Barrisle Care Home Limited

Barrisle Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This was an unannounced inspection which meant the provider did not know we were coming. It was conducted over two days on the 8 May and 12 May 2015.

Barrisle Care Home provides nursing and personal care for up to 40 adults who have mental health needs or are living with dementia. The home is situated in a residential area of Leyland, close to local amenities. Accommodation is at ground floor level in single rooms; although one shared room is available. Ensuite facilities are not available but each bedroom has a wash basin. Toilets and bathrooms are conveniently located throughout the home. There are two lounges available and a large dining room is provided. There is a garden with patio area for people to use during the warmer weather.

We last inspected this location on 19th April 2013, when we found the service to be non-compliant with Regulation 15 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which related to the safety and suitability of premises. We asked the provider to submit an action plan telling us how and

Summary of findings

when they would make improvements to the environment. This was received and a follow up visit conducted on 18th October 2013 showed improvements had been sufficiently made to demonstrate compliance.

At the time of our inspection to this location a temporary manager was on duty on both days we visited. He had been in post for three days and had been appointed as the person in charge of the home, during the absence of the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The temporary manager was supported by a long standing registered nurse, who was also on duty on both days we visited the home.

The temporary manager and the registered nurse were both very co-operative during our inspection and they provided us with many of the records we requested. However, some could not be located, or were not in place.

The cleanliness of the premises was found to be satisfactory. Clinical waste was being disposed of in accordance with current legislation and good practice guidelines. However, most areas of the home were in need of upgrading and modernising. The dementia care unit needed to be brought up to date in accordance with specific guidance around environments for people who live with dementia. Systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations, to ensure they were safe for use.

We looked at medication procedures within the home and found failings which meant that people were not protected against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed.

Areas of risk had not always been managed appropriately and legal requirements had not always been followed in relation to Deprivation of Liberty Safeguards (DoLS). The safety and well-being of people who lived at Barrisle was not protected by the employment practices adopted by the home, as there were significant gaps in the way staff were recruited. This meant that new employees were not deemed fit to work with this vulnerable client group before they commenced employment.

Induction programmes for new employees were not formally recorded. Supervision and appraisal meetings for staff were often overdue and training documents were not up to date. This meant that the staff team were not supported to gain confidence and the ability to deliver the care people needed. There were sufficient numbers of staff on duty however deployment and coordination of staff gave rise to a chaotic atmosphere within the home. We have made a recommendation regarding this.

We found the planning of people's care varied. Some records were person centred and well written, providing staff with clear guidance about people's needs and how these were to be best met. Others contained basic information only and did not cover all assessed needs or how people wished their care and support to be delivered.

The provision of activities could have been better. Although, we observed some females being taken to join in a baking activity, others who had not participated were not engaged in meaningful activities throughout the day. However, we spoke at length with the activities co-ordinated, who was new in post. She was evidently eager to support people to maintain their leisure interests and had imaginative ideas for future planning of activities for this client group. It would be beneficial if the activities co-ordinator was supported by management to introduce these new concepts for those who lived at the home. We have made a recommendation around this area.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for Person-centred care, dignity and respect, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, premises and equipment and good governance.

We also found breaches of the Care Quality Commission (Registration) Regulations 2009 in so much as we found that the registered person had not notified the Care Quality Commission of notifiable incidents.

Summary of findings

We want to ensure that services found to be providing inadequate care do not continue to do so. Therefore we have introduced special measures. 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.

•Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to cancel their registration.

Our guidance states services rated as inadequate overall will be placed straight into special measures.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

We observed that confrontations between people were not appropriately managed and therefore volatile situations were not diffused quickly. People's needs were not anticipated well and daily activities of living were responded to in a reactive way, instead of the home adopting a pro-active approach to care and support.

Some risk assessments had been conducted. However, these were not always person centred and were not consistently reflected within the plan of care. Infection control protocols were being followed. However we found failings in medication administration systems.

At the time of this inspection there were sufficient staff on duty. However, there was little evidence of leadership and organisation, so that staff could be appropriately deployed in order to protect the safety of those who lived at the home.

Recruitment practices were not thorough enough to ensure only suitable staff were appointed to work with this vulnerable client group.

Is the service effective?

Inadequate

This service was not effective.

New staff had not completed a formal induction programme when they started to work at the home. Therefore, they were not adequately supported to provide the care people needed or helped to familiarise themselves with the policies and procedures of the home.

Supervision and appraisals for staff was in some cases overdue and were not well supported in their work performance and training needs with their line manager. Training records were not current and therefore we could not establish if staff received regular mandatory updates or additional training specific to the needs of those who lived at the home.

Freedom of movement within the home was evident and we did not observe this being restricted. However, people's rights were not always protected, in accordance with the Mental Capacity Act 2005. People were at risk of being deprived of their liberty because legal requirements and best practice guidelines were not always followed.

Staff members did not interact well with those who lived at Barrisle and consent had not been obtained in relation to various areas of care and treatment. People's nutritional needs were not consistently being met, as alternatives to the meal served were not always offered and people were not supported, when necessary with their meals.

Is the service caring?

Inadequate

This service was not caring.

People's privacy and dignity was not always promoted and those who lived at the home were not always treated in a respectful way.

Summary of findings

People were supported to access advocacy services, should they wish to do so, or if a relative was not involved and they were unable to make some decisions for themselves. An advocate is an independent person, who will act on behalf of those needing support to make decisions.

Is the service responsive?

Inadequate

This service was not responsive.

An assessment of needs was conducted before a placement was arranged. However, these were found to provide basic details only and lacked person centred information.

Care plans were found to have been completed, but the standard of these varied. Some were well written, person centred documents, but others lacked important information and did not provide staff with clear guidance about people's needs, or how these were to be best met. Information about how people wished to be supported and what they liked or disliked was not always recorded.

The provision of activities could have been better, but this area was already being addressed by the newly employed activities co-ordinator.

Is the service well-led?

Inadequate

This service was not well-led.

At the time of our inspection a temporary manager had been in post for three days. We had not been formally informed of the current absence of the registered manager.

Records showed that annual surveys were conducted for those who lived at the home and their relatives. However, there was no evidence available to demonstrate that meetings were held for people who lived at Barrisle and their relatives or for the staff team.

Systems for assessing and monitoring the quality of service provided were not effective.

Evidence was available to demonstrate the home worked in partnership with other relevant personnel, such as medical practitioners and community health professionals.

Barrisle Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection was carried out over two days on 8 May and 12 May 2015 by two Adult Social Care inspectors from the Care Quality Commission, who were accompanied by a specialist pharmacy advisor and an Expert by Experience. An Expert by Experience is a person who has experience of the type of service being inspected. Their role is to find out what it is like to use the service. This was achieved through discussions with those who lived at Barrisle, their relatives and staff members, as well as observation of the day-to-day activity.

At the time of our inspection of this location there were 39 people who lived at Barrisle. Due to experiencing and living with varying degrees of dementia, the majority of people were unable to speak with us and answer our questions. However, we were able to speak with four of them and three family members. We also spoke with six staff members and the temporary manager of the home.

We toured the premises, viewing all private accommodation and communal areas. We observed people dining and we also looked at a wide range of records, including the care files of five people who used the service and the personnel records of five staff members. We 'pathway tracked' the care of four people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. We also conducted a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Other records we saw included a variety of policies and procedures, medication records and quality monitoring systems.

The provider sent us a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection and we asked local commissioners for their views about the service provided. We also requested feedback from eight community professionals, such as medical practitioners, the local Clinical Commissioning Group, community nurses and mental health teams. We received three responses. Comments about this service varied.

Inadequate

Is the service safe?

Our findings

We spoke with four people who lived at the home and three relatives. We asked people if they felt safe living at the home. One person said, "Sometimes. It's mainly the night shift. They are rough with me. They shout at me at least twice a week. Sometimes when I'm walking with my frame they rush me." When asked the same question another person commented, "Not really (feeling safe). Some of them (staff) are a bit rough. Their attitudes are awful. They're not very nice with the people. They rush you. They don't want to help you." A relative told us, "Mum rings me up, crying at night." However, positive responses from relatives included, "Yes I do think he's safe compared to the other home." And, "From my visits, yes, I've no qualms whatsoever."

One of the people we spoke with said they would not speak to staff if they were worried, whilst another said they would speak with 'one or two'. We discussed people's responses with the temporary manager at the time of our inspection, who assured us he would investigate their comments further.

Some risk assessments had been completed. These included areas, such as challenging behaviour, restraint, falls prevention, malnutrition and pressure wound development. However, these had not always been developed within a risk management framework and information was often limited with sections not being completed. Potential risks, which had been identified, were not always incorporated in to the care planning process and clear strategies of action were not always evident to reduce the possibility of harm. As an example one person had a recording on a risk assessment for restraint which stated, 'Walks short distances with a frame'. However there was no further detail around this statement or instructions for staff. As a further example, care records viewed showed that bed rails were used in some cases, to prevent people from falling out of bed. However, specific risk assessments for these individuals had not always been completed on the records we viewed to ensure people's safety was maintained around the use of bed rails.

We found that the registered person had not protected people against the risk of harm, because potential health care risks had not always been appropriately managed. This was in breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our tour of the premises we identified areas of the home, which needed to be made safer. For example, we noted plastic aprons and toiletries were easily accessible, as they were left on open shelving within bathrooms and in an unlocked store cupboard. Environmental risk assessments could not be located at the time of our inspection. This did not consistently protect people from harm.

We found that the registered person had not protected people against risks because an effective system was not in place to identify, assess and manage environmental risks relating to the health, welfare and safety of those who lived at the home. This was in breach of regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the Medication Administration Records (MARs) of all those who lived at the home, in the presence of one of the registered nurses on duty that day.

In general, good records had been made in relation to the administration of medications. A process was being followed by the registered nurse on duty. However, there was no written evidence of a procedure to follow in relation to the administration of medications.

We established that two people who lived at the home had not received their morning medicines by 11am. These were due at 8am. We asked the nurse on duty whether this was normal practice. She told us it was, since there was usually only one registered nurse available to administer the medicines. However, she also told us that very recently an extra nurse had been deployed during the day shift.

We noted that some entries on the MAR charts were hand written. These had not been checked and countersigned in order to prevent transcription errors. This created an unnecessary safety risk. It would be expected that the prescribing GP, if present would make the entries on the MAR charts, but if not then the medication should be entered by a registered nurse and checked and countersigned by a competent member of staff.

There was a small drugs fridge holding some insulin treatments and eye preparations. We noted one bottle of

eye drops had passed its shelf life, which could have rendered it ineffective. We also saw a bottle of blood glucose testing strips out of date, which if used could have produced inaccurate readings.

We asked both the registered nurse on duty and her colleague, also a nurse what procedures they had in place to check the expiry dates of their stored items. We were told that they didn't have anything in place for checking expiry dates.

Temperature record charts of the drugs fridge were being used, which showed good consistent temperatures were being maintained. Several eye preparations, such as Hypromellose, Timolol and Lacrilube were all being stored in the fridge and although not a safety issue, this is not normal practice or necessary.

The registered nurse on duty showed us through the cupboard storage for people's medications, dressings and homely remedies. Homely remedies are medications which the GP has agreed care home staff may administer without a written prescription, such as medicines for mild headache, indigestion and constipation. This system had been set up for many of the people who lived at the home and appropriate records were maintained. The homely remedy stock cupboard was not tidy. A bottle of Peptac suspension had a messy top with excess liquid congealed at the spout and the top of the bottle was not on. This created a possible safety and contamination risk.

We found that medicine storage space was totally insufficient for those who lived at the home. 'When required' medications were found to be crammed into a small kitchen cupboard space with no apparent order or separation. 'When required' medications are those which are prescribed to be given, as and when they are needed. This created an unnecessary risk of inadvertent and incorrect medicine administration.

Controlled Drugs (CD's) were being, in general, managed well. CD's are medicines which, if used inappropriately could be potentially harmful or addictive. These are categorised by law and are held under strict governmental control. However, we did notice a minor error on the label of Diamorphine 10mgs prescribed for one person. This may not have affected patient care, but it was a dispensing error by the pharmacy, which needed to be rectified. The CD record book was used correctly and accurately, except some historical CD destructions had not been countersigned by another qualified nurse, and this would be good practice. We saw that written policies and procedures for CD's were in place. However, these had not been reviewed since 2012 and they did not reflect the current practices adopted by the home.

One person who had refused their medications earlier in the day was being persuaded to take them again. On referring to their MAR it was evident that this person had refused their medicines frequently and for the last two days entirely. Records showed that the GP had authorised this individual's medication to be administered covertly, when appropriate and yet this had not been actioned by the nursing staff, nor had this instruction been incorporated in to the plan of care.

The medication policies and procedures for use within the home were dated 2012. These documents bore no relevance to what was actually happening in the home on a daily basis, with respect to medicines administration.

In a few specific instances we asked the nurse administering medications about some individual medicines. One person evidently had difficulty swallowing two large caplets twice a day. Therefore, the nurse dissolved them in some hot water and then added fruit juice before administering them. Not only could the hot water damage the integrity of the ingredients, but these caplets could easily be changed to a soluble tablet version or sachet with the same clinical benefit. We would have expected the nursing staff to have made a request to the GP for a more suitable composition for the individual.

Another person was being given prescribed medication in the morning, which is normally taken at night because of the sedative effects. This was discussed with the nurse, who was advised to ask the GP to review this medication. Another medication was being administered twice a day, although it is usually taken in one daily dose, rather than two smaller doses. The GP should be asked about this prescription.

The nurses on duty told us the home was in the process of changing supplying pharmacist. The above medication issues were discussed with them. They told us that they had very little contact from the GP's, other than for acute medications and they had asked their supplying pharmacy for a visit, but this had not yet happened.

In discussions with one of the registered nurses on duty on the day of our visit, we felt she was aware of most of the

Is the service safe?

failings in relation to the management of medications and that she did want to do better. Improvements were being made to a large store room which could be used for the storage of all medicines, local applications and dressings.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed. This was in breach of regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we looked at the personnel records of five members of staff. We found recruitment practices were not sufficient enough to protect those who lived at Barrisle. Prospective employees had produced acceptable identification documents and had completed application forms, which showed the provider was an equal opportunities employer. Registered nurses had been verified as being eligible to practice by their regulating body. However, written references had not always been obtained before people started to work at the home and those that had been received were not always dated and some had been accepted from friends of the applicants. In one instance the prospective employee had not entered any referees on their application form. This person had been employed without any references being sought. This was unacceptable and unsafe practice, which could put people at risk.

DBS (Disclosure and Barring Service) checks had been conducted before people commenced employment, to determine if prospective employees had any criminal convictions or cautions. However, we found where a past conviction had been identified, this was not explored further and evidence of decision making about employment was not available, neither had a risk assessment been developed. This meant that people who lived at Barrisle were not protected by the recruitment practices adopted by the home.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because recruitment practices were not robust. This was in breach of regulation 19(1)(a)(b)(2)(a)(b)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We witnessed two incidents during our inspection, which could have potentially caused severe injuries. One person retaliated when a fellow resident tried to take food off his plate at lunch time, by attempting to stab her in the face with a knife. He narrowly missed her face and hand. Another person tried to punch a fellow resident in the face with force. Both these incidents could have caused serious damage to the victims. At this time there were no care staff in the vicinity to intervene and de-escalate the situation.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because systems and processes did not effectively prevent abuse of service users. This was in breach of regulation 13 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people were free to move around the home, without any restrictions being imposed. Detailed policies were in place in relation to safeguarding adults and whistle-blowing procedures. We asked a care worker about safeguarding procedures. They were able to explain what safeguarding people and whistleblowing entailed.

We established that there was a sufficient number of staff on duty on the days of our inspection. However, the deployment of staff was not managed well, as we found the general environment to be disorganised without any structure or purpose to the day's activities. This meant that people did not have any meaningful structure to their day.

Records showed there was a lot of staff sickness and therefore agency staff were regularly used. This did not promote consistent continuity of care. However, although one registered nurse we spoke with confirmed this information to be accurate, she felt there were sufficient numbers of staff appointed. She told us that whenever possible the same agency staff were utilised, so that those who lived at the home were familiar with them. The duty rotas we saw confirmed this information to be accurate.

There were mixed responses to the question we asked about staffing levels. The relatives we spoke with thought there were enough staff on duty, whilst one person who lived at the home told us that there wasn't always a member of staff in the lounge. This information was confirmed as accurate by our observations throughout the day. We asked people if staff responded quickly to requests for help. One person told us, "I can't find or reach the buzzer. I shout for help and then get shouted at for shouting."

Inadequate

Is the service safe?

One person we spoke with raised a safeguarding concern with us. We advised the temporary manager to report this under safeguarding procedures to the local authority without delay. This was done immediately. Staff members we spoke with told us they would know what to do, should they be concerned about the safety and well-being of anyone in their care.

An infection control policy was in place and we noted that clinical waste was being disposed of in accordance with current legislation and good practice guidelines. Although, in general the home throughout was pleasant smelling, one bedroom we visited was very malodorous. We pointed this out to the temporary manager, who went to investigate the cause immediately.

Accident records were appropriately recorded and these were kept in line with data protection guidelines. This helped to ensure people's personal details were maintained in a confidential manner. Regular monitoring of accidents and incidents was evident, which enabled a clear audit trail to be followed and any specific patterns to be identified.

Certificates were available to demonstrate systems and equipment had been serviced, in accordance with manufacturer's recommendations and records showed that internal checks were conducted regularly, such as a weekly fire alarm test. This meant that people were protected against the risk of inadequate equipment and unsafe premises.

A contingency plan had been developed, along with individual Personal Emergency Evacuation Plans (PEEPS), which instructed staff about action they needed to take in the event of an environmental emergency incident, where people may need to be evacuated from the building. For example, in the case of fire, flood, power or utility failure. The PEEPS outlined how people would need to be assisted from the home and these were in a separate file, which was easily accessible by any relevant personnel, such as staff members, the fire brigade or ambulance crew.

In discussions with one of the registered nurses on duty on the day of our visit, we felt she was aware of most of the failings in relation to the management of medications and that she did want to do better. Improvements were being made to a large store room which could be used for the storage of all medicines, local applications and dressings.

We would recommend that a more organised routine is developed within a person centred framework, so that people have some meaningful structure to their day and a more pro-active approach to people's needs could be adopted.

Inadequate

Is the service effective?

Our findings

We spoke with one person, who had lived at the home for two months. She was able to converse with us well. We also spoke with her relative, who was visiting. The relative told us she did not know why her mother had been admitted to Barrisle from hospital. The resident confirmed that she did not know either. She told us, "I want to go home. I hate it here. I am not mentally ill you know. It is horrible to be put in a place like this, when there is nothing wrong with you mentally." The care plan entitled, 'Safe environment' stated, '(Named removed) needs to be nursed in a safe and secure environment due to 'extreme confusion' and the mental capacity assessment showed this person lacked capacity, but it failed to identify in what areas she lacked the ability to make decisions and on speaking with the person it did not appear that she lacked the capacity to make decisions. We spoke with this person at length during both days we visited the home. She was lucid throughout at that time. We raised some concerns about the placement of this individual in to Barrisle with the temporary manager of the home, who agreed with our concerns and assured us he would discuss this with the funding authority.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We asked a care worker about the MCA and DoLS. They were able to explain to us what these two pieces of legislation entailed.

Formal consent had not always been obtained from people in relation to the care and treatment they received. Records were not always available to demonstrate that people had given their consent to specific areas of are the treatment, such as the administration of medications, the taking of photographs or the use of bed rails.

We found that the registered person had not ensured that people's rights were always protected, in accordance with the Mental Capacity Act 2005. People were at risk of being deprived of their liberty because legal requirements and best practice guidelines were not always followed. This was in breach of regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Policies and procedures were in place in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). These covered areas, such as restrictive practice, capacity and best interest decision making. Records showed that some DoLS applications had been made. However, the care file for one person, following a mental capacity assessment, stated, 'DoLS application to be made.' This was dated in March 2015. We established that this had not been done.

The registered nurse told us that applications were to be made for everyone who lived at the home. We did not see any responses to the DoLS applications on the care records we examined, although evidence was available to show that an urgent application had been submitted along with a standard request for one person three weeks earlier. It was not clear if a mental capacity assessment had been conducted for one person, although the plan of care stated he had the capacity to make simple decisions and could make his needs known, but that he had no insight and could be aggressive and anxious. This needed to be explored further and clearer information provided.

We found that the registered person had not protected people from being deprived of their liberty because people's rights were not always protected, in accordance with the Mental Capacity Act 2005. This was in breach of regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we toured the premises, viewing all communal areas and a randomly selected number of bedrooms. We found the accommodation to be clean and hygienic, but basic in relation to the furnishings, fittings and décor. The bedding we saw was thin and unattractive and in need of replacement. The home throughout was in need of upgrading and modernising, in order to provide a homely environment and pleasant surroundings for the people to live in.

Inadequate

Is the service effective?

The home was not particularly well designed to meet the needs of people who lived with dementia or who were experiencing mental health issues. We did not see evidence of dementia friendly resources or adaptations in the communal areas corridors or bedrooms. People had little chance to explore their surroundings. The lack of dementia friendly amenities resulted in lost opportunities to stimulate exercise and to relieve boredom, as well as enabling people to orientate themselves to their environment. However, photographs of those who occupied the bedrooms were present on the outside of the doors.

We found colour schemes did not help with orientation and the lack of prominent picture signage did not easily identify areas, such as bathrooms and toilets. We noted one bathroom floor covering was of black and white diamond shapes, which was not suitable for those who lived at the home, as this could be confusing for people who live with dementia.

We found that the registered person had not protected people against risks associated with unsuitable premises, because some areas of the home were not of suitable design or layout. This was in breach of regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection there was a broad range of staff on duty, with different skills and qualifications. However, due to lack of direction and supervision they were not providing effective care and support for those who lived at Barrisle. For example, we saw staff members assisting people with activities of daily living with minimal communication. One person was wearing a short sleeved shirt. He told us he was cold, so we went with him to find a jumper to put on from his bedroom. One person was sitting in a communal area looking quite anxious. She was holding out her hand for some comfort and attention. We spent a few minutes with her and she settled.

One person asked a member of staff, “Where is my mum? Mum I need help!” The staff member replied, “I am not your mum!” This was an inappropriate response and did not promote effective communication.

We found that the registered person had not ensured that people’s needs were being met in accordance with their preferences. This was in breach of regulation 9(1)(a)(b)(c)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told there were no induction records maintained. Therefore, new employees were not adequately supported to provide the care people needed and were not helped to familiarise themselves with the policies, procedures and practices of the home. However, records showed that staff were provided with job descriptions relevant to their specific role and terms and conditions of employment, which outlined what was expected of them whilst working for the company and action which would be taken in the event of staff misconduct, as well as the appeals process.

Registered nurses were on duty at all times and some care staff had achieved a nationally recognised qualification in care. We saw a training plan was displayed in the office. However, this did not provide us with any current information, as dates of training had not been added and we were told this was not up to date, as several staff members had not been added. The majority of training certificates on staff personnel files were several years old and therefore evidence was not available to demonstrate the staff team were provided with a mandatory training programme or training modules specific to the needs of those who lived at the home.

The majority of supervision and appraisal records on staff files were several years old and therefore staff members had not been given the opportunity to discuss their work performance and training needs with their line managers at structured and regular intervals. Staff we spoke with confirmed this.

We found the registered person had not ensured that persons employed had received appropriate support, training, professional development, supervision and appraisal, as was necessary to enable them to carry out the duties for which they were appointed. This was in breach of regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People’s nutritional needs were not being consistently met. Although some nutritional assessments had been

Is the service effective?

conducted, dietary preferences were not always documented within individual plans of care. Any specialised diets were displayed in the kitchen, so the cook would be aware of individual nutritional needs.

On the first day of our inspection we observed lunch being served in the dining room. This was very poorly managed and disorganised. Communication between staff members and those who lived at the home was minimal during the meal. We noted the dining area to be void of staff members for long periods. One person said he did not want his main course, so a care worker took his untouched meal away and brought a pudding. He refused this also. This too was removed. No alternatives were offered and no encouragement was provided. Another person was struggling to eat her lunch with her fingers. Finger foods were not served for this person and no assistance was provided. A third was struggling to control secretions and required assistance, which was not provided quickly. Another person was walking around the dining room taking people's food off their plates, without any diversional tactics being used by staff.

We saw a member of staff assisting one person with their lunch. This was done without communication and in a rushed manner. The individual was not allowed time to eat at their own pace. There were two people who ate very slowly, eating all their chips first. It was only after pudding had been served that a carer returned to them and cut their fish up for them. Once the fish had been cut, they began to eat it. There were no napkins available and we saw one person wiping her mouth on the corner of the tablecloth. We saw one person wheeled into the dining room, left for about five minutes and then wheeled out again. We saw this person sitting in the hallway later in the day and asked if they had had their lunch. We were told they had been fed whilst sitting in the hallway. The meal time we observed was not relaxed and was not conducive to a pleasant dining experience.

On the second day we visited we observed people having breakfast. One person was sitting in the lounge in a recliner chair. A full bowl of porridge was on a bed side table next to her, but out of reach. We established this person would require assistance with eating. A member of staff arrived and took this individual away in her chair, so she could take part in a baking activity. A care worker later came and removed the untouched bowl of cold porridge.

The menu of the day showed a choice of two meals. The options were hand written on a blackboard outside the dining room. This information would not be accessible to those who were living with dementia and people were not asked which option they preferred. Likewise drinks were provided without staff asking people what they would like. We suggested a picture menu, so that people could perhaps recognise different meal options and therefore choose what they would prefer to eat.

We found people were at risk of malnutrition because their dietary preferences had not been taken in to consideration and, where needed they had not been assisted or encouraged to meet their nutritional needs. This was in breach of regulation 14(1)(2)(4)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The food served looked appetising. The last Environmental Health Officer's food hygiene inspection in 2015 rated the home at level 3, which indicates 'generally satisfactory' by the local council.

We spoke with the cook, who informed us that there were plentiful supplies of food, including fresh fruit and vegetables, which was due to be delivered on the day of our second visit. We noticed that the door handle on the fridge in the kitchen was broken and in need of repair. The cook told us that alternatives to the menu were always available, should someone prefer something else, instead of the options on the menu. She said the care staff just needed to tell her if someone would like an alternative.

The care files we saw showed the involvement of a wide range of external professionals, such as community nurses, psychiatrists, GPs, dentists, opticians, and psychologists. Hospital appointments were also evident. One person told us, "I am going to have a cataract extraction soon." This helped to ensure people's health care needs were being appropriately met. We asked people if they felt staff would listen to them if they were concerned about their health. One said, "I'm sure they would. They took me to a hospital appointment and the carer came with me." A relative commented to the same question, "Yes. He's missing a crown and they got the dentist."

Inadequate

Is the service caring?

Our findings

We asked people if the staff team took their time when helping them. One person told us, "When you ask them (the staff) to do something, they talk to somebody else." We asked relatives if staff were patient with their loved ones. One commented, "Yes. He's always clean." Another told us, "I've not witnessed anything. They may say 'come on hurry up', but it's not said with intent or malice."

People we spoke with told us they could get up and go to bed when they wished and they said their privacy and dignity was respected by the staff team. We asked people if staff had time to sit and chat with them. One person commented, "No. Only the activity co-ordinator. She's really good", but another replied, "They do sometimes."People's needs were not anticipated well and daily activities of living were responded to in a reactive way, instead of the home adopting a pro-active approach to care and support.

Support plans did not always outline the importance of promoting people's privacy and dignity and promoting their independence. We observed situations throughout our inspection, in which people's privacy and dignity was not respected and independence was not supported. For example, when a member of ancillary staff quietly informed a care worker that one person wished to go to the toilet, this member of staff replied by saying quite loudly in a communal area of the home, "I am with (name removed). I'll have to get someone. He has a pad on." We saw another person take someone else's drink. The care worker, who was in the vicinity announced loudly, "(Name removed) has taken (name removed)s drink." These responses did not promote people's dignity and could be heard by the other people who were in the communal areas at that time. We saw one person in a lounge area having breakfast with just a vest on the top part of his body. Another person was in a recliner with her jumper half way up her back. We saw moving and handling techniques being performed in an undignified manner on three separate occasions. One person, who was in a short sleeved shirt told us he was cold, so one of the inspection team went to get a jumper for him from his bedroom.

The general environment during the first day of our inspection was found to be noisy, disorganised and chaotic. On our second visit there was a calmer and more relaxed atmosphere. However, we did not observe respectful, kind and patient care being afforded to those who lived at Barrisle. People who lived at the home were not well presented. Their hair was untidy and the men had evidently not had a shave for several days. Staff members spoken with were unable to explain why this was. A notice was clearly displayed showing that the hairdresser visited the home every Thursday. However, our first visit took place on Friday and it was not evident that anyone had attended the hairdresser the previous day. People were dressed in stained clothes and we noted one person's shoes were dirty with food spillages.

Interactions we observed between staff members and those who lived at the home were very limited. Staff spoke with people only when they needed them to do something or if they needed to tell them something. For example, "(Name removed) just move your feet back, so I can get past with the trolley." "(Name removed) here's a cup of tea." The last statement was not preceded by the individual being asked what he would like to drink. There were no general conversations overheard about everyday activities, such as the meals on offer, the present weather conditions or what the plans of the day ahead were. On occasions we saw staff standing in small groups chatting or sitting away from those who lived at the home, just observing them instead of spending time with people in a meaningful way.

We saw staff approach those who lived at Barrisle in a task orientated way. We noted that those who were the most vocal were the ones who received the most attention. Interaction with others was very limited, which showed that the equality and diversity policies of the home were not being followed in day to day practice.

We found the registered person had not ensured that the privacy and dignity of people was consistently promoted. This was in breach of regulation 10(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The plans of care had been regularly reviewed and any changes in need had been recorded. However, those who used the service or their representatives had not always been given the opportunity to be involved in the assessment of people's needs or planning of their care, so they were enabled to take part in some decisions about the way in which support was being delivered.

Inadequate

Is the service caring?

We found that the registered person had not provided people with the opportunity to make decisions about the way in which care and support was provided. This was in breach of regulation 9(3)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The records of one person showed that an advocate had been appointed from the mental health team. An advocate is an independent person who will support people to make decisions about their care, support and daily activities, which meets their rights and is in their best interests.

A member of the inspection team sat with one person for lunch. They chatted the whole time. When she stood up to go the individual got hold of her hand and said, “Please don’t go. It’s been really nice talking to you.” We later saw this person sitting in the lounge, where we spent a lot of time. We did not see any staff talk with him during the afternoon, apart from giving him a cup of tea.

Inadequate

Is the service responsive?

Our findings

We looked at the care files of five people who lived at the home and who had quite different needs. We 'pathway' tracked the care of four of these people. We found that the plans of care varied in quality. Although these had been reviewed regularly and any changes in people's needs had been recorded, some provided limited information only and peoples' likes, dislikes and preferences were not often documented. Vague terminology was often used, which did not provide staff with clear guidance about the needs of people, or how these were to be best met. However, others were well-written, person centred documents. Some plans of care were particularly person centred in relation to challenging behaviour and they clearly showed how this area of need was to be best managed for each individual. A nurse and senior care worker were able to discuss the management of challenging behaviour well, in accordance with the plans of care we saw. However, one care plan viewed did not provide enough direction for staff about how challenging behaviour was to be managed for that particular person.

In some cases information was not always as detailed as it could have been. For example, the needs assessment for one person, which had been conducted before the individual moved in to the home was very basic and lacked person-centred information. The plan of care for this person did not cover all assessed needs and some contradictory information was provided within the care file. This did not provide staff with clear guidance which would enable them to deliver the care and support in accordance with this individual's needs and preferences. Although risk assessments had been conducted, these did not identify how specific risks were to be best managed. Some documents in this person's file, such as 'This is your life'; consent forms and a property list were left blank. The plan of care for one person failed to include their social care needs. We established that this person's husband was unable to visit because of ill health and distance. This was not considered during the planning of this person's care.

We found that the registered person had not protected people against the risk of unsafe care or treatment, because the care planning and assessment processes were not always sufficiently person centred and potential risks had not always been managed well. This was in breach of regulation 9(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we did not witness many leisure activities taking place. On the morning of our second visit to Barrisle we noted some people were supported to participate in a baking activity. We spoke at length with the recently appointed activity coordinator, who had some good ideas for improving this area for those who lived at the home.

We sat in the communal areas of the home for long periods of time. This allowed us to conduct a SOFI observation. At this time there were 11 people in the lounge we occupied. Over the course of one hour we saw that very little interaction was instigated by staff members, unless in connection with a task related activity. No general discussions or conversations took place about general every day topics. Several people were sleeping.

Beverages were given out in near silence. No-one was asked what they would like from the trolley. People who spoke a lot or who made a lot of noise were given a lot of attention by the staff. Those who did not speak or who sat quietly did not get any interaction or very little interaction from the staff. We noted there were a lot of missed opportunities, in which people could have been engaged in meaningful activities. Many people were walking around the home aimlessly, with no sense of purpose. We saw one person ask the staff member in charge of the tea trolley if he could go to the toilet. He was told he would have to wait until staff returned from their break. Staff arrived five minutes later to take him to the toilet. At this point he had become very agitated. However, we did observe some instances during our visits where staff responded to people's needs promptly. One was in response to someone who was distressed, another was in order to protect the dignity of a female resident and a third was to help someone to maintain their independence.

We viewed a number of bedrooms during our inspection. Some we found to be personalised with objects and pictures displayed that were clearly personal and important to those who lived in these rooms. This promoted individuality and maintained people's interests. Others we found to lack personalisation, as the walls were bare and the rooms void of personal items.

Inadequate

Is the service responsive?

A complaints policy was clearly displayed at the home and a system was available for recording and monitoring complaints received, although none had been documented since our last inspection of this location. The temporary manager and registered nurse were unsure if there were any ongoing complaints. Relatives we spoke with told us they would not hesitate to report any concerns they might have. One relative said they had made a complaint, but were not happy with how it was managed because they had not been informed of the outcome. It would be beneficial if all complainants were kept informed about the progress of the concerns they raise.

Two incidents occurred during our visit, which showed a degree of responsiveness, in relation to people's needs. One in respect of the management of medications. One person had been complaining of leg and hip pain that morning, and had recently fallen at the home. An ambulance had been called, but in the meantime the nurse on duty administered one of his medications, which had been prescribed for stress and anxiety, as he was getting agitated.

In a second incident a hospital doctor contacted the home during our visit and advised the nursing staff to stop giving one person a medication immediately, which had been prescribed at the hospital the previous day. The nurse on duty paid particular attention to this instruction and removed the medicine from the cupboard and MAR chart straight away.

We would recommend that the management team research and support any new ideas for the provision of suitable and person centred activities, so that life at Barrisle care home could be structured and meaningful. Staff need to be trained in the art of effective communication, to enable them to instigate discussions with those who live at the home.

Inadequate

Is the service well-led?

Our findings

Records showed that a company representative conducted monthly quality audits, which covered all areas of the service, including topics, such as meetings, complaints, staff training and the premises. We looked at information that was recorded on the March 2015 quality audit. Responses, such as, 'All info up to date', 'No complaints from staff', 'Moving and handling training done' and 'Objectives being met' were recorded within the monitoring forms. On this occasion none of the people who lived at the home were interviewed. The assessor had written, 'Very clear pathways through plans. Person centred. Evaluated regularly', 'Premises clean and tidy', 'No issues at this visit.'

Other recent monitoring audits included wheelchair safety, hoists, bed mattresses, the kitchen and laundry departments, bedrooms and infection control. Some areas for improvement had been identified during the internal monitoring process, such as a faulty hoist.

Internal systems for assessing and monitoring the quality of service provided were not consistently effective, because issues identified at the time of our inspection had not been recognised during the internal auditing process.

We found that the registered person had not protected people against the risk of unsafe care or treatment, because systems for assessing and monitoring the quality of service provided were not always effective. This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we examined the information we held about this location, such as notifications, safeguarding referrals and serious injuries. We noted that we had not been notified about things we needed to know. For example, one person had sustained a fractured hip during a fall. This is classed as a serious injury and is therefore a reportable incident. It is also required that the Care Quality Commission be informed of the absence of the registered manager. If the absence is due to an emergency then we must be notified within five days of the commencement of the absence. The notification must specify the expected length of the absence, the reason for the absence and the arrangements for the management of the service during the absence.

We found that the registered person had not notified the Care Quality Commission of a serious injury, which a person who lived at the home had sustained. This was in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We also found that the registered person had not notified the Care Quality Commission of the absence of the registered manager. This was in breach of regulation 14(3) of the Care Quality Commission (Registration) Regulations 2009.

During our inspection we established that no administrative staff were employed. This location is extremely busy, with the telephone constantly ringing and people regularly visiting. It would be beneficial to appoint some administrative support, so that the manager and nursing staff can concentrate on doing the jobs for which they were employed. Some records we requested could not be located and it was thought that they perhaps had not been implemented in the first place. Administrative support could help to improve the area of record keeping and also help to create more organised systems.

We found there was no evidence available to demonstrate that meetings for those who lived at the home, their relatives and the staff team were held. However, records showed that annual surveys were conducted, which covered areas, such as the environment, health and well-being, daily life and communication. This enabled people to express their opinions of the services and facilities available and any shortfalls identified could then be addressed in the most appropriate way. In general, positive responses were received. People who lived at the home who we spoke with could not remember being asked for their opinion about the service provided. However, one relative had told us they had answered a questionnaire and another said they had posted some comments to the home.

A wide range of written policies and procedures provided staff with clear guidance about current legislation and up to date good practice guidelines. These were reviewed and updated regularly and covered areas, such as The Mental Capacity Act, Deprivation of Liberty Safeguarding, fire awareness, privacy and dignity, safeguarding adults, infection control and health and safety.

Some staff had worked at the home for many years, which showed they enjoyed working at Barrisle care home.

Inadequate

Is the service well-led?

However, we found many aspects of the management style to be more reactive than pro-active. It was clear from reading care records and from talking with staff that Barrisle worked in partnership with a wide spectrum of other professional agencies.

One member of staff said, "Staff morale is at 'rock bottom', but it has just started to pick up again. It has been better over the last week than it has been for a long time."

When we asked people if they would be able to speak with the manager about any concerns, one said, "Oh, yes. He is very nice." One relative commented, "It's so friendly and he looks so relaxed." Another said, "It's so welcoming. The staff are fantastic."

Feedback we received from the community professionals contacted, included: 'I have been involved with Barrisle Nursing Home for 18 years. My main contact has been with the nurse in charge. They (the staff) treat their clients with dignity, despite challenging behaviour and health conditions. Their approach is holistic. I do not feel the home is under staffed' and 'I have noted a significant improvement in the standard of care provided at Barrisle in the last couple of years and whereas previously I shared the view of some of my colleagues that care could have been better, these concerns seem to have been addressed. From a medical point of view Barrisle now requests GP input appropriately, and is able to provide appropriate information to us when we visit, and appears to ensure that instructions/medical care changes are acted upon' A third raised some concerns with us, which we took in to consideration during our inspection.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Proper steps had not always been taken to ensure people were protected against the risks of receiving inappropriate or unsafe care or treatment. This was because risks relating to their health had not always been well managed. Regulation 12(1)(2)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected people against risks because an effective system was not in place to identify, assess and manage environmental risks relating to the health, welfare and safety of those who lived at the home. Regulation 17(1)(2)(a)(b)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because recruitment practices were not robust.

This section is primarily information for the provider

Enforcement actions

Regulation19(1)(a)(b)(2)(a)(3)(a)(b)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the registered person had not ensured that people's rights were always protected, in accordance with the Mental Capacity Act 2005. People were at risk of being deprived of their liberty because legal requirements and best practice guidelines were not always followed. Regulation 11(1)(2)(3)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with the unsafe use and management of medicines. This was because appropriate arrangements had not been made for the obtaining, recording, using and safe administration of medicines. Regulation 12 (1)(2)(g)

The enforcement action we took:

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **We found that the registered person had not protected people against risks associated with unsuitable premises, because some areas of the home were not of suitable design or layout.** Regulation 15(1)(c)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **We found that the registered person had not ensured persons employed had received appropriate support, training, professional development, supervision and appraisal, as was necessary to enable them to carry out the duties for which they were appointed.** Regulation 18(2)(a)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **We found people were at risk of malnutrition because their dietary preferences had not been taken in to consideration and, where needed they had not been assisted or encouraged to meet their nutritional needs.** Regulation 14(1)(2)(4)(a)(c)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **We found the registered person had not ensured that the privacy and dignity of people was consistently promoted.** Regulation 10(1)(2)(a)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **We found that the registered person had not provided people with the opportunity to make decisions about the way in which care and support was provided.** Regulation 9(3)(a)(b)(d)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **We found that the registered person had not protected people against the risk of unsafe care or treatment, because the care planning and assessment processes were not always sufficiently person centred and potential risks had not always been managed well.** Regulation 9(1)(a)(b)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found that the registered person had not protected people against the risk of unsafe care or treatment, because systems for assessing and monitoring the quality of service provided were not always effective.** **Regulation 17(1)(2)**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **We found that the registered person had not protected people from abuse, because systems and processes did not effectively prevent abuse of service users. A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.** **Regulation 13 (1)(2)(5)**

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Enforcement actions

We found that the registered person had not notified the Care Quality Commission of a serious injury, which a person who lived at the home had sustained.

Regulation 18

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 CQC (Registration) Regulations 2009 Notifications – notice of absence **We found that the registered person had not notified the Care Quality Commission of the absence of the registered manager.** Regulation 14(3).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.