. The registered manager was clear that if needed more frequent supervisions would be scheduled, if for example training issue was identified or a concern raised this would be discussed with the staff member and actions taken.

Significant improvements had taken place since the inspection in November 2016 regarding Mental capacity assessments and Deprivation of Liberty Safeguards (DoLS). Staff demonstrated an understanding of the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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 were being met.

People's mental health and wellbeing was assessed and reviewed regularly. Mental capacity assessments had been completed regarding specific risks or when people's mental health needs had increased and referrals to community mental health teams had been made if a person's mental health needs had changed. Many people were independent and able to go out alone or with friends. Mental capacity assessments were used to identify concerns in relation to people's mental health, capacity and understanding. The computer care plan system enabled mental health assessments to be linked to the corresponding care plan. And had been competed for identified needs and were decision specific. For example, mental capacity assessments had been completed for decisions related to amongst others, daily living, finances, living in a secure environment and medicines. A record was seen detailing who living at Blair House had a DoLS application in progress or authorised, this included the dates that these applications or authorisations had been made and relevant information for staff regarding this decision This meant that staff had access to information to ensure they were aware at all times of any DoLS restrictions in place for individuals. Staff had completed MCA and DoLS training and further information was provided for staff including the five principles of MCA which was displayed in staff areas.

People confirmed that they were asked for their consent before care and assistance was provided. Staff described how they would ask for people's permission before giving support. If people declined care or support, staff respected the person's decision and if necessary sought advice from the registered manager. The computer IPod system had a facility to record when care was offered and declined. We discussed with the registered manager the importance that all staff record this to ensure people's choice and involvement in decisions were consistently recorded. Staff were able to tell us about people and how they liked their care provided. Some people were independent and valued their privacy. Staff were aware of this and told us they just provided prompting and guidance when required.

People told us they enjoyed the meals provided, telling us, "I've not come across anything I don't like.", "Food is always nice." "It's very good here." And, "They will always do me something different if I do not fancy what they've done." Choices were offered at breakfast and lunchtime. There was a four week rolling menu,

although we were told that occasionally this would be altered to accommodate people's requests. A board was displayed to show the days meal choices and this was kept in the dining area. Hot and cold drinks were provided throughout the day. We spoke to the cook who had worked at Blair House for a number of years they told us as well as meals, snacks were provided in the afternoons and they were working to introduce healthier options for people. This included snack plates of fruit and healthier items. They had a good understanding of people's specific dietary requirements including allergies, diabetic, pureed or soft meal requirements. The cook served meals at breakfast and lunch and played a very hands-on role dishing up meals and ensuring people ate their food and had the choices they wanted, At breakfast and lunch choice was offered and provided. However at supper this was not seen to take place. Supper time meal choices had been made in advance by the cook and care staff were responsible for giving people their supper. On the day of the inspection the meal choice was sandwiches. One person was asked what sandwich they would like and they asked for tuna. The care staff member told them that there was not any tuna but there was egg or ham. The person requested egg sandwich on brown bread. They were then told there was only white bread. Although the person ate the sandwich this was not their choice and they did not seem to enjoy the sandwich. It also contained tomato which they spat out as they told us they did not like tomato. We discussed these issues with the registered manager who told us they would ensure that choices were catered for more effectively.

At lunch time we saw that people were offered choice and if people changed their minds at the last minute an alternative was available provided by the cook. One person was seen to be eating sausages as they had not liked either of the two choices that day. We saw that another person had a pureed meal provided; we were told this was meat, potatoes and vegetables. Although the person was seen to enjoy this meal, the whole meal had been pureed together. This meant the food was all the same colour and there was no variety to the flavours as all the meal ingredients had been blended together. The provider needed to make improvements to ensure pureed meals were presented to look appetising and provide varied flavours on the plate and meal choices provided by care staff at supper time were based on people's likes, dislikes and preferences.

People's weights were monitored monthly or more frequently if needed. We saw that referrals had been made to other health professional if needed. This included Speech and Language Therapy (SALT).

Good

Is the service caring?

Our findings

At our inspection in November 2016 we found that improvements were needed to ensure that people's belongings and personal items were treated with respect. Laundry items had not been appropriately stored and confidential documentation had not been kept safely or securely. At this inspection we found that improvements had been made.

People told us they felt staff were caring. One person said, "I really could not ask for more, they really are very good". Relatives told us, "The only thing Mum worries about is not being able to stay here, they do all the things she needs and that are important to her, staff are lovely."

Staff had a good understanding of people as individuals. People were also supported to maintain their own independence and staff worked with people at their own pace to achieve this. Blair House provided care to people, some of whom were fairly independent and went out alone. Others due to mental health or health related concerns were independent to a degree but needed more support, encouragement and prompting to maintain their appearance and to ensure that personal care needs were met. This was provided by staff in a kind and caring manner. One person was reluctant to have a bath. Staff were aware of this and we saw that they were asked if they would like a bath on two occasions and had declined both times. Another staff member returned later and asked the person if they wanted them to run the bath for them, to which the person replied that they would. They then came to the registered managers office to tell them they were about to have their bath. Staff knew and understood this person, they were aware that they would often decline care but if they returned or a different member of staff approached them, they may change their mind. This was done with patience ensuring the person's dignity was maintained. Advocacy information was displayed in the main reception area. People had been supported to access advocacy services when appropriate for example, people who did not have any next of kin to support them in their day to day life.

Staff were able to tell us about people, their personal histories, likes, dislikes and care needs. They knew how people were able to make their own choices and supported them to do so. One person liked to have all their drinks in a specific cup which they carried with them throughout the day. Staff were aware of this and we saw that all drinks were given to this person using their preferred cup. For people with limited verbal communication, staff were clearly aware of this and ensured they maintained communication with them allowing them time to respond.

Some bedrooms contained people's personal items and furniture. One person had a large collection of items that were important to them. We saw that a specific care plan and risk assessment were in place regarding these items as this person needed guidance and support to keep them stored tidily.

People were able to access the areas of the home they wished. We saw people regularly access the garden to smoke cigarettes or to sit outside. People went from room to room dependant on where they wanted to sit and returned to their room as they chose. Assistance was provided by staff when needed. One person returned from their room to the lounge after a short rest, they were able to walk independently, however staff were beside them offering reassuring communication until they were seated. There was light- hearted

friendly banter and people responded positively to staff when they entered a room. When people asked for assistance this was provided promptly. Staff told us they enjoyed their role and tried to provide the best care possible for people.

Care records were computerised and staff accessed most care records via the hand held tablet or by computer. These were password protected. Some records were stored in a cupboard in the lounge. Records were kept safely and securely.

Good

Is the service responsive?

Our findings

At the last inspection in November 2016, the provider had not ensured that documentation was completed to inform staff. This meant that people were not receiving care in a way that supported their needs. Care records did not include individual likes, dislikes or preferences and care was not person centred. This was a breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was submitted by the provider that detailed how they would meet the legal requirements. At this inspection we found improvements had been made and the provider was now meeting this regulation.

A detailed pre admission assessment had been implemented. The registered manager told us this gave more information to enable a decision to be made regarding whether a person's needs could be met safely at Blair House. Information from the assessment was then used to develop the care plans and risk assessments when people moved into Blair House. Care plans contained detailed information about people's needs in relation to personal care, mobility, sexuality, mental capacity, medicines, and nutrition, health and personal preferences. Peoples' care needs were regularly assessed and reviewed to ensure information was up to date and relevant. Care plans included relevant individual and person centred information to advise and support staff to provide safe and responsive care. Information about people included background, life choices and significant events. For example, one person's included that they were very private and their choice had been not to discuss their past and childhood. Staff were aware of this and respected their decision. Another said the person loved to go out to the shops most days. This was to be supported, however staff were to ensure the person was appropriately dressed. Health related needs including diabetes were clearly documented in care plans, with supporting information for staff regarding how to respond in an emergency if a person's blood sugars where too high or too low.
Care plans were reviewed monthly or more frequently if changes occurred. We saw that this level of detailed care documentation and reviews had taken place consistently over previous months and had become embedded into practice.

People told us they knew that there were care plans but they did not look at them. One telling us, "I don't need to see it; staff tell me what I need to know." Relatives said, "I was involved at the beginning but I have not seen it since, however nothing would have changed. They talk to me every time I visit so I am kept up to date." Staff were able to access all care information on their hand held tablet. They were able to show us how they could find out information about peoples' care needs and how they recorded the care they provided.

At the inspection in November 2016 we identified that activities needed to improve. At this inspection we found an activities coordinator had been employed who worked over two locations owned by the provider. People spoke very positively about the activities provided. One person told us, "I do the puzzles to keep my brain working, that's why I like all the quizzes and games (activity coordinator) does". And, "I like them." Relatives spoke highly of the change they had noted in their loved one. Telling us, "Mum has come on in leaps and bounds; the activity lady (name) is amazing." They went on to tell us how their Mum had spent time with the coordinator using a tablet computer to look things up on the internet. This had led to an

amusing conversation between mother and daughter where a query had come up regarding what something was called. The relative told us, "Mum said, don't worry I will ask (activity coordinator) to google it" They were amazed that this was something their mum was able to do and impressed with the variety of activities taking place.

A list of daily activities were displayed in the main communal lounge. These included some in- house activities which were varied and subject to change dependant on people's choices and participation. The activity provider worked mornings or afternoons on a rotating basis with the sister home. Care staff also provided activities at other times. During the inspection we observed a bean bag activity where the bag was thrown by people onto squares on the floor which contained a letter of the alphabet. This then prompted lively conversation and reminiscence on a subject beginning with that letter. People were seen to actively engage in the activity and at one point six people were fully and actively involved in this game. For people who preferred quieter activities or were unable to participate in group games, the activity coordinator spent time with them later in the day; we saw that they were reading to one person at lunch time. They told us this person "Loved to read but loses concentration very quickly when reading to her-self so I read to her which she enjoys."

People told us they were able to do what they liked throughout the day. They were able to get up and go to bed when they chose and this is what we saw during the inspection. People had a variety of hobbies which they still enjoyed, telling us, "I do all my sewing and knitting in my room". Another told us they enjoyed puzzles and word searches and did those most days. People had access to a hairdresser and chiropodist appointments. Visiting entertainers were included in the activity schedule these included, exercise, motivation and music. One person told us, "I have no family to visit, so I really like it when the singers come in."

There was a complaints policy and procedure and complaints were recorded and responded to appropriately. People told us they would make a complaint if they needed to. We saw day to day concerns were addressed promptly. The registered manager was aware of the importance of responding to all concerns, however minor, promptly to ensure people felt listened to and their concerns were addressed. People told us they would be happy to speak to staff if they had a concern. Everyone we asked felt that they would most likely speak directly to the registered manager. Relatives said they would speak to staff or the manager and would feel happy to discuss any issues, if needed.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2016, the provider did not have systems in place to assess, monitor or improve the quality of service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was submitted by the provider that detailed how they would meet the legal requirements. At this inspection we found improvements had been made and the provider was now meeting this regulation. However, these improvements now needed to be sustained and reviewed as the service continued to develop and improve.

The registered manager told us that there had been a change to the nominated individual (NI) since the inspection in November 2016. The new NI had worked closely with them to make the necessary improvements. They felt supported by the NI who had encouraged them to progress and grow within the registered manager's role. They were aware of their role and responsibilities and felt the previous inspection had led to the home making vast changes and improvements.

A robust quality assurance process had been implemented since the inspection in November 2016. This had been reviewed and developed over previous months to ensure that all areas of the home were incorporated. Whilst the service provided had greatly improved, there is a need for all the changes to embed and be maintained. This increased level of management and provider oversight needed to be maintained and managed as more people moved into the service. Therefore this is something that will need to be monitored to ensure continued improvement.

A CQC folder was in place to keep copies of all audits and documentation used within the home and where this information corresponded within a CQC report. Audits included monthly and quarterly checks. These included amongst others, dependency, premises, equipment, accidents, incidents, falls, care and welfare, food and hygiene, quality of service medicines, safety and suitability of premises and supporting workers. This meant that there was an effective system in use which enabled the registered manager and provider to have oversight of the service and assess and monitor the safety and effectiveness of services provided. We saw that audits had been consistently completed and appropriate actions identified and addressed. This included, actions identified as part of the fire risk assessment. As well as monthly audits, a further daily walk around/audit was carried out by the registered manager. This reviewed staffing levels, covering of shifts, staff sickness and daily checks and observations. The provider also completed a monthly audit which was detailed and covered all five CQC domains. This included checks on documentation, environment, cleanliness and care documentation as well as monitoring information being completed by the registered manager. This meant there was provider oversight to ensure that improvements were maintained. They also gained feedback from people and carried out observations around the home.

Care plans and risk assessments were checked and audited. The provider used an electronic care planning system and all care plans and risk assessments were written on this system. The information was accessible to staff via computers and hand held devises. The hand-held digital device was linked to the main computer

system on which staff accessed care plans and recorded the care and support people received. Some daily documentation and charts were still hand written and stored in folders in the communal lounge. All the previous days care record entries were reviewed at the start of each day on the computer system. The registered manager told us they looked at these to check that information had been recorded correctly. Any issues identified could then be responded to and addressed promptly.

A handover form was used to share information at the start of each shift. The handover report included any relevant changes or incidents that had occurred. One form was used throughout each 24 hour period so there was a clear audit trail of information for staff detailing the previous shifts. This also included moving and handling information, who had a Do Not Attempt Resuscitation (DNAR) or a DoLS authorisation in place. Staff signed these to show who had given the information and who had received it.

People told us they felt that improvements had been happening. One person said, "I have been here five years oh yes, it's much better, (registered manager's name) is a good boss, my daughter likes her too." A relative told us, "The manager has made some positive changes, they have got rid of some staff that needed to go, and the environment is improving, some areas have been redecorated and more planned I think. Mums the happiest she has been in years."

People had been asked for their feedback. Resident meetings had taken place and minutes included a monthly account of actions from the previous meeting. We saw that this included people being involved in choices of curtains as part of the on-going redecoration. Discussion around new activities people wanted and information sharing reminding people to drink plenty when the weather was hot. An open day had been planned for August and all relatives and visitors had been invited to attend. Staff meetings had also taken place with future meetings scheduled. Staff told us that information was shared and they felt that their views were sought and considered.

There was an open and transparent culture and both the NI and registered manager told us that the emphasis was to continue with the improvements implemented to ensure these were maintained. They were aware that some further environmental refurbishment may be required to support an increase in numbers of people living at Blair House.