Regal Care Trading Ltd

Blair House

Inspection report

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16 November 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Blair House is a large Georgian building registered with CQC to provide residential care for up to 29 older people. At the time of the inspection there were 20 people living at the home including four people staying at Blair House for a period of respite care. There was a lift at the home and due to the layout of the home a chair lift was available to some of the upper floor rooms which could not be accessed by the lift.

This was an unannounced inspection which took place on 14 and 16 November 2016.

Blair House was inspected in September 2015. Two breaches of Regulation were identified in Regulation 15 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured all premises and equipment was properly maintained. The provider did not have systems in place to assess, monitor or improve the quality of service provided.

The provider sent us an action plan stating they would have addressed all of these concerns by October 2016. However, at this inspection we found although some improvements had been made in relation to the premises, new areas of concern were identified. This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that the provider had failed to make adequate improvements to ensure an effective system was in place to regularly assess and monitor the quality of service that people received. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some further breeches of regulation were also found during this inspection.

People's level of care and support needs varied. Whilst some people could take care of themselves and were mobile, others used walking frames or required assistance from staff for all personal care and mobility needs. Those who remained predominantly independent required prompting and support at times to ensure they remained safe. Some people had mental health concerns, dementia or memory loss. A couple of people went out alone or with friends and family, whilst others required more assistance with all care needs and remained in bed or in the communal areas of the home as they chose.

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.

Pre admission assessments did not identify people's health needs. People with specific health and care needs did not have care plans and documentation in place to inform staff. People with dementia did not have any assessments to identify how this impacted on their daily lives or how their dementia presented in day to day life. People who used continence aids did not have this information included in their continence

care plan. Care plans did not routinely include information regarding peoples mental health needs. People who were assessed as requiring pressure care equipment did not have daily checks in place to ensure pressure areas were assessed and monitored to identify concerns. People's safety was not being fully assessed and maintained. One person who was unsafe to go out alone had the door opened by staff who were unaware they were not safe to leave unaccompanied and they went out.

Some health and safety checks had not been completed since the maintenance employee left in May 2016. This included water temperature, descaling, cleaning and flushing of water systems, fire alarm checks and some day to day maintenance around the home. Infection control measures had not been maintained. We found areas of the home that needed cleaning. There was no designated laundry person and care staff were currently responsible for this. People's personal items of clothing had not been treated with respect. Laundered clothing had not been folded and stored tidily. Personal and confidential care records had not been safely stored to ensure peoples personal information could not be accessed by others.

Systems to manage and store medicines needed to be improved. Medicines were not safely stored and this could pose a potential risk to people living at Blair House as they were not locked away at all times. Medicine procedures for PRN or 'as required' medicines were not consistent. People were risk of being given their medicines in an inconsistent manner.

Procedures to document and report accidents and incidents were not consistently followed. Forms were not always completed or lacked detail. Body maps were not in place for all injuries. Actions taken in the response to accidents and incidents were not documented on the form. The registered manager had not completed an audit/ analysis of accidents and incidents since February 2016. The documentation did not show that people's safety was being maintained after injuries or accidents occurred.

Mental Capacity Assessments (MCA) had not been completed. Deprivation of Liberty Safeguards (DoLS) applications had been made without underlying information about how this decision had been made. Information regarding people's capacity, mental health and who was legally entitled to be involved in decisions had not been completed in care files.

The registered manager had not ensured that staff had the appropriate, skills, knowledge or experience to meet people's needs. Staff inductions did not show how staff were assessed as confident and competent before working unsupervised. Training records were not up to date to identify who had completed e-learning recently. New staff who had been left in charge of the home did not have a full understanding the homes procedures and reporting systems. Staffing levels had not been assessed in accordance with the needs of people living at Blair House. Dependency assessments had not been completed and staff felt that they needed more staff due to the number of new admissions to the home and people who required a high level of care and support.

An activity schedule was in place including visiting entertainers. However, there was no designated activity person and staff were responsible for providing activities for people at other times. Activities were not individualised and staff told us they did not always have time to do them.

An effective quality assurance systems was not in place. Audits had not identified concerns we found during the inspection. Audits completed by the registered manager and sent to the provider did not correspond with areas of concern we found during the inspection. Some audits were delegated to other staff but had not been checked to ensure they had been completed. The registered manager did not have oversight of all areas of the home and the checks completed.

Staff had an understanding of recognising and reporting abuse. Care staff new to the home were keen to improve and increase their skills and knowledge to enable them to provide the best care they could for people. We saw that care staff spoke to people in a kind and considerate manner. When providing care, staff spoke to people to ensure they were involved and aware of what was happening. For example whilst assisting people to move using a lifting hoist support and guidance was given in a calm and supportive manner.

We received positive feedback regarding the meals. People were offered a choice at mealtimes and could request an alternative if they wished. People had access to hot and cold drinks throughout the day.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Blair House was not safe.

Individual and environmental risk assessments were not in place when risks to people's safety had been identified. One person who was unsafe to go out alone had left the building unaccompanied.

Infection control measures had not been maintained around the home. Cleaning in bathrooms, toilets and laundry areas where not to an acceptable standard.

Medicine systems and storage needed to be improved to ensure they were safe.

Accident and incident reporting systems were not consistently followed.

Staff had an understanding of recognising and reporting abuse.

Gas and electrical servicing had taken place.

Is the service effective?

Requires Improvement

Blair House was not effective.

Mental Capacity Assessments (MCA) had not been completed. Deprivation of Liberty Safeguard (DoLS) applications had been made without underlying information about how this decision had been made.

Information regarding people's capacity, mental health and who was legally entitled to be involved in decisions had not been completed in care files.

Staff inductions did not show how staff were assessed as confident and competent before working unsupervised.

The registered manager had not ensured that staff had the appropriate, skills, knowledge or experience to meet people's needs.

People spoke positively about the meals provided.

Is the service caring?

Requires Improvement

People's personal care documentation, charts and medicine documentation had not been stored securely and confidentially.

People's personal items of clothing had not been treated with respect. Laundered clothing had not been folded and stored tidily.

Care staff spent time with people and spoke to people with kindness and consideration.

Staff communicated with people whilst providing care engaging people in the task to ensure they felt supported and involved.

Is the service responsive?

Requires Improvement

Blair House was not responsive.

Assessments completed before people moved in did not identify their health needs. Care plans and documentation did not identify specific health needs to inform staff how to provide care.

Pressure area care was not assessed and monitored. People with dementia did not have any assessments to identify how this impacted on their daily lives.

An activity schedule was in place including visiting entertainers. There was no designated activity person and staff were responsible for providing activities for people at other times.

Is the service well-led?

Inadequate

Blair House was not well led.

An effective quality assurance systems was not in place. Audits had not identified concerns found during the inspection.

The registered manager did not have oversight of all areas of the home and the checks completed.

Accidents and incidents were not being managed to ensure that appropriate documentation and actions had been completed.

Training records were not up to date. A number of new staff were working at the home. Senior staff left in charge did not have the

knowledge or experience of people living at Blair House to ensure the home was appropriately managed at all times.

Blair House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 14 and 16 November 2016 and was unannounced. 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.

The last inspection took place in September 2015 where two breaches of Regulation were identified.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and the Provider Information Return (PIR) which we received in 2015. 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 and notifications which had been submitted by the home. A notification is information about important events which the provider is required by law to tell us about. We also reviewed any other information that had been shared with us by the local authority and quality monitoring team.

We spoke with 10 people living at Blair House and eight staff. This included the registered individual, registered manager and five care and support staff working at the home during the inspection. There were no professional or personal visitors to the home during the inspection. Not everyone was able to tell us about their experiences of living at Blair House there fore we carried out observations in communal areas and throughout the home to see how people were supported throughout the day and during their meals.

We spent time looking at care records and case tracked six people. Case tracking is when we look at care documentation for that person to get a picture of their care needs and how these are met. This included people staying at the home for a period of respite care. We also looked at documentation in a further seven plans to follow up on specific health conditions and areas of care for the person, including risk assessments.

Medicine Administration Records (MAR) charts and medicine storage and administration were checked and we read daily records and other information completed by staff. We reviewed two staff files including one staff member who had recently began work at Blair House and other records relating to the management of the home, such as complaints and accident / incident recording, quality assurance and audit documentation.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living at Blair House. Two people told us they had their own key to their rooms and that they could spend time in their room when they wanted to be alone. Another told us that they would look for staff if they needed anything. Despite this positive feedback we found a number of areas which impacted on people's safety at the home.

At the inspection in September 2015 we found that the provider had not ensured that premises and equipment had been properly maintained. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, despite the specific areas in the last report being rectified, a number of new areas of concern were found. The provider had not ensured that suitable levels of cleanliness and maintenance had been maintained throughout the premises and this impacted on people's safety. Environmental risk assessments had not been completed or updated. Water temperature checks throughout the home, including peoples rooms had not been checked since May 2016. There were no thermometers in bathrooms or peoples rooms for staff or people to use to ensure safe water temperatures. The registered manager told us that water checks had not taken place as the maintenance person had left employment in May 2016; however, we were unable to see evidence that any action had been taken to ensure required checks were continued until a new maintenance person was employed. Not monitoring water temperaturesput people at risk of scalding or unsafe water temperatures and maintenance of the water system.

Appropriate levels of cleanliness had not been maintained around the home. Although the home had designated cleaning staff, some areas of the home required further attention to ensure they were clean and safe levels of infection control were maintained. We found a used mattress which had been removed from a person's room being stored in a communal hallway. Staff told us this was waiting to be thrown away as it was soiled. Communal bathrooms and toilets had not been cleaned to an acceptable standard, baths in two bathrooms required cleaning and one had a dry stained flannel in the sink and a number of towels on the floor around the toilet base. The outside laundry area was dirty with a large amount of dust and dirt in a pile next to the washing machine. There was an overflowing bin used for soiled waste including empty red bags which are used for soiled clothing. The nominated individual responded to the concerns identified in relation to infection control and the above issues were rectified before the end of the inspection. However the provider had not ensured that suitable levels of cleanliness and maintenance had been maintained.

The above issues are a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in September 2015, we made recommendations that the provider should seek guidance from appropriate organisations in relation to the safe management of medicines. This was because we found that documentation for 'as required' medicines or (PRN) needed to be improved. At this inspection we found that PRN protocols were in place but documentation when PRN medicines were given to people was not completed adequately. Accurate documentation should be in place to show what dose was given, when it was given and why. PRN medicines had highlighted timings on the Medicine Administration Records (MAR)

chart and this is not correct procedure for PRN medicines which should only be given 'as and when required'. When medicines had been hand written onto MAR charts, for example when someone moved into Blair House for a period of respite care, these had not consistently been signed by two members of staff. This system is in place to ensure the correct documentation of medicines and dosage to prevent errors when giving people their medicines. This meant people were at risk of receiving medicines in an unsafe or inconsistent manner. During the inspection we found the medicine room located on the ground floor was not locked. The medicine trolley was in the medicines room and the doors to the trolley were open with people's medicines easily accessible. People living at Blair House including those with memory loss and dementia were walking up and down this corridor and medicines could have been taken by people. People were at risk of taking medicines inappropriately as they were not stored or managed safely.

The above issues in relation to medicines are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of the inspection the police arrived at the home with one of the residents. This person had been assessed as lacking capacity to make decisions around their safety and a Deprivation of Liberty Safeguard (DoLS) application had been made for this person to prevent them going out alone as they were not safe to leave the building. A carer when asked by the person to let them out the front door had opened the door for them and the person had gone out alone. The staff member was not aware they were not allowed to go out alone. It was shortly after, another staff member queried the person's whereabouts and the concern was raised. The police had been called and the person was found and returned by the police after approximately 40 minutes, unharmed. The provider had not ensured risks to people's safety had been maintained. People were at serious risk of harm or injury. 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.

The above issues in relation to safe care and treatment are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The response to accidents and incidents was not consistent. Information documented on one person's challenging behaviour (ABC) chart showed an incident had occurred. Another had been used to document an incident where staff had needed to intervene when a person displayed behaviours that may challenge. No incident form had been completed for either of these incidents. The registered manager confirmed that staff were required to complete accident and incident forms when they occurred. Accident and incident forms which had been completed gave limited information and no actions were documented to show who had been informed, if further medical treatment or guidance had been sought or whether the registered manager was aware. Body maps were not always in place or lacked detail and information. For example, records for one person said 'found on floor has a bruised hand' a body map had been started which showed where the bruise was but no details to indicate the size of the bruise or whether this was reported to anyone. Another body map said, 'small graze to upper back' but included no further details regarding how this had occurred or whether any actions had been taken in response to this. This meant that injuries and risks to people had not been responded to consistently and this meant people were at risk of harming themselves again the same way in the future.

Systems were not in in place to support people who were identified as at risk of pressure damage. People's weights had not been monitored regularly. Gaps were evident in documentation and it was unclear if this was because the person had declined to be weighed or weights had not been monitored. When people moved into Blair House for a period of respite care, weights were not routinely assessed. The provider was unable to assure themselves that peoples care and safety had been monitored and maintained. For

example, to identify weight loss or gain and the impact this could have on a person's overall health and welfare if not responded to promptly.

One person staying at Blair House for a period of respite had not been assessed as requiring pressure relieving equipment during the pre-admission assessment. However after moving into Blair House other health professionals had highlighted the need for pressure relieving equipment and this was now in place. The care plan for this person stated 'pressure ulcer' but there was no information about where this was, the size, treatment plan or what other health professionals where involved in their care. Two people were currently using pressure relieving air mattresses. Both mattresses had not been set in accordance with the person's weight. One person weighed 43kg and the pressure relieving air mattress was set for a person weighing 80 kgs. The second person had not been weighed since they had been admitted so it was unclear how the mattress setting had been determined as safe and appropriate to ensure pressure area care was maintained. This meant people were at risk of further pressure area damage as documentation and checks had not been completed.

We identified areas of the home where items had been stored which could impact on fire safety. A used mattress had been leaned against a wall in the hallway on an upper floor. This was obscuring the emergency evacuation chair. A basement room had been used to store a large amount of clothing, documentation and unused furniture, this was piled up on the floor and blocked access to one of the windows. People's rooms were cluttered with personal belongings and it was unclear how this was being managed to ensure that people's rooms were monitored and people's safety was maintained. The above issues meant that systems in place to ensure peoples safety and welfare had not been maintained.

People were not safe due to a lack of documentation and information about their health and care needs. There were some risk assessments, including consumption of alcohol, use of bedrails and not complying with dietary advice. However, risk assessments were not in place for all diagnosed health conditions to identify specific risks this may present for the person. This included diabetes, dementia, nutrition and risk of choking, skin integrity and other areas of concern identified by the registered manager. A smoking risk assessment had been completed for one person however, this was related to smoking in general and had not been updated to include the issue recently identified with regards to the person not complying with the homes fire safety rules that people did not smoke in their rooms.

Personal emergency evacuation procedures (PEEPS) were in place for people. However this did not include people who had recently moved into Blair House or workmen who were currently staying in the building at night. The PEEPS folder still included people who had left or passed away. Workmen in the home did not use the sign in/out book to show who was in the building at any given time. The above issues meant that information was not current or accurate in the event of a fire or emergency evacuation. In the event of a fire, staff and fire officers would not have the necessary information to support people to evacuate the building. This could potentially slow an evacuation and place people and staff at risk.

The above issues in relation to safe care and treatment are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A recruitment process was in place, overseen by the registered manager. We looked at two staff recruitment files; this included one file for a recently employed staff member. Files showed relevant checks had been completed before staff began work. For example, disclosure and barring service (DBS) checks, a DBS check is completed before staff began work unsupervised to help employers make safer recruitment decisions and prevent unsuitable staff from working within the care environment. Application forms included information on past employment, however both files only contained one reference when two had been requested. The

registered manager told us they would follow this up to ensure it was in place. The registered manager confirmed that staff turnover had been high, and many of the care staff we met during the inspection had worked at the home for less than four months. Recruitment was on-going. The registered manager told us they were unsure why the staff turnover was so high. Exit interviews had not taken place to gain feedback from staff who were leaving employment.

Staff were able to tell us about different types of abuse and the actions they would take to report their concerns if they thought anyone was at risk. All staff told us they would report issues directly to the registered manager who was always on call if they were not at the home. Staff were not clear how they would raise a concern directly but knew that they could speak to someone at provider level if they needed to raise an issue and were unable to do this via the registered manager. We spoke to the registered manager about displaying relevant contact details for Adult Social Care (ASC) to ensure staff knew how to do this if needed. Staff told us they had access to safeguarding policies within the home if needed.

There were policies and procedures in place for the management of medicines. Staff responsible for giving medicines had received training and had their competencies assessed. Staff told us that medicines were administered one at a time from the medicines room and taken to the person. We saw people receiving medicines at lunch time and staff stayed with the person to ensure they were taken correctly. Staff then returned to the medicines room to sign the MAR chart. The registered manager told us MAR charts were checked monthly to check for any gaps or errors.

Maintenance of gas and electrical services, including Personal Appliance Testing (PAT) and lift servicing had taken place. We were told that despite two occasions since the last inspection when the lift had been reported to CQC as out of action this had been regularly serviced and was working well. An emergency contingency plan was also in place should people need to be relocated in the event of an emergency.

Blair House had an outside professional responsible for servicing and maintenance of the fire alarm, emergency lighting, fire extinguishers and call bell system. This had been completed regularly to ensure they were suitably maintained and some communal areas of the home had been redecorated.

Requires Improvement

Is the service effective?

Our findings

The registered manager was able to tell us about people and their needs. However much of this information had not been documented or included within peoples computerised care files which staff had access to via an IPad. Staff turnover had been high and many of the staff we met and spoke to during the inspection had only worked at Blair House for a short time. One member of staff told us they had worked at Blair House for about a week and had not worked in care before. We asked the registered manager about the induction process for this new staff member we were shown an induction form which was a tick list and included orientation to the building and general information regarding the home. Staff had not received information regarding the systems and processes to follow within the home. Staff had not received adequate guidance and induction to ensure they knew people and their needs and were able to provide care and support appropriately.

Systems to ensure that there was an appropriate staff skill mix on each shift and that staff were competent in their role were not in place. On arrival at the home we were told that the registered manager and deputy were on a training course. The senior carer had been left in charge. This staff member had only worked at Blair House for three weeks. Two further staff on duty at that time were new, and one carer had been at the home for over a year. Staff told us they knew how to provide day to day care to people as the registered manager had told them about people and their needs. Both staff we spoke to on the day confirmed that they had not read peoples care plans in full and used the information in the handover and daily records. The senior staff member in charge told us they had not yet completed all their online training, and had not had the opportunity to read peoples care plans in full. This left people at risk of receiving care and support that did not meet their needs. They were unclear on all the reporting and documentation systems in place including the reporting of accidents and incidents. They informed us that if anything happened or they had any concerns they would contact the registered manager. They did not feel suitably experienced to support the inspection so contacted the registered manager. The registered and deputy manager returned to the home shortly into the inspection.

The registered manager told us that new staff members shadowed other staff before being deemed competent to work unsupervised and their competency assessed. One staff member had only been employed a week and told us they were working alone that day as they had completed their induction and shadowing. Another who had been working at Blair House for approximately three weeks was in charge on our arrival to carry out the inspection. No information had been completed within their induction paperwork to show how the induction had been structured, who had assessed their competencies and when they had completed the induction within this timescale. Therfore staff understanding of their role had not been reviewed by the registered manager or provider to ensure it met required standards to ensure they were able to provide care safely and effectively.

The registered manager had attended Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) training. Six staff had also completed this training in 2016 and three in 2015. The training record did not show that newly recruited staff had completed this training. 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 conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us they had identified people who lacked capacity to make decisions regarding leaving the building alone and DoLS applications had been submitted. We were told by the registered manager one person lacked capacity due to mental health concerns and two people had dementia and lacked capacity to make decisions. We looked at the care documentation for these three people and found that no mental capacity assessment completed. There was no information on how a decision had been reached to make a DoLS application and who had been involved in this decision. Other people had a lasting power of attorney responsible for decisions regarding their health and welfare. This information had not been included in their care documentation or communicated effectively to staff to ensure staff were aware who was legally entitled to be involved in decisions about the persons care. The provider had not ensured that peoples capacity had been assessed and any decisions made regarding capacity and choice documented. Best interests meetings or discussions regarding peoples involvement in decisions about their health and welfare were had not been completed.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out observation on both days of the inspection in communal areas of the home. On the first day staff were very busy throughout the morning. We were told that the maintenance person had left employment in May 2016 and the laundry staff member had also left recently. Staff confirmed that they were now responsible for people's laundry and were expected to incorporate this into their daily duties. There was no designated activity person and staff were responsible for providing activities to people on some days, staff told us they were often too busy to do everything that was expected. The person responsible for domestic duties that day was asked on three occasions to observe people in the main lounge/dining area whilst care staff were busy elsewhere. We were informed that the domestic staff had attended all relevant training and were competent to provide support to people. Staff told us they felt that more staff were required as many of the recent admissions to the home had higher level needs and this had impacted on staffing. All staff told us they were very busy. Two people currently needed two staff to assist them with all personal care and health needs including the use of a lifting hoist. Others needed help to mobilise safely around the home due to visual impairments and short term memory loss. The registered manager telephoned a staff member during the inspection to come in to tidy the laundry and this was done. On the second day of the inspection the registered manager confirmed that they had an extra member of agency care staff working that day and an extra person assisting with the cleaning. This demonstrated that extra staff were needed to ensure the home was clean and people's needs were met. The registered manager told us that staffing levels were assessed based on the needs of people living at Blair House, this was determined by the completion of dependency assessments. Dependency assessments are used to determine the level of care and support needed for each person and this can then be used to determine safe staffing levels. However, we found that a number of people did not have dependency assessments completed; therefore it there was no evidence provided on how levels of staffing had been assessed as safe and appropriate. When more people had moved into Blair House with high level of care needs, staffing levels had not been reviewed to ensure safe and appropriate numbers of staffing were maintained. This could put people at risk.

Appropriate staffing throughout the home had not been assessed appropriately, managed and maintained.

Staff training was predominantly e-learning. We saw that a schedule was in place and staff told us they were reminded to complete training that was overdue. We were told that a number of new staff had completed e-learning before our inspection, however this information had not yet been documented so we did not have up to date information of how the training programme was being met. One senior member of care staff told us they had not yet completed the e-learning and were aware this was something they needed to do soon. Therefore staff had not completed required training before working unsupervised. We did not see any evidence to demonstrate how the registered manager assessed staff competencies after training to ensure they were competent to put the training into practice and were able to meet people's needs effectively. The training schedule did not identify if staff had completed any dementia based learning or supporting people with behaviours that challenged. Staff who had completed health related qualifications told us these areas were included, however for those staff who did not have NVQ qualifications or were new; it was unclear how this was supported. Staff training and how competencies are assessed needs to be improved to ensure people are supported by appropriately trained and experienced staff and that there is an appropriate skill mix at all times. Staff did not know people and their care and support needs. New staff lacked confidence in relation to peoples needs and the systems and processes used within the home.

The above issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One staff member confirmed they had completed on-line training of Safeguarding and Moving and Handling and they were completing their Care Certificate as part of their induction. This staff member was clear about the whistleblowing policy and procedure and told us they would not hesitate to raise a concern with the registered manager if they needed to. Staff told us they had found the face to face moving and handling training very useful, and had been able to observe other staff until they felt comfortable to use equipment themselves. Further moving and handling and first aid training had been booked for December 2016. Six current care staff had completed or were working towards health related qualifications at various levels. this included the registered and deputy managers, however, it was unclear how this training was being used to ensure an adequate skill mix at all times.

The registered manager told us supervision schedules were in place and these were completed by the deputy manager and themselves. The registered manager was unable to access the schedule as they were unsure where the deputy had recorded this information. Staff told us that they had not had supervision as they had only worked at Blair House for a short time. Staff told us if they did not know something they went to the registered manager. Staff felt that if they had any concerns they would talk to the registered manager. We saw throughout the inspection that staff approached the registered manager frequently and lacked confidence to make decisions. This demonstrated the impact of lack of appropriate training and support for new staff including those working in a senior capacity.

Information regarding referrals to other health professionals was not always documented in care documentation, the registered manager told us who was being seen by district nurses, or had been referred to speech and language therapy (SALT) or community mental health teams. However this information was not included in peoples care plans to inform staff. There was an over reliance on verbal information sharing and although the registered manager told us things that had taken place, staff were not always aware of this.

People were offered a choice of meals, with alternatives available. Biscuits were provided with hot and cold drinks throughout the day. We spoke to the cook who had information regarding people's specific dietary

requirements including allergies and diabetic meal requirements. The cook served meals at breakfast and lunch. The cook told us they provided a variety of meal choices for people and if people changed their minds at the last minute an alternative was available. People told us they were given a choice of meals. We saw that people were asked each day what their choices were for lunch and dinner. The cook told us there was a four week menu. We saw that menus were displayed in the main hallway; however this did not tally with the menu choices that day. We asked staff whether the menu had been changed and were told that the menu on display must be old. There were no pictorial menus for people with dementia, memory loss or poor verbal communication to facilitate their involvement in choice around their meals. This in an area that needed to be improved.

During the inspection we saw there was a selection of breakfast choices and lunch choices. People told us they enjoyed the meals. "The food is quite good, always something I like." One person came to the office to request a specific choice of soup and a wholemeal roll for their evening meal, as they were feeling 'under the weather'. The cook was no longer on shift so a member of care staff was asked to make this and this was done immediately.

Requires Improvement

Is the service caring?

Our findings

General feedback from people was positive and we were told staff were, "Caring and listen," and, "Staff are caring." We saw staff offer support and assistance to people throughout the day. This was done with patience and in a kind and considerate way. People were orientated to the time and staff told people who was in the room when people entered. This meant that people with a visual impairment were aware of their surroundings.

Despite this positive feedback we found that improvements were required to ensure peoples personal items and belongings were treated with respect. People's laundry and other belongings were not always stored tidily. Clothing which had been laundered was left unfolded on chairs, tables and on the floor in the basement. Although this was rectified on the day of the inspection respect for peoples personal clothing needed to be improved to ensure that appropriate standards were maintained.

Peoples personal care documentation, charts and medicine documentation was being stored in various places around the building. One room was being used to store archived boxes of care records. However the door to this room was wide open and accessed via a communal stairwell. Further documentation was in piles in the basement room and further daily records were in an old wardrobe. These were not stored in any boxes or files and it was unclear why various documentation had not been archived tidily and safely. This was also rectified during the inspection. However improvements are required to ensure all documentation is stored securely to maintain people's privacy and confidentiality at all times.

Staff communicated in a friendly and supportive manner when people needed assistance. One person was who used a lifting hoist, was supported by two staff. Both staff spoke clearly to the person, explained what they were going to do and involved the person in decisions about where they would like to sit. Another staff member told us they were one person's keyworker. It was clear that in a relatively short time they had built up a good relationship and trust with this person. They sat and chatted to them and ensured they were aware of their surroundings and the location of their drink.

Staff in the communal areas stopped to speak to people and engaged them in conversations about what was happening that day. People received care in a kind and compassionate way. Staff knocked before entering people's rooms. When staff were assisting people their room doors were closed. People told us they found staff were approachable and kind.

Staff told us they spoke to people when assisting them to ensure they felt supported. One told us, "I try to sit with people when they move in to get to know them a bit. To find out what they like and what they enjoy." Another said, "When I am helping someone to dress I ask them what they would like to wear so they are involved, I think it's important."

Two new staff members told us how much they enjoyed caring for people. One told us, "This is what I have always wanted to do; I want to stay here so that I can learn as much as possible and provide consistency for people. I know it's difficult when staff keep changing." And "I love my job, it's all about making things the

best you possibly can for someone."

Requires Improvement

Is the service responsive?

Our findings

People using wheelchairs and moving and handling equipment were not able to access all areas of the building; this included some communal baths and shower rooms. It was therefore unclear how people were offered choice with regards to personal hygiene. Assessments did not show discussions had taken place with people regarding this before they moved into Blair House. Or information in place to show how decisions around room choices had been decided, for example which floor people's bedroom was located.

Staff were able to tell us about some people's care needs but did not have complete knowledge of everyone's care and support needs. Care plans were not person centred and did not include vital information about people, their physical and mental health diagnosis. Newly employed staff were not aware of who had a dementia diagnosis. The registered manager told us two people had dementia. Neither of these people had care documentation in place regarding their dementia, or information for staff regarding specific ways this impacted on day to day life, how their dementia presented, or whether they displayed behaviours that may need support. New staff did not have experience of working with people with a dementia diagnosis. This lack of experience and supporting documentation led to an incident when a person's health and welfare was put at risk.

Staff lacked an understanding of their responsibilities in relation to people's pressure areas. Staff were not aware who was at risk or how pressure care should be managed. Including how pressure relieving equipment should be set in accordance with people's weights to ensure it was working correctly. Two people had pressure relieving mattresses and neither were correctly set. There was no documentation in place to inform staff and support daily monitoring of skin integrity and how this should be monitored to identify any new concerns. Therefore, people were at risk of further pressure area damage. Pre-admission assessments did not include detailed exploration regarding people's health conditions, whether a person required pressure relieving equipment, or a visual assessment of pressure areas. When people developed pressure areas there was no updated plan of care to ensure people received appropriate care to meet their needs. One person who had moved in to the home on 26 October 2016 had no care information completed to inform staff about their specific health needs. Staff were able to tell us about some of this persons care needs but not all. Therefore, they were at risk of receiving inappropriate care which was not based on their personal preferences and care needs.

Another person whose room was located on an upper floor could only access a bathroom on the ground floor if they chose to, as they used a wheelchair and required hoisting from wheelchair to bath or shower seat. The registered manager told us this would have been discussed with the person when they were assessed before moving into the home. We looked at the pre-admission assessment and did not see any documented conversation regarding this information. We spoke with this person who told us they were happy to have personal care provided in their room, however, they had not been asked before they came to Blair House for respite care whether they wanted access to a bathroom or shower or informed that this would be on another floor accessed via the lift. They were unsure if this was a possibility as staff had not suggested this since they moved into Blair House. Staff said they had been told that this person was washed in bed at home so they had just continued to do the same during their stay at Blair House. Staff were not

providing choice and person centred care for people based on their individual preferences and needs.

Due to the turnover in the staff team and the lack of documentation people were not supported in a way that suited their needs. Care records did not include detail about the individual, their preferences, likes, dislikes or information about their lives before they moved to Blair House. This lack of communication and written information to advise and inform staff meant that care was not person centred.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting entertainers including singers did visit the home on certain days throughout the week. However, on other days staff told us it was their responsibility to provide activities. An activity planner was displayed in the lounge and included games, a visiting hairdresser (who had a designated salon within the building) and crafts. During the inspection the nominated individual and registered manager told us that flower arranging was to be the activity that day. We saw that posters were displayed around the building and bunches of fresh flowers and vases had been purchased. We asked staff who was going to be carrying out this activity and they were not sure, one thought someone might be coming to visit to teach people how to flower arrange. The staff member that took the session was unaware that she would be doing so until minutes before; this demonstrated a lack of organisation and communication between staff and management. The staff member assisted people to cut flowers and arrange them in vases. People who took part in the activity enjoyed it, one person who was visually impaired was assisted by staff to touch and smell the flowers.

We did not see any record of one to one activity provided for people who were unable to attend group activities. For example people who remained in their rooms, due to their health or dementia. We asked people whether they liked the activities provided. One said, "When people come in its Ok and I come along, other times there's not much going on." And, "No, not really, nothing much happening." Both communal lounges had the television on throughout the day, one afternoon a film was put on. When this finished the film re-started and we had to ask staff to turn it off as it was on a loop. There were no dementia focussed activities or items to access for people whilst they sat in the communal lounges. After breakfast and in the afternoon we saw that people fell asleep in the communal lounges or returned to their rooms. Some people went out alone and others preferred to stay in their rooms. One person was walking around the ground floor of the building throughout the day and went out into the garden on two occasions. Both times staff encouraged them to come indoors as they were not wearing a coat. Staff did not get the persons coat so that they could sit outside if they wished. There was no evidence to show how activity schedules were determined involving people living at Blair House to ensure they focussed on people's hobbies and interests and to prevent social isolation. Staff told us they did not take people out as "There is not enough time, but if they need something from the shops we will get it for them." There was no dementia friendly signage around the home or accessible games/rummage items to engage people whilst they sat in communal areas.

Communication within the home needed to be improved to ensure all staff were able to respond to people's queries and concerns consistently. One person was asking staff to check that a medication had been ordered, they were becoming anxious regarding this. Staff told them they would check with the manager, but later in the day the person was still unaware if this had been done. We asked the registered manager who confirmed the fax had been sent and the person had been told. However, when we saw this person ask a staff member later in the day, the staff member responded that they were unaware and said they would ask the manager. The person became distressed again as they were unsure whether the medicines had been ordered or not.

A complaints policy and procedure was displayed in the main reception area. People told us they would be

happy to raise concerns and would tell any of the staff if they had a problem. The registered manager confirmed there were no on-going complaints at the time of the inspection.

Inadequate

Is the service well-led?

Our findings

We carried out an inspection at Blair House iIn September 2015 where we found that the provider did not have systems in place to assess, monitor or improve the quality of service provided. The provider sent us an action plan telling us these issues would be addressed. However at this inspection we identified there was a continued breach of Regulation regarding quality assurance systems.

People knew who the manager was and told us that they could always speak to them if they needed. One said, "X's the manager, lovely person. We have occasional residents meetings, and I think they have staff meetings". Staff told us that they felt supported by the registered manager and would go to them if they had any queries. All staff reiterated that when the manager was not in the building they would ring them at any time, as they "Always had their phone." Staff told us if there was ever a time they could not contact the registered manager then they would try the senior or deputy for advice.

Systems and processes to assess and monitor the service were inadequate because of a lack of appropriate oversight and leadership in the home. The registered manager and provider had not identified a number of areas which did not meet regulatory requirements. Current auditing systems had not identified issues in relation to care planning, accidents and incidents, risk assessments, care reviews, MCA, changes to health and care needs and Power of Attorney (POA) details not being completed for all people living at Blair House.

When audits had been completed the overall outcome did not correspond with the findings during the inspection. For example, the previous two care documentation audits which were sent from the provider to the registered manager, completed in August 2016 and October 2016, both showed 100% compliance. During the inspection we found a number of areas of care documentation which had not been completed. We asked the registered manager whether the care plan audit included all care plans and we were told that two care plans were checked each time an audit took place.
However, the registered manager was unable to tell us which two care plans had been audited in August 2016 or October 2016 as they had not recorded this. This lack of accurate auditing meant that missing care documentation, risk assessments and other health related records had not been identified. A quarterly health and safety audit and infection control audit had been completed in October 2016. This stated that the home was compliant with legionella and water temperature testing, however during the inspection we found that water temperature checks had not been completed since May 2016 and water flushing and descaling for taps and shower heads as identified in the legionella risk assessment had not taken place since May 2016. This meant information completed in this audit was not accurate and therefore did not identify issues found within the home.

When people moved into Blair House for respite care, it had not been identified through the audit process that documentation was not completed in a timely way to ensure staff were aware of their care needs and any risks for that individual. Changes to peoples care needs and involvement of outside healthcare professionals was not updated and included in peoples care records.

The audit process had not identified that staff did not have the experience and knowledge about people and

there care needs to ensure they were met at all times. Training and induction records were not up to date. A clear staff mix of knowledge and experience was not clear during each shift to ensure new staff were adequately supported. New staff members were left in charge of the home. The registered manager had not ensured newly employed senior and care staff knew the home or the people living there well.

Systems for auditing of accidents and incidents were inadequate and did not ensure that appropriate preventative measures were taken to reduce occurrences. Accident and incidents had been reviewed monthly up until February 2016. However, there was no analysis or audit of accidents and incidents since that time. The registered manager told us they were aware of accidents and incidents that had occurred. However, we looked at forms recently completed and saw these did not show that the registered manager had reviewed them to ensure all appropriate actions had been taken. It was therefore unclear how the registered manager could identify any concerns or themes which may need responding to. Some accidents and incidents did not have forms completed or related body maps in place. The registered manager said that this area of documentation was not included in care record auditing. Therefore it was unclear how the registered manager had oversight and was managing peoples risk to ensure that reviews, actions or improvements took place in response to these.

The registered manager told us that they completed some of the audits and others were delegated to other staff. The pharmacy used by Blair House had completed a medicine audit and a provider medicines audit was completed during the second day of the inspection. When audits or checks had been delegated to other staff the registered manager had lacked oversight of the outcome, or had not checked that the audit had been completed. For example, weekly fire alarm checks which were the responsibility of the home had not been documented to show when this had last taken place and monthly fire drills had not been documented since 17 June 2016. The registered manager told us they thought staff had completed these but had not documented them. Given the turnover in the staff team this meant that the registered manger could not be confident that staff would respond appropriately in the event of an emergency. The registered manager has responsibility to assess and monitor the service to ensure safe working systems are in place and being maintained and to identify areas of the service which need to be improved and respond appropriately.

Some provider audits had taken place. Most recently one was completed by another home manager who looked at a number of areas around the service provision and documentation. A report had been produced which identified some issues found and an action plan had been written by the registered manager. However, most of the concerns had an 'on-going' timescale for completion and a number of areas did not evidence a clear response. For example, individualised activities had been identified as needing improvement and the response included that 'staff did activities when they had appropriate staffing' and 'hard to do activities in the morning as staff getting people up and dressed.' The action plan also stated that all work had been completed to meet The CQC concerns identified in the last inspection. For areas that were 'on-going' no further information was included to show how these areas would be met. The home's internal auditing action plan had not been acted upon in a way that demonstrated the issues raised had been analysed and improvements made as a result. The nominated individual told us that changes were in place to the auditing system. However, this did not explain why audits had been completed incorrectly and issues had not been identified.

The lack of robust quality assurance in place meant the provider had not identified a number of gaps and omissions to the records in relation to peoples care, dependency and risk. Training information had not been kept up to date and competencies had not been completed to evidence when new staff were competent and confident to work unsupervised. New staff had been left in charge of the home before they had knowledge of everyone living at the home. This lack of knowledge of people living at Blair House was clearly evidenced when a new staff member let a person out of the building as they were unaware they were

not deemed safe to leave the building unsupervised.

When staff left employment it was unclear what steps had been taken to ensure safe standards and maintenance had been continued. The maintenance employee had left employment in May 2016, therefore no Health and Safety meeting, or water checks had taken place in this time. The laundry person had recently left employment and care staff had been responsible for the laundry during this time. It was clear that staff were not managing the laundry effectively and that areas of maintenance had not been addressed in a timely manner.

Issues found during the inspection demonstrated a lack of management oversight and timely response to issues. Although we acknowledge the work which took place to rectify areas of concern identified during the inspection this response was reactive to our findings and did not show that a pro-active on-going level of maintenance and cleanliness had been maintained or identified by the registered manager before the inspection. A lack of appropriate leadership and oversight meant that there was a potential for people to receive care that was inappropriate and could cause harm to the individual.

The failure to provide appropriate systems or processes to assess, monitor and improve quality and safety of services were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff meetings had taken place. The last recorded meeting was in September 2016. The minutes had been recorded to show areas which had been discussed. This included information regarding staff leaving employment and current recruitment. People living at Blair House and their relatives or next of kin were asked for feedback. This was a six monthly feedback which included a number of areas of service provision. The results of these were sent to the provider and a full report collated with any actions identified. A copy of the report was then displayed in the main reception area. It was not clear if this had been discussed with people who were unable to read the information. Resident and relatives meetings had been scheduled but no one had attended in May or August 2016. The registered manager told us people living at Blair House did not want to attend meetings; however it was unclear if any other ways had been explored to encourage feedback and involvement of people living at Blair House.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured care provided for people was appropriate, met their needs or reflected their preferences. 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably, qualified, competent, skilled and experienced staff were in place at all times. 18(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured care, treatment and risks to people had been assessed and mitigated. Safe medicine systems had not been maintained. 12(1)(2)(a)(b)(g)(h)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and systems used by the service were not clean or properly maintained. 15(1)(a)(c)(d)(e)(2)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess monitor or identify areas for improvement, or show timely response when issues found. 17(1)(2)(a)(b)(c)(f)

The enforcement action we took:

Warning Notice