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Balliol Lodge Nursing 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

The inspection was unannounced and took place on 5 and 6 November 2015.

Balliol Lodge is a care home that provides nursing and personal care for up to 32 people. The care provided is for people with a diagnosed condition of dementia although some people have other enduring mental health needs. The home consists of two converted buildings over three floors. It is located very close to shops, local amenities and public transport links.

At the time of our inspection there were 22 people living at the home.

There was no registered manager in post. The previous manager had left the service shortly before our last inspection on 29 July 2015. An existing member of staff had taken up the role of manager shortly before this inspection. However, they had not applied to be registered. A registered manager is a person who has registered with the 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.

Following the inspection in July 2015, the home was rated 'inadequate' overall. This meant the home was placed into 'Special Measures' by the Care Quality Commission (CQC). The purpose of special measures is to:

Summary of findings

- 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 take further action, for example cancel their registration.

Services placed in Special Measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

People living at the home were not protected from abuse. There were a large number of serious incidents between people living at the home, many resulting in injury. Effective risk management measures had not been put in place to minimise the occurrences of such incidents. Not all staff had received training in adult safeguarding. The home did not have an adult safeguarding policy.

Individual risk was not managed effectively. Individual risk assessments and risk management plans were either not in place or were poorly completed.

We found the staffing levels were inadequate to ensure people's safety was maintained at all times. The staffing levels had been reduced since our inspection in July 2015 despite an increase in dependency levels and continual incidents between people living at the home. Staffing levels were insufficient to ensure the shared areas were supervised by staff at all times.

The approach to recruitment of staff was not robust. Character references were accepted and references from previous employers were not always sought. Induction was not role-specific. Staff supervision was taking place but staff were not up-to-date with training needed to fulfil their role effectively.

Medicines were not managed in a safe way. For example, there was either no information or insufficient information to guide staff when administering medicines that are given when needed. There was also insufficient information recorded to enable staff to apply topical medicines (creams) properly. People's medicines were not always given as prescribed and no explanations for these omissions were recorded. No action was taken by nurses to review people's medicines, or seek medical advice, when they refused the medicines on a regular basis.

We found that the home was not very clean, safe or well-maintained. For example, not all of the window restrictors had been replaced following our last inspection. A stair gate was broken which meant people at risk of falling could access the stairs. Merseyside Fire and Rescue Authority had been monitoring the home closely following an allegation of serious deficiencies under the Regulatory Reform (Fire Safety) Order 2005. As a result of the visit, a Fire Safety Inspection was carried out and appropriate action was being taken. Despite these concerns, we found that weekly visual checks of smoke detectors, emergency lighting, door self-closures and firefighting equipment had not taken place since the end of August 2015.

Families informed us that their relatives had access to healthcare services when they needed it. Care records confirmed this.

Adequate measures and support were not in place to ensure people received enough to eat and drink to meet their nutritional and hydration needs. Snacks and drinks were not provided between meals. Water was not routinely offered to people as a drink.

Mental capacity assessments were not being undertaken in accordance with the principles of the Mental Capacity Act (2005). This showed staff lacked an understanding of the Act. Staff had not received training in mental capacity. Deprivation of Liberty safeguarding (DoLS) applications had been submitted to the Council for the people who needed them.

Summary of findings

We found that not all staff were kind or caring towards the people living at the home. We heard staff speak sharply to people and we saw a member of staff displaying a dispassionate attitude towards people on a number of occasions. Staff did not make sure that people's privacy and dignity was maintained at all times.

Care was not person-centred. Care records concentrated mainly on people's physical health care needs and contained minimal information about people's personal history, preferences and interests. Preferred routines were not recorded for people.

We observed no meaningful recreational or social activities taking place throughout the inspection. There was no evidence in the care records of activities taking place. Families told us activities had not taken place since the activities coordinator left in August 2015.

A complaints procedure was in place and the manager provided details of a complaint that had been resolved to the satisfaction of the complainant.

Since the registered manager left the service in July 2015, another manager and a deputy manager had been appointed but they had both since left. A registered nurse working at the home had been promoted to nurse-manager with only 10 hours of managerial time negotiable with the owner each week.

Staff meetings and meetings for relatives were taking place. The provider was not acting on feedback from these meetings. For example, staff raised concern about the low staffing levels in August 2015 yet the staff levels were reduced after this.

Structures to monitor the quality and safety of the service were ineffective. Audits and checks of the service had not picked up on serious issues we identified, such as concerns with the safety of the environment and the management of medicines. The provider was not informing the CQC of all the events CQC are required to be notified about.

CQC used its urgent powers to remove the location so that Balliol Lodge was no longer registered to carry out the regulated activities.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Medicines were not managed in a safe way.

Staffing levels were inadequate to ensure the safety of the people living at the home.

People were not safeguarded from abuse.

Behaviour that challenged was not always managed appropriately.

Effective arrangements were not in place for the recruitment of staff.

The environment was not safe, clean or well maintained.

Inadequate

Is the service effective?
The service was not effective.

Staff had limited understanding of the Mental Capacity Act (2005). Mental capacity assessments were not being completed in accordance with the principles of the Act.

Staff training was not up-to-date.

Adequate measures and support were not in place to ensure people received enough to eat and drink to meet their nutritional and hydration needs.

People had access to health care services when they needed it.

Inadequate

Is the service caring?
The service was not caring.

Some staff were not caring and kind in the way they engaged with people. People's dignity and privacy was not maintained at all times.

People were sat unnecessarily in hoist slings all day, which was undignified.

Inadequate

Is the service responsive?
The service was not responsive.

Many of the care records contained either no or limited information about people's relationships, working life, hobbies, interests and preferred routines to support staff with understanding each person's needs.

There were no arrangements in place to meet people's social and recreational needs.

A complaints procedure was in place.

Inadequate

Is the service well-led?
The service was not well-led.

Inadequate

Summary of findings

There had been three changes of manager in 2015. A nurse had been promoted to nurse-manager with just 10 hours of managerial time per week.

The feedback from relative and staff meetings about the service had not been acted upon.

Systems to monitor the quality and safety of the service were ineffective. Audits and checks of the service had not picked up on serious issues we identified, such as concerns with the safety of the environment and the management of medicines.

The provider was not informing the CQC of all the events CQC are required to be notified about.

Balliol Lodge Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection of Balliol Lodge Nursing Home took place on 5 and 6 November 2015. The inspection was in response to concerns that had been raised by other stakeholders and also to follow up on the concerns found at the last inspection in July 2015.

The inspection team consisted of an inspection manager, an adult social care inspector, a pharmacist inspector, a specialist advisor in health and safety and an expert by experience with expertise in services for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We usually request a Provider Information Return (PIR) prior to the inspection but had not done so for this inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the statutory notifications the home was required to inform CQC about and other information CQC had received about the service. We contacted the Merseyside Fire and Rescue Authority, the local Clinical Commissioning Group (CCG), Sefton Social Services and the local infection prevention and control team and asked any updates about the service.

During the inspection we spent time in the company of or talking with 15 people who lived at the home and six family members who were visiting their relatives at the time of our inspection. We also spoke with the nurse-manager, a registered nurse, the housekeeper, the chef and five care staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at the care records for eight people living at the home, five staff recruitment files and records relevant to the quality monitoring of the service. We looked round all areas of the home, including people's bedrooms, bathrooms, dining rooms and lounge areas.

Inadequate

Is the service safe?

Our findings

When we carried out a comprehensive inspection of Balliol Lodge Nursing Home in July 2015 we identified breaches of regulation in relation to keeping people safe. The 'safe' domain was judged to be 'inadequate'. This inspection checked the action the provider had taken to address the breaches in regulation and was also in response to concerns raised by other stakeholders. The breaches were in relation to: the management of medicines; safeguarding people from abuse; the recruitment of staff; the management of individual risk; risks associated with the environment and equipment and the unsafe use of equipment.

In relation to medicines, at the previous inspection we found supplementary dietary drinks were inappropriately stored on the floor. The allergy status of people living at the home had not been completed. Oxygen was not stored safely. The plans for prescribed medicines to be given when needed (often referred to as PRN medicines) lacked detail. Covert medicines were not being given in a lawful way or in accordance with the home's medicines policy.

We found that only one improvement had been made in the safe handling of medicines since the inspection in July 2015; people's allergy status was now recorded. However, we found further significant and serious issues with regards to other aspects of medicines management. We looked at how medicines were handled for 15 people living in the home; there were concerns about the way prescribed medicines were handled for all of those people.

Safe operating procedures and policies were not in place for staff to follow to enable them to handle medicines safely. The medication policy was four years old and did not include the recent 2014 NICE guidelines for managing medicines in care homes. NICE (National Institute for Health and Care Excellence) provides national guidance and advice to improve health and social care services.

The nurses administering medicines were not competent to oversee the safe administration of medication. The provider had failed to ensure that a nurse who had made a recent drug administration error received any training or support before further administering medicines to vulnerable people living in the home. We had concerns about this nurse's practice at the previous inspection and the provider had not taken action to monitor the nurse's performance

We found that there were no systems in place to make sure when people had their medication changed by the GP or following discharge from hospital they were given the new dose of their medicines safely. We also found there was no robust method of communicating these changes between staff and between shifts. This placed people's health at a serious risk of harm.

The day before our visit a pharmacist and technician from the Clinical Commissioning Group (CCG) had visited the home and found two people had not been given their prescribed medicines, despite the fact the home had obtained them. We found this had happened because records and communication between nurses was poor. People could have missed having prescribed doses of their medicines for a long time if the CCG had not visited and found the error.

We found some people living in the home were prescribed a thickening powder to add to all their fluids to reduce the risk of choking. No information was available for care staff to refer to when making drinks for the people. This meant they had to rely upon their memory which is unsafe practice. We also saw that staff failed to make any records to show that people's drinks were thickened so it was not possible to evidence that people were given fluids safely. We also found a tin of thickening powder left unattended in an area accessible to people living at the home. This meant there was a risk of harm if a person ingested the powder.

There was either no information or insufficient information to guide staff when administering PRN medicines. There was also insufficient information recorded to enable staff to apply topical medicines (creams) properly. If this information is missing, especially for people living with dementia then creams and medicines may not be given or applied effectively or consistently, and people's health could be at risk.

We saw that people's medicines were not always given as prescribed and no explanations for these omissions were recorded. We found that no action was taken by nurses to

review people's medicines or seek medical advice when they refused the medicines on a regular basis. This meant people's health could be at risk from not receiving their prescribed medicines.

We found that records about medicines were not always completed accurately. On the day of the inspection we saw that the nurse manager failed to sign the medication administration records (MAR) in a timely manner. We also saw that the nurse administering the medicines failed to refer to the MARs when preparing peoples medication for administration. There were a number of gaps on the MARs where it was not possible to tell if people have been given their medicines or not. Nurses signed the MARs to confirm they had applied creams when they had not applied them. Creams were applied by care staff but nurses signed the records without even checking if creams had been applied. The records about how much medication was in the home were not always accurate which made it impossible to tell if medicines had been given as prescribed or could be accounted for.

We found concerns in relation to the storage of medicines. The medication room was tiny, overheated and cluttered. There were flies constantly flying about the room, and the staff indicated it was a persistent problem yet no action had been taken to ensure medicines were stored and prepared in a more hygienic environment. The thermometer for the room and fridge showed that medicines had been stored well outside the manufacturers' guidance for the safe storage of medication. Nurses recorded these temperatures most days. When we asked, one nurse had no idea what the safe storage temperatures should be but was aware they were incorrect and had not taken any action to rectify the problem. We noted that the medicines stored in the room were warm to touch on the day of the inspection visit. If medicines are not stored at the correct temperatures they may not work properly.

We saw that medicines which were waste or no longer needed were in a medical waste bin but the top was not closed or locked and tablets were accessible and visible and therefore at risk of misuse. We also saw that the mouthpiece of an inhaler was very dirty. The nurse said that the person did not need a new inhaler because they just rinsed the inhaler through. The nurse also said, "If you think the inhaler is dirty you should see their mouth."

This was a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection effective measures were not in place to protect people from the risks associated with the environment and equipment. Our findings included: broken bathroom tiles and sealant; dirty extractor fans; incomplete cleaning schedules; inappropriate or missing window restrictors; a dirty fish tank and ineffective water temperature control. We found that very little improvement had been made. Although some of the window restrictors had been replaced, we expressed concern that not all had been replaced even though it was over three months since the last inspection.

We reviewed the health and safety documents and information available at the home, including on-going maintenance records. The Health and Safety Law poster displayed in the staff tea room was out of date and should have been replaced by 5 April 2014. A fixed electrical wiring certificate was unavailable therefore we could not tell if the electrics within the home had been certified as safe. The gas safety certificate was dated 18 June 2015 so was in-date. The monthly water checks were last completed on 4 August 2015. There was no entry in the yearly maintenance record folder since 14 August 2015.

The home's equipment register did not contain details of any of the equipment located at the home. It was recorded that portable appliance testing was due to be undertaken on 10 August 2015 but there was no evidence provided to show this had happened. Task or job orientated risk assessments had started but these lacked detail in terms of identifying the risk, who could be harmed, control measures put in place and the level of risk.

Merseyside Fire and Rescue Authority attended the home on 5 October 2015 following an allegation of serious deficiencies under the Regulatory Reform (Fire Safety) Order 2005. As a result of the visit a Fire Safety Inspection was carried out. The Fire and Rescue Authority has taken appropriate action and is keeping the on-going situation under review.

Despite the serious concerns identified by the fire service, we found that weekly visual checks of smoke detectors, emergency lighting, door self-closures and firefighting equipment had not taken place since the end of August 2015. We found two fire doors were blocked with

combustible items, placing people at risk in the event of a fire. Major refurbishment was taking place in the basement as a result of the findings of the fire service. There were no risk assessments in place regarding the work being undertaken and how it was being managed.

The home's health and safety policy stated that no smoking was allowed on the premises. However, there was a designated smoking room for people living there. Building work was taking place in the smoke room on the days of the inspection. There was a hole in the ceiling and rubble on the floor and table. We observed a person with a walking aid using this room on their own to smoke. We asked a member of staff why the person was using such an unsafe area unaccompanied and they said, "We've explained all the risks, but he gets quite abusive." When we raised concern about the safety of the room staff closed it off and the person went outside to smoke.

We had a look around the building and found numerous concerns, including issues identified at the previous inspection that had not been addressed. A bathroom was out of use and staff told us it was because the bath hoist was "wobbly". There was no signage indicating it was out of use. One of the hoists for moving people failed when it was subject to a thorough examination in May 2015. A member of staff was unable to tell us why it failed. It was stored in an empty bedroom. Again, there was no signage indicating it was out of use. There was a risk of these hoists being put back into use if there is no signage to alert staff that they are is out-of-order. The hoist slings were last inspected on 15 March 2015, which was out-of-date as they should have been inspected in September 2015.

We noted damage to some of bathroom sinks. There were light pulls in use that were dirty with no protective sheaths. Sealant, grouting and tiles were damaged in some of the bathrooms. The toilet seat was missing in one bathroom. Two bathrooms had a pungent smell of urine. We looked at the cleaning schedule checks and saw they were not-up-to-date. For example, the 'Domestic cleaning weekday' sheet was last completed on 31 August 2015.

First aid boxes were located throughout the home but they contained insufficient first aid equipment. A fish tank was located in the lounge and it required cleaning. We found radiator covers that were not fixed to the wall. One radiator without a fixed cover was very hot to the touch, which meant the person residing in the bedroom was at risk from getting burnt. We found four bedrooms that did not have a nurse call system, which meant the person residing in the room or staff could not summon help in an emergency.

We looked at three incident reports related to the same person, all of which resulted in an injury due to equipment. Although the home's health and safety policy stated that incidents would be investigated, there was no evidence of any investigations having taken place. One of these incidents involved a person trying to get out of bed when they had a bed rail in position.

There was no evidence in people's care records as to how the decision to use bed rails had been reached. There were at least three profiling beds that had telescopic bedrails attached to them. There was no evidence that the manager had liaised with the manufacturer as to whether or not such rails were compatible with the bed they were attached to. Although appropriate bumpers were in place, but there was a lot of 'play' in terms of movement, which can create a potential entrapment risk. One bedroom had bed rails that had a defective release button and exposed only the screw mechanism. This presented a risk of injury to the person and staff.

There were two passenger lifts at the home. Both had a thorough examination on 24 April 2015. The Lifting Operations and Lifting Equipment Regulation (1998) require that lifts are thoroughly examined every six months. Therefore the lifts should have been re-examined on or before 24 October 2015. We were not provided with evidence to confirm this had happened. One lift was not working but there was no signage on the lift to advice people of this. This meant there was a risk that someone could attempt to use the lift.

At the previous inspection a member of staff was observed to be hoisting a person in a way that was unsafe. Training records at that time showed only two staff were up-to-date with lifting and handling training. The manager confirmed at this inspection that no lifting and handling training had taken place since the last inspection. This meant that people living at the home were still at risk of injury from being hoisted incorrectly.

This was a breach of Regulation 12(1)(2)(d)(e)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

At the previous inspection we found routine checks had not taken place to ensure recently recruited staff were safe to work with vulnerable adults. We looked at the personnel records for three members of recently recruited staff. We found that sufficient improvements had not been made in the way staff were recruited. References were mainly character references, from employee's friends rather than references from previous employment. Background checks showing criminal offences were not followed up with a risk assessment to check the person was suitable to work at the home. This meant that vulnerable living at the home could be placed at risk.

This was a breach of Regulation 19(1)(a)(b)(2)(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection effective measures were not in place to protect people from the risk of abuse. The home's safeguarding policy could not be located so therefore was not available for staff to reference. Many of the staff we spoke with were unclear about what constituted an adult safeguarding concern. Staff were not up-to-date with safeguarding training. We found that sufficient improvements had not been made to protect people from the risk of abuse.

We asked for the home's safeguarding policy and were provided with a policy that belonged to another organisation. This policy had been made available in the staff tea room for staff to read. When we pointed out it was not the home's policy we were then provided with a printed copy of Sefton Council's adult safeguarding policy. The manager was unable to explain why the home did not have its own policy. We checked the training records both the manager provided us with and the records provided by the previous manager on the 28 August 2015. Not all staff had received training in adult safeguarding, including refresher training.

We observed two people living at the home had bruises to their faces. Staff were unable to explain one of the bruises but did inform us that one person with a bruise had been assaulted by another person living there. We spoke with the person's relative who said, "I was upset when I saw her eye. I dread the phone going in case it's a call to say she has been hit again. It happens a lot. Some of the people don't like her. It was worse last time. She had two big black eyes. A man [person living at the home] hit her because she went into his bedroom. I worry in case she gets hit badly." We overhead two people living at the home shouting at each other. One person said to the other, "Shut up, or I'll shut you up". Relatives were present and had to intervene when one person tried to hit the other person with a plastic waste paper bin. Staff were not present when this incident occurred.

We reviewed the incident forms held by the service. Most incidents related to altercations and events between people living at the home. We could see that these incidents had been reported to Sefton Social Services as safeguarding alerts but CQC had not been notified of all of them, particularly incidents that had occurred since the last inspection. Because we lacked confidence that the provider had notified CQC appropriately, we requested from Sefton Social Services all the safeguarding referrals involving incidents between people living at the home since July 2014. We reviewed these alongside the notifications received by CQC. Seventeen safeguarding referrals were identified and at least nine of these were of a very concerning nature. There were clear themes to these incidents and they could have been avoided if the provider had put robust risk management measures in place, including effective staff supervision of the shared areas at all times.

This was a breach of Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care records to see what risk management arrangements were in place for the people who displayed behaviour that put other people living at the home at risk. Neither the risk assessments nor care plans contained sufficient detail. For example, the documentation for a person just stated they had 'challenging behaviour' but how this behaviour manifested was not described. Care plans lacked detail in terms of how staff should respond to behaviour that challenges. For example, a care plan stated, 'Staff to monitor for triggers; keep challenging behaviour records; de-escalation techniques to be used.' A description of the triggers the person presented with and de-escalation techniques specific to the person were not defined. The provider had advised Sefton Social Services in a 'Provider Response Form' on 20 May 2015 that the lounges would be attended

by a member of staff at all times and that staff would monitor the people living there closely. During our two day inspection we found that staff were not monitoring the lounges at all times.

In addition, we looked at the care records for two people at risk to falling. One person's risk assessment stated, "[Person] is at risk of falling down the stairs if she attempts the stairs unaided." The stair gates were identified as a control measure. Each of the two sets of stairs had stair gates in place. One stair gate had no locking mechanism and the bannister was moving freely. We found that the other stair gate was easy to open. This meant the person and other people at risk could access the stairs. There was not a risk assessment in place for the stair gates.

Over the two inspection days we observed that people living at the home made use of all three lounges and the two dining areas. We observed closely how staff monitored all these areas. There were long periods of time (up to 20 minutes) when no staff were present or even checked these areas, in particular the three lounges. We went up to a person who was shouting for assistance. They said, "I'm sick of shouting for them, they don't come". Twice during the inspection we had to seek out staff assistance for this person. This lack of staff monitoring meant people were at risk to falls and at risk of harm from other people living at the home.

This was a breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Given the absence of on-going staff monitoring of the shared areas, we asked people living at the home and families who were visiting their views of the staffing levels. A person living there said, "It's quite poor – short staffed". A family member told us, "The carers do a great job but there does not seem to be enough of them around." Another family member said, "What bothers me is that there is not enough staff. I was told by the last manager that it was laid down in law how many staff are needed. How come they get their breakfast just before lunch?" We heard from a family member that, "There should be four [carers] on but there are three at the moment."

We also asked staff their views. Some staff opted not to give their opinion of the staffing levels but others were very unhappy with the staffing levels on both days and nights. A member of staff said, "We are struggling with staffing levels all day. If anyone is off sick we get no cover. How can we give them good care & attention." Another member of staff told us, "I think we could do with some more [staff]. Some of the clients are quite difficult. Normally we have one member of staff in the lounge by the front door, one member of staff in the furthest lounge and one walks round". One of the night staff said to us, "It's not enough [staff] because of workload. If someone needs to go to hospital [you lose a staff]. There are three floors to cover. It's okay when there is one nurse and three carers. It's not easy with just two carers." The home had three members of staff on nights as a temporary measure until Merseyside Fire and Rescue Authority was satisfied that sufficient measures had been put in place in the event of a fire during the night.

At 10.15 am staff were still supporting people with their morning routine and then bringing them to the dining room for breakfast. We asked staff why breakfast was still being served so close to lunch, which was usually served at 12.00 noon. Staff advised us it was due to the reduced staffing levels in the morning, which meant people had to wait longer for staff to support them to get up.

The staffing levels during the day had been reduced since our previous inspection. In July 2015 the staffing levels during the day were one nurse, four care staff and a full time manager who was supernumerary Monday to Friday. At this inspection the levels were a nurse-manager with 10 hours supernumerary (negotiable with the owner) time for management duties per week and three care staff. The manager said this was because the number of people living there had dropped from 23 to 22. The duty rotas confirmed this drop in staffing levels.

The manager explained that based on the dependency tool used by the provider there was sufficient staff in place at all times. We looked at this 2009 tool and noted it was produced by the Regulation and Quality Improvement Authority for Northern Ireland and not England. The nurse took us through the dependency needs of all the people living there and could see that the dependency of at least one person had significantly increased since the previous inspection. During the day there were three care staff to cover three floors within the home. Nine people needed a hoist supported by two staff to move. In addition, eight people presented with behaviour that challenges and five people needed assistance with feeding. We concluded that

Inadequate

Is the service safe?

the staffing levels were wholly inadequate to ensure people's safety and in particular there was not enough staff to ensure the shared areas were monitored by staff at all times.

Furthermore the skill mix of staff was inadequate. The registered nurses on days, including the manager, were general trained. Training records informed us that very few of the general trained nurses employed had completed training in dementia care or the management of behaviour that challenges. This was concerning as the people living there had either mental needs and/or needs associated with a diagnosis of dementia. A mental health trained nurse had recently been appointed to work on days.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Such was our concerns regarding the management of medicines by the registered nurses we reported the matter to the Nursing and Midwifery Council (NMC). The NMC is the UK regulator for nursing and midwifery professions.

Inadequate

Is the service effective?

Our findings

The comprehensive inspection of Balliol Lodge Nursing Home in July 2015 identified breaches of regulation in relation to providing an effective service. The 'effective' domain was judged to be 'requires improvement'. This inspection checked the action the provider had taken to address the breach in regulation and was also in response to concerns raised by other stakeholders. The breach was in relation to the provider not adhering to the principles of the Mental Capacity Act (2005).

At the previous inspection we found that people were given their medication disguised in food or drink (often referred to as covert medicine) without the service doing so in accordance with the Mental Capacity Act (2005). This is legislation to protect and empower people who may lack mental capacity to make their own decisions, particularly about their health care, welfare or finances. Arrangements had still not been made to involve the pharmacist so they could advise with disguising medicines in food or drink safely. In addition, there was still no information recorded to guide staff as to how covert medicines should be managed for each person.

Deprivation of Liberty Safeguards (DoLS) had been submitted to the Local Authority for each of the people living at the home. Some of the DoLS had been authorised and some were awaiting a DoLS assessment. DoLS is part of the Mental Capacity Act (MCA) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

The service had revised the way it conducted mental capacity assessments. The assessment was now linked to the 'activities of living'; a widely used nursing model of care. This meant all the people living there had a mental capacity assessment in place that assessed their capacity to make decisions for matters, such as breathing, sleeping and communication. This was not in accordance with the principles of the MCA and demonstrated a clear lack of understanding of the MCA on behalf of the provider, manager and nursing staff. Some people living with dementia had no family to represent them and there was no information in place to suggest that complex decisions they may need support with had been considered, such as support with managing personal finances.

The manager confirmed that the staff team had not received training in the MCA. We asked a member of staff what they understood by the MCA and DoLS and they told us they had never heard of those terms. Staff did not understand what we meant when we asked them about restrictive practices.

This was a breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At 10.15 am on the second day of the inspection we were observing activity in a dining area. One of the people sat at a dining room table said to us, "I have had nothing to eat yet. We are getting neglected." The person pointed to the person sat opposite and said they had not had anything to eat either. We sought out a member of staff who said the person had eaten breakfast but had forgotten. We insisted the person was given something to eat as they were asking for food. At 10.25 am the person was given cornflakes, which they readily ate. They were also given a cup of tea from a tea pot that had been there for some time. We asked the person to check the temperature of the tea and they confirmed it was cold.

We observed lunch on the first day of the inspection. The pureed diets were delivered first to the dining area in bowls at 12.05 pm but staff did not start supporting people with feeding until 12.20 pm. Some people waited longer until staff were free to feed them. A member of staff started to feed a person when the meal had been sat on the table for at least 20 minutes. We intervened to ensure the member of staff gave the person a meal that was at a suitable temperature. Because the pureed diets were all mixed together, we asked what it was. The chef said it was vegetables, potato and gravy. We asked about protein and were informed that the meat was not ready on time when the pureed meals were prepared so the people on pureed diets would get meat at tea time.

Although some people had been sat at the table since 11.45 am, the main meal was not served until 12.22 pm. It was a roast beef dinner but people on soft diets were given minced meat and mashed potato to minimise a risk of choking. We observed that other people were unable to cut their meat. One person put a large slice of meat in their mouth and seemed to have difficulty chewing it. This meant they were at risk of choking. We did not see staff

prompting, encouraging or supporting people with their meal. We observed staff take plates away from the table with food left on them and without asking the people if they had finished.

A person was still sat at the table with their uneaten lunch at 2.15 pm. We asked staff if they had been offered an alternative. The member of staff said, "[Person] doesn't eat much. He has supplements, Ensure or something." The member of staff was unable to confirm for us if the person had had their supplement. We noticed another person sat in the lounge at 1.30 pm with three uneaten sandwiches they had been given for lunch.

We asked about drinks and snacks between meals as we did not seen any served throughout the inspection. A relative said to us, "I've never known there to be a break [drinks] in the morning. How could there be with lunch served so close to breakfast. Things need to be better organised. Having a tea trolley would be a social event." A member of staff said, "If they have breakfast late they will wait until 12.00 pm for a drink but they can have a drink if they ask." We pointed out that many people living with dementia may not be able to ask for a drink. Another member of staff said snacks were not served between meals and that the people got a biscuit with their drink at 6.00 pm. This meant people could potentially not have anything to eat or drink for over five hours.

Staff told us that tea, coffee, hot chocolate, Horlicks and cordials were regularly offered to people. They confirmed that water was not routinely offered to people as a drink.

This was a breach of Regulation 14(1)(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although all the staff we spoke with confirmed they had had supervision recently with the manager, they were not up-to-date with training to support them in their role. We confirmed that there were deficits in the staff training programme for moving and handling, adult safeguarding and the MCA. Further examples included gaps in dementia care training and first aid training.

At the last inspection and again at this inspection staff told us the training via DVD was not very good and that some of the DVDs were out-of-date. We asked to see these DVDs but the manager was unable to locate them.

We looked at the induction record for the maintenance person recently employed. The induction was not role-specific but was the same as the induction care staff received, even though the role was very different.

This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the families we spoke with said their relative living at the home could see a doctor, chiropodist or optician when they needed. We asked families if staff discussed with them the health needs of their relatives. A family member said, "Yes, every day I come in." Another said, "If I go and ask them they tell me." We could see from the care files that a record was made when people had input from health professionals including the GP, optician and chiropodist. Some people had received specialist health care input when necessary. This included input from the local community mental health team and the speech and language therapy service.

Using a nationally recognised dementia-friendly home assessment tool, we determined that the service did not provide a dementia-friendly environment. For example, people living at the home did not have sufficient toileting and washing facilities appropriately located to use. This was because there was a number of bathrooms and toilets out of use for various reasons. One bathroom was not being used because the bath hoist was broken. A shower was not been in use for some time because of low water pressure. Colour contrasting in bathrooms had not been used, such as different coloured toilet seats to support people to locate the toilet. Although some signage was in place on doors, it was not particularly suitable for people living with dementia.

Lounges were not laid out in a way that encouraged small group conversation and engagement. There were no points of interest, such as photographs or artworks of a size that could be easily seen. Memory boxes or similar were not in place. Some areas of the home had been painted since our last inspection but contrasting colour had not been used to support people to locate rooms easily, such as finding the toilet or their bedroom. People did not have independent access to the garden.

A large clock was located in the hall way but it would not have assisted people with orientation to time because it had not been altered when the clocks went back. There

Inadequate

Is the service effective?

were three notice boards in the dining areas and all had different dates recorded; two had dates in November and the other included a date in August. We asked a person what date it was and they looked at the board with the August date. The person looked confused when we told them it was the 5 November 2015. Despite pointing out to staff on the first day of our inspection that these various dates could add to people's confusion, the dates on the notice boards had not been changed on the second day of the inspection.

This was a breach of Regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

The 'caring' domain was rated as 'requires improvement' following the comprehensive inspection in July 2015. This was because people living at the home and their relatives were not routinely involved in care reviews and menus were not made available to relatives when they requested them. Staff notices and reminders were displayed in the dining area, which meant the area which did not lend itself to a homely environment.

The staff notices had been removed. Menus had been produced and were displayed on dining room tables. However, the layout, font type and font size was not dementia-friendly, and/or suitable for a visually impaired person to read.

Families spoke well of the staff. A family member said, "The staff are brilliant". Another family member told us, "It's excellent - like a family here." Families said that the staff were kind, caring, and treated their relatives with dignity and respect. Families told us they could visit whenever they wished. They said they were not formally involved in care reviews but said the staff communicated promptly about changes to their relative's care needs.

We found the majority of staff were kind and caring towards the people living at the home. However, they were rushed and at times seemed stressed. They told us it was because they had so much do and there was not enough staff. Not all staff demonstrated a caring or respectful attitude towards people. We heard a member of staff say "shut up" through the glass window in the nurse's office to a person who was shouting in the dining area. The person did not appear to hear this. We heard the same member of staff say in a sharp tone to a person who was asking for his wife, "She's at home with the cat."

We heard a person living at the home ask a member of staff to take her to the toilet. The staff member told her to go on her own, which she did. We then found the person sat on the toilet directly across from the front door with the door wide open. We closed the door. The person had no support to flush the toilet or wash their hands. We later saw another member of staff accompany the person to the toilet.

At lunch time on the first day of the inspection a person living at the home was persistently asking for their dessert. A member of staff said in a dispassionate way and in ear shot of other people, "If you are going to start I will have to remove you from the dining room. I've explained you can have a sweet when they come up. I can offer you a banana." The person then asked the member of staff to help with peeling the banana and was told by the same member of staff, "You're more than capable of opening a banana." The person received no help peeling the banana.

At the previous inspection we observed people sat in hoist slings all the time. We questioned staff about this. They reassured us the slings were special ones to minimise the risk of pressure ulcers developing. However, we perceived it to be undignified to be sat in a sling all day. National guidance suggests that if a person needs to sit continually in a sling then this should be risk assessed and a care plan developed outlining the reason for this practice. None of the people sat in slings had a relevant risk assessment or care plan in place to support this practice.

The manager identified five people living at the home who did not have family to represent them. Advocacy services had not been approached to provide representation for these people. This meant the people did not have independent support with decision making, and planning and reviewing their care.

We observed a 'Stool chart' pinned to the wall above a toilet used by the people living at the home. It was based on the Bristol Stool Scale; a reference tool for health professionals to classify stools. However, this chart was comparing stool types to chocolate bars. It was inappropriate and disrespectful to have such a chart on display in the bathroom of the home people live in. We asked staff to remove it.

We spoke with a person who represented another regulatory body. They had visited the home on 2 November 2015. They said one of the women living there was sat in the dining room and was naked from the waist up. They informed a member staff who started laughing and told them not to worry and said, "She is always doing that." A man living at the home came into the dining room and the person heard a member of staff refer to him as a 'pervert'. We looked at the women's care record and did not see a care plan outlining how staff should provide support to dissuade the person from removing their clothes in shared areas of the home.

This was a breach of Regulation 10(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

The comprehensive inspection of the home in July 2015 identified a breach of regulation because there was a lack of choice at meal times. The 'responsive' domain was judged to be 'requires improvement'. This inspection checked the action the provider had taken to address the breach in regulation and was also in response to concerns raised by other stakeholders.

We spoke with the same relatives who had told us previously about the lack of choice at meal times. They said this had improved and that the quality and choice of food was better now. We observed that there was choice at lunchtime. However, the main meal served was not the meal identified on the menu. This could be confusing for people if they were expecting the meal on the menu but received something different.

The care records were more orientated to people's physical health needs with much less of a focus on people's needs associated with mental health or dementia. Similar to our findings at the previous inspection, the care records were not person-centred. Information about people's life, background and interests was both lacking and variable. The life history, dietary preference and social profile sections in the care records we looked at were mostly blank or, at best, contained limited information. We asked a member of staff how they found out about people's likes and dislikes. They responded with, "We just speak to them." From our time spent with people living at the home, it was clear some people would be unable to coherently express their preferences. It is important that such information is recorded early on before people's memory or cognitive ability deteriorates. There was no information in the care records we looked at to suggest that families had been consulted if their relative was unable to provide this background and personal information.

There was a section in the care records to include each person's preferred arrangements for meal times. The word 'arranged' was recorded alongside each meal time in all the records. The member of staff who completed the records was on duty so we asked about this and they said this meant each meal was 'arranged' for the person. This did not make sense and showed a lack of insight into a person-centred approach to care provision.

We asked families if their relatives had a choice as to whether their relative was supported with personal care by a male or a female. Three family members said they had not been consulted about this. A family member said, "The nurse showers him. He's not been asked if he would like a male or female carer. It doesn't bother him that he hasn't got a choice." Another family member told us, "I don't know to be honest but it wouldn't bother her."

Some of the people living there, in particular the men were unkempt; one man had food spillage down the front of his clothing. Some men had body odour, unwashed hair and were unshaven. One man said he could shave himself but "couldn't be bothered". We asked another man if he was growing a beard and he said he did not know. Staff told us some of the men were reluctant with personal care and this was confirmed in the care records. However, there was no evidence that staff spent time periodically trying to encourage and prompt the people who were reluctant with personal care. We noticed that the finger nails of a person sat waiting for their lunch were encrusted with dirt. A staff member supported the person to wash their hands but their finger nails were still dirty. The member of staff later told us the dirt was faeces and that the person's finger nails were often like that. This showed that people were not being adequately supported with their personal care.

An activity coordinator had been in post during our previous inspection but they had not been in work for over two months. A family member said to us, "The person who did the activities was very good but she is not there now. Since she has gone there is not much in the way of activities. She did baking with them, planted seeds and encouraged them to write." Over the two day inspection we did not see any activities taking place. The television was on in all three lounges. In one lounge a person liked to watch particular films and had hold of the remote control. In another lounge Jeremy Kyle was on in the morning. We asked people if they liked that programme. They said, "I just watch what's on." None of the people we spoke with said they went out.

Staff told us they sometimes took people out locally but this was not recorded anywhere. A member of staff said, "We take them out shopping and they watch films. We try to do as much as we can." In comparison to the previous inspection, we saw very little social interaction between staff and the people living there. Staff appeared to be rushed and busy and the only interaction was when a

Inadequate

Is the service responsive?

person was being moved, supported with feeding or giving medicine. A member of staff said, “Less staff hasn’t affected the way we look after them [people living there] but we don’t have much time to sit with them.”

We asked families about activities. They told us they had not seen any happen. A family member said about their relative, “He sleeps and watches TV.” Another family member said, “At the moment she doesn’t do anything.”

This was a breach of Regulation 9(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Families told us they knew how to complain. A complaints procedure was in place. There was an audit trail to show how complaints had been dealt with, including a complaints log and correspondence regarding each complaint. The one complaint we looked at had been resolved within a reasonable timeframe.

Inadequate

Is the service well-led?

Our findings

The comprehensive inspection of the home in July 2015 identified a breach of regulation because effective systems and processes were not in place to assess, monitor and improve the safety and quality of the service. The 'well-led' domain was judged to be 'inadequate'. This inspection checked the action the provider had taken to address the breach in regulation, and was also in response to concerns raised by other stakeholders.

A registered manager was not in post as they had left the service shortly before our inspection in July 2015. The new manager who had been appointed before the July inspection left in September 2015. In addition, a deputy manager who started working at the home in October 2015 had left by the time of our inspection.

One of the registered nurses, who had worked at the home for approximately 18 months had been promoted to nurse-manager. The plan was for the nurse-manager to work within the staffing numbers but with 10 hours supernumerary, negotiable with the owner, for managerial tasks. We highlighted our concern about this low number of managerial hours especially given the concerns we were finding with the service. To effectively address concerns we found with the service would require significant managerial input. The nurse-manager was planning to apply to register as a manager with CQC.

We checked to see if the ratings from the July 2015 were displayed as it is a requirement to do this within 20 days of publication of a CQC rating. The report of the last inspection was located in a magazine rack in the foyer. It was amongst other documents and was not clearly displayed for people to see.

We asked with families who were visiting the home at the time of our inspection their views of how the home was managed. A family member said, "I'm happy with who is running it." Another family member told us, "The manager is alright; very approachable. I think it is better with less people in. When it is full they are jammed together against the wall like sardines." Another family member said, "It upsets me the amount of managers they have had over the years."

We also asked families what they liked about the home. A family member said, "It's handy. I don't have to rely on transport." Another family member told us, "They [staff] are all friendly." We also sought the views of families as to how the service could be improved upon. A family member said, "They could do with more activities and entertainment."

Families told us relative's meeting were held at the home. We were provided with a copy of the minutes from the meetings held on 13 September and 29 October 2015. The meetings were well attended by families. Issues raised at the first meeting included: the need for more one-to-one activities; request for drinks to be provided mid-morning; investment in the building and the smell from the toilet opposite the main entrance. Families highlighted at the second meeting that meals provided were not always those shown on the menu. They also said that food came from the kitchen before people were ready to eat. In addition, families enquired about the lack of snacks throughout the day. We also identified all of these issues and were not given assurance that plans were in place to address them. At the last inspection a family member pointed out a small television in one of the lounges and said they had told the manager that the television was too small for their relative to see. We noted that the same small television was still there. This showed that the provider had not acted on feedback from families.

Staff were pleased with the new manager and a member of staff said, "The manager is new but I think she is very good." We asked staff what improvements had been made since the inspection in July 2015. They told us nurses had been doing more paperwork and the building has been painted outside. Staff were unsure what we meant when we asked what challenges the service faced.

Staff said there was a whistle blowing policy but some said they had not read it. A member of staff said, "We've got a policy in the office but being under all this pressure I haven't sat down to read it." They said they would challenge practice if they were concerned about something.

We asked staff what communication systems were in place so they could provide feedback and share views about the service. They said staff meetings were held every month. We were provided with the copies of the minutes from the last two meetings held. We looked at the minutes of the meeting held on 17 August 2015. It was clearly recorded that staff advised the manager there were not enough staff in the morning as people were not having breakfast until 10.30 am, followed shortly by their lunch. The staffing levels

were dropped in the morning after this meeting. The minutes of the meeting held on 22 October 2015 informed us that staff asked for beef to be taken off the menu as people found it hard to chew; beef was on the menu on one of the days of the inspection. The following was recorded in the minutes, "Can we ensure that a member of staff is around the lounges at all times they are occupied." It was clear from our findings at the inspection that feedback from staff had not been taken into account in the way the service was run.

We observed a notice in the kitchen and nurses office advising staff they were not to contact the owners unless it was an emergency. We asked why this had been placed there and none of the staff knew why. The manager and staff told us that the provider visited the home regularly. We were not provided with recorded evidence of how these visits were used to audit or monitor the service. We asked the provider for an urgent action plan following this inspection in light of the serious concerns we had found. The action plan provided was not sufficient so we were not confident that people would be protected from the serious risk of harm.

We asked the manager about the systems in place to monitor the quality and safety of the service. We were provided with a range of audits or checks. The audits were either not effective as they had not identified the issues we had found or actions identified from the audits had not been addressed. For example, a full environmental audit was carried out on the 27 July 2015 identified a radiator cover in a person's bedroom needed fixing to the wall. It also identified a 'foul smell' in the bathroom opposite the main entrance. We found these same issues when we inspected on the 29 July 2015 and again at this inspection; many other actions also identified in the audit had not been rectified.

Medicine audits took place but they were not sufficiently robust to recognise the serious failings in how medicines were managed; it took a visit from the Clinical Commissioning Group (CCG) to discover the concerns. A process for auditing care records was in place. We looked at two completed audits; one from June 2015 and the other from October 2015. Both members of staff who completed the audits had since left the service. As the audits did not include the names of the people whose records had been audited, we were unable to establish if the actions had been completed.

We reviewed how accidents and incidents were analysed to identify themes and patterns. We looked at the analysis for August 2015 and September 2015. There was no structure at all as to how incidents were analysed and both months were completed by different staff taking different approaches. This lack of structure and absence of measurement criteria meant that themes could not be clearly or easily identified. There was no evidence that the service had identified the themes we had picked up.

Operational policies were not up-to-date as they were not reflective of the service provided and/or national guidance. Examples included the medicines policy and the health and safety policy. A policy on restraint was in place yet staff told us they did use restraint and were not trained to do so. Policies were not readily available for staff to reference as they were stored in the manager's office, which was locked when the manager was not in work. We raised this issue at the last inspection and were advised that the policies would be made available to staff at all times. This had not happened

This was a breach of Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the completed incident forms in the home and also reviewed the adult safeguarding referrals to Sefton Social Services alongside statutory notifications received by Care Quality Commission (CQC). It was clear that CQC had not been informed of all events the provider is required to legally notify CQC about.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2014.

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 Medicines were not managed in a safe way. The premises and equipment were not safe. The risks to people's safety were not effectively managed.

The enforcement action we took:
CQC used its urgent powers to close the home

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 Safe staff recruitment process were not in place.

The enforcement action we took:
CQC used its urgent powers to close the home.

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 People living at the home were not protected from abuse.

The enforcement action we took:
CQC used its urgent powers to close the home.

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 Sufficient numbers of staff were not on duty at all times to ensure people were safe and received effective care.

The enforcement action we took:
CQC used its urgent powers to close the home.

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 11 HSCA (RA) Regulations 2014 Need for consent The service was not working within the principles of the Mental Capacity Act (2005)

The enforcement action we took:
CQC used its urgent powers to close the home.

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 People's nutritional and hydration needs were not being met.

The enforcement action we took:
CQC used its urgent powers to close the home.

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 Staff had not received sufficient training or supervision and had not received an annual appraisal.

The enforcement action we took:
CQC used its urgent powers to close the home.

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 The environment had not been adapted to ensure it was meeting the needs of the people living there.

The enforcement action we took:
CQC used its urgent powers to close the home.

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 10 HSCA (RA) Regulations 2014 Dignity and respect People's privacy and dignity was not maintained.

The enforcement action we took:
CQC used its urgent powers to close the home.

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 The care and support was not individualised or person-centred.

The enforcement action we took:
CQC used its urgent powers to close the home.

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 Systems and processes to monitor the safety of the service were not effective.

The enforcement action we took:
CQC used its urgent powers to close the home.

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 CQC were not being informed of events the provider is required to notify CQC about.

The enforcement action we took:
CQC used its urgent powers to close the home.