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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The first day of this comprehensive inspection was unannounced, which meant the provider did not know we were coming. It was conducted over two days on 12 October and 15 October 2015. The manager of the home was given short notice of the second day of our inspection.

Barrisle Care Home provides nursing and personal care for up to 40 adults who have mental health needs or who 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 provided, but each bedroom has a wash hand 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 08 May and 12 May 2015, when we found the registered provider had breached a total of 13 regulations of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 and two of the Care Quality Commission (Registration) Regulations 2009. The breaches related to person centred care, safeguarding service users from abuse and improper treatment, meeting nutritional and

Summary of findings

hydration needs, dignity and respect, need for consent, safety and suitability of premises, staffing, fit and proper persons employed, safe care and treatment and good governance. These significant failings resulted in each domain of the report being rated as, 'inadequate' and therefore an overall rating of 'inadequate' was awarded.

As the overall rating for this service was inadequate, the Care Quality Commission (CQC) placed the home into special measures and further enforcement action was taken. Our guidance states services rated as inadequate overall will be placed straight into special measures. 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.

A formal notice of proposal was issued under Section 26(4)(a) of the Health and Social Care Act 2008 to cancel the provider's registration in respect of the regulated activities, which were being carried on at Barrisle Care Home. We asked the provider to submit an action plan telling us how and when they would make improvements. This was received and the service was closely monitored by a wide range of community professionals and the CQC, during which time regular support was provided.

At the time of this inspection there was no registered manager appointed. However, a manager had recently been employed, but at that time had not submitted an application for registration to the CQC. She was on duty on both days of our inspection. 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 cleanliness of the premises was found to be satisfactory. It was pleasing to note that some improvements had been made to the general environment of the home. However, some areas were still in need of modernising and updating. The manager was in the process of introducing a dementia friendly environment, so that those who lived at Barrisle could experience a meaningful lifestyle.

Systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations, to ensure they were safe for use. However, during our tour of the premises and the external grounds of the home we found several areas, which were unsafe and therefore this did not protect people from harm.

We looked at medication practices adopted by 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 being well managed.

Areas of risk had not always been managed appropriately and the correct procedures had not always been followed to safeguard those who lived at the home. Consent had not always been obtained before care and treatment was provided and legal requirements had not always been followed in relation to Deprivation of Liberty Safeguards (DoLS). New staff were appropriately recruited and therefore deemed fit to work with this vulnerable client group.

Induction programmes for new employees were not always formally recorded. Some staff members we spoke with told us they did not have an induction when they started to work at the home. This included agency staff. Supervision and appraisal meetings for staff were irregular and not structured. 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 on the days of our inspection. Some improvements had been made to the training programme for staff since our last inspection, which was pleasing to note. However, we found that training in relation to the management of challenging behaviour had not been delivered, which we considered to be an important learning module for those who worked at Barrisle Nursing Home.

Summary of findings

We found that people's privacy and dignity was not always respected and their health care needs, including nutritional support, had not always been met. Guidance from community health care professionals had not been consistently followed. This meant that some people did not receive the care and support they needed. 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 bathing and showering arrangements were very task orientated and did not allow choice and control. We have made a recommendation about this.

We spoke at length with the activities co-ordinator, 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 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, fit and proper persons 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. The home remains in special measures, due to the fact that one or more domains remained inadequate and also an overall rating of inadequate was given.

You can see what action we told the provider to take at the back of the full version of this report. We are continuing to take enforcement action against the service and will report on that when it is complete. Therefore, this service remains in special measures.

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.

Some risk assessments had been conducted. However, these were not always person centred and did not consistently reflect people's needs accurately. The correct procedures were not always being followed in order to safeguard those who lived at the home from abusive situations and medicines were not being well managed.

Infection control protocols were being followed. However, we found some areas of the premises and external grounds were unsafe for those who used the service.

At the time of this inspection there were sufficient staff on duty and recruitment practices were thorough enough to help 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.

There were no structured mechanisms in place for staff support, such as formal supervision sessions and annual appraisals, as these were found to be irregular and informal.

We noted some improvements in the area of staff training. Mandatory learning programmes were provided for the staff team and additional modules were available, in relation to the specific 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, consent had not always been obtained before care and treatment was provided and 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.

People's health care needs, including nutritional support were not always being met. Staff members did not always interact well with those who lived at Barrisle and consent had not been obtained in relation to various areas of care and treatment.

Is the service caring?

Requires improvement

This service was not always caring.

Summary of findings

People's privacy and dignity was not always promoted. However, staff were seen to engage with people in a kind and caring manner and people, in general, were well presented.

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?

Requires improvement 

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 new manager was in post. This was the fifth manager appointed during the previous five months. This did not demonstrate good leadership and did not promote team stability, which had a negative impact on the care and support delivered for those who lived at the home.

Records showed that annual surveys were conducted for those who lived at the home and their relatives. A staff meeting had recently been held and meetings for people who lived at the home and their relatives had been arranged.

Systems for assessing the quality of service provided had not been sufficiently established and therefore it was not evident that the home was adequately monitored, so that any improvements could be implemented, in accordance with the results of a robust auditing mechanism.

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 12 October and 15 October 2015 by four Adult Social Care inspectors from the Care Quality Commission, who were accompanied by a specialist pharmacy advisor, a specialist dementia care 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 and their relatives, as well as observation of the day-to-day activity.

At the time of our inspection of this location there were 37 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 or answer our questions. However, we were able to speak with three of them and five family members. We also spoke with five staff members and the 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 nine people who used the service and the personnel records of five staff members. We 'pathway tracked' the care of six 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) before the last inspection, five months previously. Therefore, we did not request another to be submitted on this occasion. 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.

Prior to this inspection we looked at all the information we held about this service. At our last inspection on 08 May and 12 May 2015 we had found significant failings at the service. We reviewed notifications of incidents that the provider had sent us since our last inspection, such as serious incidents, injuries and deaths. We were in regular discussion with local commissioners and community professionals about the service provided at Barrisle Nursing Home. As a result of these discussions and notifications a decision was made to re inspect the service as a full comprehensive inspection to follow up on previous findings.

Inadequate

Is the service safe?

Our findings

There were mixed responses about staffing levels within the home. The relatives we spoke with thought that, in general there were enough staff on duty. However, one person who lived at Barrisle told us, "No (not enough staff), not for what they have to do. It's very hard work for them." We asked people if staff responded quickly to requests for help. One person told us, "I don't normally have to wait long" and a relative said, "Generally, they're very good."At our last inspection in May 2015 we found that this service was not safe. We observed that confrontations between people were not appropriately managed and people's needs were not anticipated well. Risk assessments were not consistently reflected within the plans of care. There were failings in medication administration systems and there was little evidence of leadership and organisation. Recruitment practices were not thorough enough to ensure only suitable staff were appointed to work with this vulnerable client group.

During our previous inspection we spoke at length with one particular person who lived at the home, who was very unsettled and unhappy because she had been placed in a home for people who lived with dementia or a mental illness. She was very complimentary about the staff team. However, she did not suffer from any mental health condition and therefore felt she had been misplaced at Barrisle Nursing Home. During this inspection we noted this person still lived at the home. We spoke at length with her again. She told us, "I'm still not happy. I've not got dementia and I find this place very hard and very lonely. I'm still waiting for another social worker. There are one or two residents I'm a bit wary of. When I sit here I feel on edge. I am frightened of a couple of residents."

One relative told us, "[Name removed] is at risk of falling. He has a 1:1 care worker at night. I come here from 10.30am to 4.15pm. When I'm not here with him he goes in the lounge. If I wasn't with him he would have to stay in the lounge from 8am to 10pm." Another relative commented, "I think [name removed] is vulnerable from other residents."

Some of the people who used the service had very complex needs and sometimes presented in a manner which could be a risk to themselves and those around them. We saw that people's risk assessments and care plans were not person centred in this respect. There was a generic tick box risk assessment which listed a variety of behaviours but contained little information about individual triggers or how to safely support the person in challenging situations. In one case we saw that the home had been advised by external professionals to improve the behavioural support plan for one person, but this had not been done. It was also noted that the support plans in place referred to 'methods of control' rather than 'methods of support' which was of concern.

We saw various risk assessments in people's care plans in areas such as falling, moving and handling or skin integrity. However, these were not dated or signed and only minimal information was provided. They had not been reviewed regularly and we found some examples which did not reflect the current circumstances of the person. This meant that staff were not always provided with up to date guidance about how to support people in a safe manner and protect them from harm. We viewed the care plan of one person assessed as being at very high risk of developing pressure ulcers. Whilst the risk had been identified, there was no plan of care in place to reduce the possibility of skin damage due to pressure.

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.

We spoke with one person who used the service who advised us she had experienced a physical assault by another person. When we looked into this further we saw that staff had recorded an incident which had taken place several months previously but this was not reported through safeguarding procedures.

Some information we saw in one staff member's personnel record was concerning and resulted in a safeguarding referral being made to the Local Authority at the time of our inspection, as the correct disciplinary procedures had not been followed in order to ensure the safety of those who lived at the home. This situation related to three witnessed safeguarding incidents involving a staff member, which had not been referred through the correct safeguarding procedures. Statements from those who witnessed the incidents, along with notes from a disciplinary meeting were on file. An initial decision was made to suspend the member of staff in question, followed by possible dismissal following disciplinary proceedings. However, this decision

was then overturned without a satisfactory explanation. There was also no detail within the hand written notes as to why the decision was overturned, who had made the decision or when the decision was made. There was further hand written notes stating that the issues would be addressed through regular supervisory sessions. The next recorded supervision session was five months later and the record of this meeting failed to mention the previous incidents or if the staff member in question had received appropriate training to prevent similar behaviour. This issue of concern was discussed with the manager of the home and a company representative at the time of our inspection. Appropriate disciplinary action was then taken retrospectively.

None of the staff spoken with had been provided with up to date training in supporting people with challenging behaviour. This meant there was a risk staff did not have the necessary skills or knowledge to support people in a safe manner.

We found that the registered person had not protected people from abusive situations, because safeguarding procedures had not been appropriately followed. This was in breach of regulation 13 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our tour of the premises and external grounds of the home we identified areas, which needed to be made safer.

The garden was untidy with cigarette ends littering the floor near to the patio doors and general clutter around the barbeque area was evident. Paving flags were uneven, so this would have made it difficult for people with mobility problems to walk in the garden, even with support. At the time of our inspection the grounds of the home were unsuitable for people to access safely.

We were told that the communal toilets next to the lounge area were only utilised by one person. We noted that the lighting was very poor in these toilets, one toilet basin was dirty and wheelchairs were stored in the narrow corridor, which blocked the entrance to the furthest toilet facility.

We observed that the notice board in the main entrance did not lock and contained drawing pins which were easily accessible and which could have dropped to the floor. This did not consistently protect people from harm.

One vacant bedroom was being refurbished at the time of our inspection. We noted that the room was full of tools, including power tools, and was only locked with a simple latch at floor level. We were told by a member of staff that previously this room had been left with no locking mechanism at all, so people could easily access dangerous tools, as well as walk into a hazardous environment.

The sluice room near the nurses' station only had a simple latch at the top of the door to keep it locked and this was not in place several times throughout the first day of our inspection. This meant that those who lived at the home could easily access the sluice room, which contained soiled clothing and bedding, floor mops and detergent. Despite this being brought to the attention of staff members at the time, this sluice was still unlocked later in the day.

A second sluice room was also only secured with a small latch at the top of the door. Again, we tested this door on several occasions and found it to be unlocked on some of those occasions. A store room that contained toiletries was locked, but the key was kept on a hook next to the top of the door, which was easily accessible by anyone within the home.

One of the gates securing the garden area was in a state of bad repair. Clinical waste bins were stored directly outside people's bedrooms, which was unsightly for those who lived in these rooms. On the second day of our inspection one of the clinical waste bins was overflowing, which posed a danger to the public. However, these bins were emptied later that day. We were told that alternative accommodation for the bins was being looked into.

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.

At the time of this inspection we checked the medicines and medication records of five people, who lived at the home. We spoke with six members of staff including the registered manager, deputy manager, two registered nurses and two care workers. We found that most of the records we looked at had photographs attached and any allergies were documented appropriately. This was in line with current guidance and reduced the risk of medicines being given to the wrong person or to someone with a specific allergy.

Inadequate

Is the service safe?

We observed the morning medicines being given to four people who lived at the home. One care worker who was present knew the people very well, as they were able to support those who had become anxious about taking their medicines. The morning medicine round took a long time to complete, finishing at 1pm in the afternoon. This meant that the lunchtime medicines had to be significantly delayed.

We observed that one person was given a large tablet to swallow whole, which should have been dissolved in water. The person took this medicine with a cup of tea. Another person was given a liquid medicine to help them to swallow their prescribed tablets, which is against medicine guidelines and this liquid medicine should be taken separately from all other medications.

Medicines were not always given as prescribed by the doctor. One person was not given their inhaler for several days, as the inhaler device was not in the home. A person who was prescribed a medicine to thin their blood should have had a new dose prescribed by the hospital clinic, following blood tests. Although a blood sample had been sent, the home had not checked why a new dose had not been prescribed by the hospital and so they continued to administer the previous dose.

A bottle of liquid medicine, which had a short shelf life, did not have the date of opening written on it. This made it difficult for nursing staff to know exactly when the medicine expired. We checked the total balances of medicines remaining for five people who lived at the home. It was difficult to check the quantities recorded, as medicines from previous months were not accounted for. For example one person should have had 72 tablets left in stock, according to the Medicines Administration Record (MAR). However, there were 114 tablets in stock.

The fridge temperatures were not recorded every day. The temperature of the drug fridge should be maintained between 2°C and 8°C. However, the temperatures recorded ranged between -2°C and 20°C. Members of staff were unaware of how to reset the fridge temperature after a reading had been taken. No action had been taken for the temperatures recorded below 2°C or above 8°C. The fridge had opened chocolate bars belonging to people who lived the home and a wound swab for one person was being stored there, both of which should not have been kept in the medicine fridge.

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 that these were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place prior to them being offered employment. We also saw good evidence that references had been sought from previous employers. At least two forms of identification, one of which was photographic, had also been retained on people's files. All personnel files contained a signed copy of a job description and terms and conditions of employment. Staff members we spoke with confirmed they had been police checked as being fit to work with vulnerable people through the Disclosure and Barring System (DBS).

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. Staff spoken with were aware of action they needed to take, should they be concerned about the safety or welfare of someone who lived at Barrisle Nursing Home.

In discussion the manager advised us that staffing levels had been reviewed in conjunction with the local Clinical Commissioning Group (CCG). This is a clinically led statutory National Health Service body responsible for the planning and commissioning of health care services for their local area. Agreement had been made to increase the levels of care workers and the number of qualified nurses on duty at any time. Records seen confirmed this information to be accurate and the increase in staff numbers was being achieved with the additional use of agency staff, until the manager had the opportunity to recruit additional staff. This did not promote continuity of care. However, staff we spoke with told us that whenever possible the same agency staff were utilised, so that those who lived at the home were familiar with them, which is an important aspect of providing care and support for this vulnerable client group.

Inadequate

Is the service safe?

One member of staff we spoke with told us he felt people were 100% safe. He confirmed that the number of care staff on duty during the day had recently increased from six to eight and that agency staff were on duty every day to cover holidays and sick leave. We were told that working at Barrisle could be stressful as most staff worked twelve hour shifts and many people who lived there had challenging behaviour. However, we were told that staff did get breaks away from the floor during that time.

An infection control policy was in place at the home and we noted the premises to be clean and hygienic throughout without any unpleasant smells being identified. There was evidence of cleaning staff and we witnessed spillages being cleaned quickly with appropriate warning signs in place. However, during our walk around the home we noted cleaning schedules had not been completed for one week. Aprons, gloves and hair nets were used by staff and these were changed throughout the day.

Accidents 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.

We were told there were plans to create a sensory garden to the rear of the premises, which sounded very positive. Work had also taken place to clear a number of trees from the outside area to let more light into the home. We had a lengthy discussion with the maintenance manager for the organisation who talked us through the changes they were making and the progress of outstanding areas. There was an action plan in place and we saw that some progress was being made. However, further improvements were still needed.

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.

We were told by the manager that a business continuity plan was under development. Personal Emergency Evacuation Plans (PEEPs) were in place. The purpose of these is to provide guidance for any relevant party, such as the emergency services, about how each person would need to be evacuated from the building in the event of an emergency, should the need arise. For example, in the case of fire or flood. However, the PEEPs we saw did not always correspond with the information provided in other records, such as care plans and risk assessments. This therefore, provided staff with conflicting information about people's abilities.

It is recommended that the PEEPs be brought in line with other documentation, so that information provided is consistent.

Inadequate

Is the service effective?

Our findings

One person who lived at the home told us that she felt the care workers provided effective support for her. She said, "I've no complaints with them (the staff). None whatsoever." She told us that the care staff understood her needs well, but added, "There's nothing they can do about it (the loneliness). I appreciate that and I try not to be demanding." This person told us she was able to talk with some of the staff if she was worried. She told us, "The new manager seems to be lovely and the staff are always kind and respectful."

At our last inspection in May 2015 we found this service was not effective. New staff had not completed a formal induction programme. Staff were not well supported. Freedom of movement within the home was evident. However, people's rights were not always protected and they were at risk of being deprived of their liberty. Staff members did not interact well with people and consent had not been obtained in relation to various areas of care and treatment. People's nutritional needs were not consistently being met and people were not supported, when necessary with their meals.

At the time of this inspection one visitor we spoke with told us, "I help (name removed) with his food. If I didn't help him he might spill it." Another commented, "There are a lot of staff work here that are not permanent, but they have to make the numbers up." And a third stated, "The staff are lovely with mum, but they are quite vague when asked about bruises. They are trying to improve. They seem to have recently taken in a lot of noisy people, which sets mum off."

Other relatives commented, "I'd say they (the staff) are quite good. Nobody's perfect. They're very helpful"; "Some are (competent) and some aren't. Some are very dismissive. The laundry ladies are particularly good." And "They are very capable."

The manager told us that the home was working closely with the Care Home Effective Support Service (CHESS) to review people's care plans and to ensure their health care needs were being addressed. The CHESS team has been developed with an aim to supportolder people in care homes to meet their health care needs. The nurses within the team have clinical assessment skills to be able to diagnose and treat episodes of acute ill health for people in care homes.However, we viewed one care plan that had been reviewed with this team and found that none of their advice in relation to the person's health care had been followed. The CHESS team had provided the home with an action plan in August 2015, advising measures be taken to further safeguard the person in relation to their diabetes, skin condition, blood pressure and mental capacity, but in viewing the care plan, we found none of these measures had taken place.

We had concerns about one person's health care. Staff had failed to closely monitor their blood sugar levels, despite the fact they were erratic and frequently too high. The person's levels should have been checked twice every day, which according to records rarely happened. On most occasions, they were checked once each day and on one recent occasion, had not been checked for three days. In addition, staff had failed to take appropriate action such as seeking further medical advice, despite the person's levels frequently being raised. The same person had some ulcers which had first been identified almost a week previously. The ulcers had started to show signs of infection and the person had been advised that antibiotics would be obtained several days before the inspection. On the day of our inspection the antibiotics had not been arranged. We spoke with this person who was very worried about her ulcers and upset that she had not yet seen a doctor. We discussed this with the manager of the home. Arrangements were made for the individual to see the doctor later that day.

We found that the registered person had not protected people against the risk of unsafe care or treatment because health care needs had not been consistently met. This was in breach of regulation 9(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can

only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

There were various consent forms in place in people's care files. However, in many cases these were not signed. Therefore, formal consent had not always been obtained from people and records were not available to demonstrate that people had given their consent to specific areas of care or treatment, such as the administration of medications, the taking of photographs or the use of bed rails. We viewed the care plan of another person who had a mental capacity assessment on file. This stated that she was 'unable to consent' but didn't state what she was unable to consent to. Such assessments should be decision specific to ensure the person's care is as least restrictive as possible.

We found that the registered person had not ensured people's rights were always protected, because consent had not been obtained prior to the provision of specific areas of care and treatment. This was in breach of regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. 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. However, they were not being followed in day to day practice.

We observed one person who used the service constantly asking to leave the home and asking staff to help him get out of the door. At one point we saw that the person became quite distressed. This person was unable to open the door as there was a keypad in place that he was unable to use. We checked this person's care file and found that there was no mental capacity assessment and no application had been made to the local authority to deprive him of his liberty. This meant the person was being unlawfully detained. We found this concerning, as we had identified this restrictive practice in place five months earlier and had advised a Deprivation of Liberty Safeguard application to be made for this individual at that time. We were aware that other professionals had advised the manager of the home on several occasions, to submit this application.

One person was sitting in a recliner chair and was unable to get out unaided. We reviewed the care records of this person and found a mental capacity assessment had been completed in 2009 and again in 2015. Both stated the person lacked capacity. There was a risk assessment for restraint, which included the recliner chair and bedrails but there was no evidence available to show a DoLS application had been made, consent had been obtained or a best interest decision meeting had been held.

We saw one person frequently request to leave the home to go to a relative's house. A mental capacity assessment for this individual determined they did not have the capacity to make decisions, but this did not identify what decisions they were unable to make. A DoLS application had not been made to enable the staff team to lawfully detain the individual at Barrisle Nursing Home.

During our inspection we walked along the corridor with the yellow bedroom doors. We found all the doors to be locked. We knocked on many of them, but there was no reply. However, someone shouted to us from inside one bedroom. We tried to open the door, but it was locked. We asked the person if they were alright and they said they were. The person invited us in, but said they did not have a key to open the door. The person was not distressed by being in a locked room. We spoke with staff about this, who did not seem to be aware that someone was in a locked bedroom. We advised that staff check all the other bedrooms, to ensure no-one was locked in, without being able to get out of their bedroom. We were later informed that all bedroom doors had been opened, to ensure people were not locked inside.

We found that 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 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the manager of the home about the Deprivation of Liberty Safeguards (DoLS). We were told that 12 applications had been submitted since out last inspection, which was pleasing to note. However, it was

unclear which ones had been sent. The manager believed the ones submitted were the urgent ones, but was unsure. We saw that an urgent DoLS had been made for one person on admission to the home. There was some delay in requesting a standard authorisation, as the management team understood that one made in the previous care setting was also applicable for the person, whilst living at Barrisle, which is not the case.

The meal time we observed appeared more of a task orientated affair, rather than a potential for meaningful activity. Some people ate in the dining room and others were served their meals in the lounge areas. Some people were asked what they preferred for lunch, but the majority of choices were made by staff members. Initially this was a very chaotic and noisy procedure, with at least six members of staff serving up the food.

The level of noise in the lounge where some people were dining was very loud with staff and residents all talking over each other. The TV remained on. There were no comments made by staff in relation to this. We did observe two members of staff assisting people with their meals, whilst standing over them. This gave the impression of being rushed and did not create a pleasant dining experience for the individuals concerned. However, the majority of care workers did sit beside the people they were assisting.

One of the main menu choices was hot dog, served on a white finger roll with onions and red sauce. This was served with potato wedges. Once people started to eat, it was clear that the food was very hot. However, no warning had been given by the staff to alert people to be careful. The hot dogs were very difficult to pick up and eat. We saw two people eat the sausage first and then attempt to eat the dry bread roll. People were not asked if they needed help cutting up their food. However, one person was brought a plate guard after a care worker noticed he was struggling. One person did not eat any of his lunch and alternatives were not offered. After the meals had been served in the dining room all the staff left with the lunch trolley to serve those who were dining in the lounges. Once they had left the quietness in the room was tangible and people were left to eat their meals unsupervised. One person attempted to take food from another person's plate. This resulted in some friendly banter, but could have escalated into something more serious.

One person was left at the dining table with two drinks, his hot lunch and a pudding in front of him. This appeared confusing for this individual. People who live with dementia can usually only concentrate on one task at a time and therefore putting too many different things in front of them at the same time can often lead that person to lose concentration and stop eating altogether. This could be easily remedied with simple but effective staff education.

Drinks and snacks were offered at regular intervals, but these were often refused because of people being so sleepy. This activity appeared to be very task orientated, with staff needing to complete the job of providing beverages. Staff did not return to those who were asleep and try to encourage them to take some fluid. It was not clear how people's fluid and dietary intake was monitored.

We viewed a nutritional risk assessment for one person who was at high risk of malnutrition. However, because nutritional guidance had not been followed the risk assessment reflected inaccurate results. This was despite the CHESS team advising staff that the risk assessment was incorrect and needed to be reviewed in light of the person's recorded Body Mass Index (BMI) several months previously. Weight charts were erratic and some showed extremely big differences in a short period of time. However, this had not been followed up by staff which meant they were not checking how people's weights had changed over time or following up potential risks.

We observed one person choking with their meal. One staff member suggested they be referred to the Speech and Language Therapist, but this was immediately dismissed by another staff member. The staff member implied it was becoming a regular occurrence. We looked at this individual's care file, but there was no information around episodes of choking or if it had happened previously. A senior member of staff asked another staff member to observe this person whilst they were eating lunch, but as soon as the senior left they walked off to undertake a different task.

We reviewed the weight records for people who lived at the home and saw some erratic results, from significant weight losses to massive increases in weight. However, there was no evidence in the relevant care files to indicate what the provider was doing to support these people. The records of one person at high risk of malnutrition stated he needed to be weighed each month. However, his weight charts showed that this instruction had not been followed in day to day practice. One food chart showed that someone was on a pureed diet and this indicated how many mouthfuls of

diet had been taken. This individual's plan of care stated they should be offered snacks in-between meals, as they were losing weight, which was clear from the records we saw. We looked at their food and fluid charts for the previous two weeks, which did not demonstrate that snacks had been offered. Records also showed that this person always declined Weetabix, yet it was consistently offered each morning. However, despite them liking cake and custard and porridge, these were not offered any more frequently.

We saw one person walking around the home. They were accompanied into the dining room to have their breakfast. The staff member assisting this person was interrupted and their attention was diverted. When they looked back the person they were helping had gone. No further attempts were made to encourage this individual to eat their breakfast and their weight had not been recorded.

We found people were at risk of malnutrition because people's dietary needs were not being well managed. This was in breach of regulation 14(1)(2)(4)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We established that as people got up throughout the morning they were offered a staggered breakfast, which consisted of porridge, a cooked breakfast and beverages. We were told that the arrangement of meals had recently been altered to benefit those who lived at the home. A main meal was now served in the evening and a lighter lunch was provided, due to the breakfast being staggered and therefore some people eating later in the morning. This was considered to be good practice, as the new arrangement appeared a very effective way of ensuring everyone had a cooked meal during the day and that providing a staggered breakfast did not impact on this.

The menu board was outside the dining room and this displayed the menu choices for the day. There was a choice of hot and cold meals at lunch time. There was also a hot pudding available.

However, this was hand written and would be difficult to decipher for people who lived with dementia. There were a variety of sandwiches and crisps available and one person reported that the vegetable soup was nice. There were no picture formats of the meals served, which would have encouraged choice and discussion. Menus could provide a source of interest and communication between those who lived at the home, the staff team and family members. However, the manager told us that this was in the process of being arranged.

There was a white board in the dining room used as a 'birthday' board. There were no birthdays on the day of our inspection, so this was left blank. This could have been used as a better resource, as it was in such a prominent position. However, it was pleasing to see that the home acknowledged people's birthdays.

Dining tables were set with colourful tablecloths and brightly coloured drinking vessels. Everyone was provided with paper aprons tied around their necks. There were no serviettes available, as an alternative, although there was a box of tissues on the window sill that were used by the staff to help people keep clean.

We observed meals being provided in one of the lounges, where more dependant people dined, some of whom needed assistance with eating. The care workers sat beside the individuals they were assisting and offered regular prompts. There was evidence of some people coughing due to their diet of hot dogs and potato wedges. It may have been more appropriate to offer a softer diet.

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. One relative commented, "The food is very nice. It really is lovely, but they (the staff) don't cut up the food for mum. They just put the plate of food in front of her with a knife and fork, which she cannot use."

At the time of our inspection there was a broad range of staff on duty, with different skills and qualifications. We looked at the personnel files of five members of staff. The records of one member of staff showed no evidence that the person's three month probationary period had been completed or formally signed off. One person's file did not contain any evidence of an induction taking place and other people's inductions were in the form of a tick list and slides from a presentation being placed within their files. Some staff members we spoke with told us they had not received a formal induction when they started to work at Barrisle, but others said they shadowed longer standing members of staff for about a week, although did not think there was any formal recording of an induction programme being provided.

Inadequate

Is the service effective?

There was an agency nurse on duty at the time of our inspection. We noted she was carrying out a medicines round and providing various aspects of care. We were advised this was the nurse's first shift. We spoke with the manager and requested to see evidence that the new agency nurse had been inducted. We were told this had not been done although the manager stated agency nurse induction was normal procedure. We asked the manager if a profile had been provided by the agency regarding the nurse's training and skills. We were told this had not been provided. This meant the manager had failed to check the agency nurse's skills, competence and suitability to support people who used the service.

Records we looked at showed that formal supervision of staff was irregular and staff appraisals were sporadic. This meant there were no structured processes in place to assess the work performance and professional development of staff. Therefore, support mechanisms for the staff team were not effective.

We found that the registered person had not ensured persons employed had received appropriate support, 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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the external trainer for the organisation, who provided training for staff on site at the home. On the first day of our inspection he was delivering learning modules in relation to record keeping, report writing and communication. He told us that courses were ordinarily well attended, with an average attendance rate of approximately 95%. The external trainer was returning the following day to deliver training about challenging behaviour and safeguarding vulnerable adults. He gave us some examples of other training he had delivered to the staff team, including support planning and nutritional screening.

The external trainer told us that he had seen big changes at the home recently and he described the new manager as, 'outward looking' and he said she had 'taken the bull by the horns' in terms of tackling issues at the home. He told us that staff were competent and person centred, but that systems within the home still needed to be improved. He went on to tell us that there was openness, which meant that frank discussions about what still needed to be improved were had.

We were told that a new e-learning module was being produced to support face-to-face training delivered and that systems were being put in place to make it easier for night staff to attend training. The external trainer finished by telling us that he felt a lot of effort had been made by the home with regards to training and improving the workforce at Barrisle. We saw evidence of training certificates in all, except one of the staff files we examined, which included areas such as infection control, challenging behaviour, dignity in care, health and safety and safeguarding vulnerable adults.

Registered nurses were on duty at all times and some care staff had achieved a nationally recognised qualification in care. It was pleasing to note that training for staff had improved since the last inspection. Staff we spoke with told us that they received sufficient training now, although this area had been poor in the past. Records showed that mandatory training was provided, along with modules specific to people's needs.

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 throughout. We were pleased to note that the manager of the home was in the process of developing a dementia friendly environment for those who lived at Barrisle. This encouraged people to explore their surroundings and provided them with opportunities to stimulate exercise and to relieve boredom, as well as enabling people to orientate themselves to their environment. However, some areas were still in need of upgrading and modernising, in order to provide a homely environment and pleasant surroundings for the people to live in. This was discussed with the manager at the time of our inspection, who confirmed this was included in the programme of renovation at the home.

Requires improvement

Is the service caring?

Our findings

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. However, care plans did not always outline the importance of promoting people's privacy and dignity and promoting their independence.

At our last inspection in May 2015 we found that 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.

At this inspection we observed two situations in which people's privacy and dignity was not respected and independence was not appropriately supported. For example, one person was served his lunch without cutlery and so he began eating his food with his fingers, which was not finger food and therefore was undignified for the individual concerned. We saw one person having their toe nails cut in the hallway. This did not promote the individual's privacy and dignity.

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.

We saw people being supported to eat by one staff member who was called away to get a cushion for another person who had fallen asleep in a chair. The staff member did not communicate with the person they were supporting. They returned some minutes later without any conversation.

We looked at the care plan of one person who was very recently bereaved. This person was described to us by a staff member as being 'broken hearted.' We found that their care plan made no mention of their bereavement and there was no reference to any emotional support she may have required. The person's daily notes did on occasion refer to the fact that emotional support had been provided, but these occasions were few and far between.

We observed one person being moved from their seat at a dining table to a lounge chair. They were not asked if they wanted to move. They were told they were going to be moved to a 'comfy' chair, without any agreement from them.

We spoke with a relative of someone who lived in the home. We were told that their family member needed a haircut and that they had asked staff a couple of times, but it had still not been done. They told us that sometimes their relative's finger nails were long and dirty and that they had to ask staff to get things done. One relative asked about the possibility of a priest visiting their loved one, as religion was an important part of their life. This was discussed with the manager of the home, who assured us that the next time the priest visited, which was regularly, she would ensure he visited this particular person.

We used the Short Observational Framework for Inspection (SOFI) on the first day of our visit to Barrisle Nursing Home. SOFI is a way of observing care to help us to understand the experience of people who could not talk with us. We carried out the SOFI during the evening meal time.

There were initially ten people, who were dining in the particular lounge, where we were conducting our SOFI observation. One other person joined us approximately ten minutes later. This meant that, including staff, there were 16 people in this room. The television was on and the volume was turned up to 'loud.' Three people were shouting at various times which, along with the television, other people talking and the amount of people in the lounge area meant the meal was chaotic and not conducive to a pleasant dining experience.

We found that the care and treatment of people did not always meet their needs, was not always appropriate and did not consistently reflect people's preferences. This was in breach of regulation 9(1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff to be patient and caring towards those who lived at Barrisle. Staff appeared to know people well and what individuals liked and disliked. We saw staff laughing and joking with people in an appropriate manner and chatting with them in a kind and caring way. However, we did observe one person slumped in their chair whilst quietly asking for help. It took five minutes for staff to notice this individual and offer the necessary assistance for them to sit up and eat their meal.

Requires improvement

Is the service caring?

People's needs were not always 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. However, most people who lived at the home were better presented than at our last inspection, which was pleasing to see. They were clean, with tidy hair styles and men were shaven. However, one person we saw was dressed in stained clothing and dirty shoes.

Records showed that people were able to access the support of advocacy services, should they so wish. An advocate is an independent person who will help people to make decisions about their care, support and daily activities, which meets their rights and is in their best interests.

Requires improvement

Is the service responsive?

Our findings

One relative we spoke with told us, "It would be better if there were more activities. The staff have Jeremy Kyle on TV. This is for the benefit of the staff. The home is the carers' home and not the residents'. Residents are very bored and that is why there are problems." Another commented, "My relative would love to watch Oklahoma or South Pacific or something pleasant. She would like to have a walk out more often. They (the staff) don't listen to you."

At our last inspection in May 2015 we found that this service was not responsive. The assessments of people's needs 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.

During this inspection of Barrisle Nursing Home we looked at the care files of nine people who lived there and who had quite different needs. We 'pathway' tracked the care of four of these people.

We found that care plans contained a picture of people's daily care needs, although this information was limited and very brief. The plans of care lacked person centred information such as how people wanted their care to be provided and what was important to them on a daily basis. We also found that in some cases, the information in people's care plans was difficult to understand and often contained contradictory information. For example, we viewed the care plan for one person, which indicated that she was able to mobilise with the use of a zimmer frame, but in another section of her care file it stated she was unable to weight bear and required full assistance with transfers. This provided confusing and conflicting information for the staff team.

We found evidence that people's care plans were not always updated to reflect changes in their needs and quite often reviews of plans of care stated, 'No changes in needs', despite the daily diaries showing that there were some significant changes prior to the review taking place. We looked at the communication section in a care plan belonging to a person whose health had deteriorated in recent months. We were aware that the person was no longer able to speak as a result of their worsening health, but their communication care plan which had not been reviewed for a period of over four months, made no mention of this change in circumstance.

There were gaps in people's care plans which meant important aspects of their care were not addressed. For example, we viewed the care plan of one person which stated they regularly became distressed and screamed and shouted. However, there was no support plan in place for this.

There was very little information about people's social care needs in the care files we looked at.

Forms were in place to record people's social histories, important relationships and significant life events, but these had not often been completed. There was no information about people's valued hobbies and pastimes or how they liked to spend their time. In one example, we saw a very significant recent life event was not recorded and there was no information regarding any additional support the person may have needed.

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 did not accurately reflect people's needs and was not always sufficiently person centred. We also found that 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.

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.

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.

Some plans of care we saw were a little more person centred, providing staff with better information about how people's needs could be best met.

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

Is the service responsive?

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.

Relatives we spoke with told us that they would be able to raise concerns with the manager of the home, should the need arise. 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. We saw several written compliments from relatives of people who lived at Barrisle.

There was a new activity co-ordinator employed at the time of our inspection. She appeared very enthusiastic and passionate about her role and the potential for improvement at Barrisle, although this was still evolving. She showed us future plans for the garden area, which would make it more accessible for people to use, with raised flower and vegetable beds and a sensory and wildlife area, with more appropriate garden furniture.

There was evidence of a new timetable, which came into effect just prior to our inspection. This outlined morning and afternoon activity sessions, including 1:1 input for those being nursed in bed. Other activities included on the programme were 'cook and eat' sessions and trips out in to the local community and other places of interest. Communion services were offered each month by local ministers, so that people were able to continue to follow their religious beliefs, whilst living at Barrisle Nursing Home. We were told that relatives were encouraged to participate in all the activities provided. At the time of our inspection these plans were in the primary stages, but with management support, improvements in this area could be made.

On the day of our visit we saw the activity co-ordinator providing nail care for some people who lived at the home. She also spent quality time chatting with people on an individual basis. During the afternoon one lounge area was set up to resemble a cinema. A film was chosen by those who wished to participate and ice cream cones were served. Those who joined in appeared to enjoy their afternoon, 'At the movies'.

Other plans included the development of "This is me" booklets, which would provide more individualised information gathered with the input of family and friends wherever possible. A more structured activity record for each person who lived at Barrisle had also been recently introduced, which over time could identify anyone who was susceptible to isolation or who was becoming withdrawn.

We observed staff encouraging activity with one person during their 1:1 support. This was achieved through colouring, dominoes and ball games. However, a large proportion of people spent most of the morning asleep. Some memory boxes had been purchased and were in the early stages of being developed. We also saw one person busily cleaning the dining chairs after breakfast. He was being appropriately supported to complete this task, as he enjoyed doing this each day.

There was evidence of plans to develop and provide a more therapeutic day for people. However, for this to be effective there needed to be specific plans in relation to a more structured approach and identified support for the activity co-ordinator. Simple meaningful activity could be encouraged for the more mobile people, rather than a member of staff just following them around the home.

Throughout the day we observed staff members interacting with people in a warm and positive manner and it was clear they were knowledgeable about those they were supporting. We saw a member of staff reassuring one person who was upset in a meaningful way, which prompted further conversation and enhanced positive interaction, which was pleasing to see.

There was evidence of people being offered choices, in relation to what time they got up in the morning and this was confirmed through our observations. This meant that breakfasts were staggered throughout the morning, dependant on what time they arose.

We noted that the arrangements for bathing and showering were very task orientated, which did not enable people to make choices. There was a list on the notice board, which stated the days of the week people were to be bathed or showered, rather than when they requested or when they needed this personal care to be offered. Staff we spoke with told us this list was used at 'handover' to tell them which people were to be bathed or showered on that particular day. We noted from the bathing records we looked at in detail that the frequency of bathing or showering was between seven and ten days.

Inadequate

Is the service well-led?

Our findings

One relative we spoke with commented, "There's no transparency. It goes from one disaster to another." Another told us, "It winds me up and frustrates me. I would like to see more interaction with people. It would be nice to not see mum sitting in the same chair all the time" and a third said she felt improvements in the home had been made. This family member told us that her relative had put on weight since she was admitted to Barrisle Nursing Home and she looked much better.

At our last inspection in May 2015 we found that this service was not well-led. A temporary manager had been in post for three days. We had not been formally informed of the current absence of the registered manager. 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.

At this inspection a new manager was in post, who was striving to make improvements at Barrisle Nursing Home. However, this was the fifth manager appointed in five months and the management structure of the organisation had also changed several times. This did not provide any management stability and therefore expected improvements were slow.

We found that in one person's care file there were documents belonging to another person, who lived at the home. This did not demonstrate good record keeping and did not promote confidentiality.

We found that the registered person had not maintained people's confidential records in a safe and secure manner. This was in breach of regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told by the manager of the home that progress was being made towards improved care planning and that ten care plans had been rewritten, with the support of a variety of community health care professionals. We were also told of plans for future developments. This included implementing a quality monitoring tool, which would incorporate all the key questions used by inspection teams. A range of audits had been commenced since our last inspection. However, many of these had not been continued over the previous four months, despite them being recognised as monthly audits. Therefore, this area was still in need of significant improvement, so that the service could be sufficiently monitored under a continuous assessment process.

We spoke with a health and safety audit group, who had recently been appointed by the organisation to audit their registered locations and at the time of our inspection, they were conducting a full health and safety audit of Barrisle Nursing Home. This group was also appointed to develop an employee handbook and develop a risk assessment tool for the care homes within the company. We asked the provider to send us a copy of the audit once completed. This was received as we requested, which identified some areas of none compliance with health and safety regulations. At the time of our inspection we were unable to evidence that a consistent robust mechanism had been implemented to effectively assess and monitor the quality of service provided.

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.

The management team acknowledged a cultural shift was required and said they had spoken with the staff team, who were clear of steps needed to be taken in order to move the service forward. We were told that the care certificate was to be introduced as the new induction programme and that new staff training tools were also to be developed, which would be competency based. This would include a clear training plan and would help to ensure the staff team were able to deliver the care and treatment needed by each individual who lived at the home. We were also told that under the new systems, reviews of care plans would be comprehensive and audits would be robust.

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. During this inspection we identified a situation of alleged abuse, which had occurred since our previous inspection and which not been managed appropriately. We reported this under safeguarding procedures and the home then took appropriate disciplinary action retrospectively.

Inadequate

Is the service well-led?

We found that the registered person had failed to notify the Care Quality Commission of a safeguarding incident. This was in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We saw notices displayed in the home inviting people to attend a residents' meeting and one for their relatives or friends. Minutes of a recent staff meeting were also seen. These meetings had recently been introduced and would allow people to discuss any topics of interest and to talk about any concerns or areas of good practice within an open forum. 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.

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.

We found many aspects of the management style to be more reactive than pro-active. This was most likely due to no consistent leadership of the home and a regular change of the management team. 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.

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 still Inadequate, we have decided that the service will remain in 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 still Inadequate, we have decided that the service will remain in 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 11 HSCA (RA) Regulations 2014 Need for consent We found that the registered person had not ensured people's rights were always protected, because consent had not been obtained prior to the provision of specific areas of care and treatment.

This section is primarily information for the provider

Enforcement actions

Regulation 11(1)(2)(3)

The enforcement action we took:
As the overall rating for this service is still Inadequate, we have decided that the service will remain in 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 were not protected against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not being well managed.** Regulation 12 (1)(2)(g)

The enforcement action we took:
As the overall rating for this service is still Inadequate, we have decided that the service will remain in 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, 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 still Inadequate, we have decided that the service will remain in 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	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	We found people were at risk of malnutrition because people's dietary needs were not being well managed. Regulation 14(1)(2)(4)(a)(c)

The enforcement action we took:
As the overall rating for this service is still Inadequate, we have decided that the service will remain in 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 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 still Inadequate, we have decided that the service will remain in 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 still Inadequate, we have decided that the service will remain in 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

This section is primarily information for the provider

Enforcement actions

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 care and treatment of people did not always meet their needs, was not always appropriate and did not consistently reflect people's preferences.** **Regulation 9(1)(a)(b)(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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **We found that the registered person had not protected people from abusive situations, because safeguarding procedures had not been appropriately followed.** **Regulation 13 (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 18 CQC (Registration) Regulations 2009 Notification of other incidents **We found that the registered person had not notified the Care Quality Commission of an incident of abuse.** **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.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People were at risk of being deprived of their liberty because legal requirements and best practice guidelines were not always followed.** Regulation 13 (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.