Rosewood Health Care Limited

Barley Brook

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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Barley Brook provides accommodation, care and support for up to 28 people who have a primary diagnosis of dementia. At the time of the inspection, 23 people were living in the home. The home is situated close to the town centre of Wigan. The home was arranged over three floors with lift access between floors.

A registered manager was in place at Barley Brook. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and are taking enforcement action. You can see what action we told the provider to take at the back of the full version of the report.

People had been put at risk because appropriate steps had not been taken to identify, assess and manage all the risks relating to the welfare and safety of people using the service. We found a number of environmental risks within

Summary of findings

the building, which had not been minimised. This made the service unsafe. In addition, the layout and design of the building was not ideal for people living with a diagnosis of dementia.

An application for a Deprivation of Liberty Safeguards (DoLS) authorisation that should have been made had not taken place. This meant the person could be subject to a breach of their human rights. We also found medication was managed unsafely and inappropriately for one person on their return from hospital.

Staff that had been employed by the service for longer than six months had received training in key areas. However, staff that had started more recently had only received a basic induction and moving and handling training whilst employed by the service. This meant they may not have the skills required to deliver care and support effectively. Staff were supported through supervision, however the appraisal system had lapsed.

Care records identified people's care and support needs and we saw evidence people's care was regularly reviewed. However, people's care records lacked detail about their personal preferences and social histories. Accurate records had not been maintained for each person who used the service.

People's nutritional and hydration needs were being met. In addition, there was evidence of people being visited by a range of healthcare professionals, which demonstrated people's healthcare needs were being met.

Staff were caring and treated with people with dignity and respect. Efforts were made in the majority of cases to support people to remain independent. We observed positive interactions between staff and people who used the service but there were missed opportunities for staff to initiate communication and engage people in conversation.

People and their relatives had opportunities to raise their views and experiences about Barley Brook. There was a complaints system place and people told us they would feel confident raising any concerns with the registered manager or other staff.

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

The service was not safe. Adequate steps had not been taken to ensure the building was safe and suitable for people living with a diagnosis of dementia. There were a number of environmental risks that had not been managed sufficently including the use of appropriate window restrictors.

Although the manager had an understanding of the Deprivation of Liberty Safeguards (DoLS), one application for a DoLS authorisation that should have been made had not taken place.

Medicines were managed unsafely and inappropriately for one person on their return from hospital.

On the first day of the inspection, staffing levels were not sufficient to ensure risks relating to the building could be managed safely, particularly during the night. Night time staffing levels were increased by the second day of the inspection and we received assurances from the registered manager that staffing levels wuld be maintained.

We found staff knew how to identify and report abuse. Recruitment checks were undertaken to ensure staff were suitable to work with vulnerable adults.

Is the service effective?

Inadequate

The service was not effective. Staff that had been employed by the service for longer than six months had received training in key areas. However, staff that had started more recently had only received a basic induction and moving and handling training whilst employed by the service. This meant they may not have the skills required to deliver care and support effectively. Staff were supported through supervision and although appraisals had not yet been undertaken these were planned for completion by the end of July 2014.

People's nutritional and hydration needs were being met. People told us they enjoyed the food and people with specific nutritional needs, such as soft or pureed diets, were catered for. Where people required assessment for their dietary requirements by professionals referrals had been made appropriately. In addition, there was evidence of people being visited by a range of healthcare professionals, which demonstrated people's healthcare needs were being met.

The design and layout of the home was not ideal for the support of people with a diagnosis of dementia. Signage within the home was limited and the layout of the building made it difficult for staff to observe people effectively with the staffing levels in place.

Summary of findings

Is the service caring?

Requires Improvement

Overall, staff at the service were caring and supported people to maintain their independence as much as was possible. People told us their privacy and dignity was respected by staff when they were receiving personal care.

We observed a number of positive interactions between staff and people who used the service. However, there were missed opportunities for staff to initiate communication and engage people in conversation. In addition, whilst many staff demonstrated they understood people's needs and preferences we observed one incident where a staff member had not recognised a person's needs, which had caused them anxiety.

People and their relatives had opportunities to raise their views and experiences about Barley Brook. There were meetings held within the home for people to raise suggestions and a survey had recently been distributed to ask people whether they were satisfied with the service. The results of the survey were on display on the staff notice board.

Is the service responsive?

Inadequate

The service was not responsive to people's needs. Care records did not always show accurate or sufficient information of people's care needs. Care records lacked detail about people's personal preferences and social histories. Risks to people's care were not always effectively identified, assessed and monitored.

Our observations and feedback from people who used the service and relatives about the availability of activities and engagement with staff were mixed. Activities were limited on the first day of the inspection. On the second day a wider range of activities were available.

There was a complaints system in use at the service, which helped ensure that people had their comments and complaints listened to and acted on.

Is the service well-led?

Inadequate

The service was not well led. Risks relating to the environment within Barley Brook were not being adequately managed. Learning from previous incidents had not been undertaken and people had subsequently been placed at risk.

There was a system in place to quality assure the care being provided. Incidents, accidents and safeguarding issues were appropriately identified and reported. However, we found that care records were not always fully and accurately completed, and that care was not always planned and delivered to meet the needs of people using the service. This had not been identified through the quality assurance process.

Barley Brook

Detailed findings

Background to this inspection

We visited the home on 07 and 09 July 2014. Our inspection team was made up of an inspector, a specialist advisor for dementia care, and an expert by experience who had experience of older people's care services. 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 all the information we held about the home including notifications received by the Care Quality Commission. We contacted the local authority, which commissions care from Barley Brook and Wigan Healthwatch to gather information about the service. We also spoke with an Environmental Health Officer from the local authority who had worked with the home.

During the inspection, we spent time observing care in the communal areas of the home such as the open plan lounge and dining area. We used the Short Observation Framework for Inspection (SOFI), which is a specific way of observing care to help us understand the experience of people who could not talk with us. We were shown around the building and saw all areas of the home.

Over, the two days of the inspection we spoke with six people and three relatives. We also spoke with six members of staff, the deputy manager, the registered manager, and the area manager. We also spent time looking at records.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.'

Inadequate

Is the service safe?

Our findings

At this inspection we found problems with the safety and suitability of the service premises that could affect people's safety. For example, next to the communal lounge a room was being decorated and therefore contained a number of hazards for people with dementia such as tools and equipment. This room was not locked. The registered manager told us this was a fire door and had to be kept unlocked, and that the risk to people was managed by one staff member being in this room at all times. An incident had taken place, the day before the inspection where a person had accessed this room, and had got out of the building through the window. A chain as opposed to a suitable window restrictor was in place, which had meant the person was able to break the chain to get out of the window. Environmental checks of the windows were not in place.

Through the room being decorated there was a small hairdressing salon. The registered manager told us this was not in use at the time of the inspection. The salon had a door to the basement in it, this door accessed steep stairs. We found the door had been left open, although it should have been kept locked. The salon led out into the back courtyard, which was untidy and contained hazards to people living at Barley Brook. Two large hose pipes had been left in different parts of the court yard on the floor. The courtyard was paved and the gaps between the paving were quite deep and in places presented potential trip hazards. The environment within the service had not been maintained and secured in a way that ensured the safety of people with dementia. This meant there had been a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

For one person, we found their medicines were managed unsafely and inappropriately on their return from hospital. Concerns identified included late and non-administration of their medicines; administration without signature; and unsafe practices in terms of re-admission procedures relating to their medicines. During the inspection the registered manager also made us aware of an attempt by a member of staff to deliver this person's medicines covertly without any agreement being in place for this. The registered manager had suspended the member of staff concerned and this was referred under the local authority safeguarding procedures and accepted for investigation. This placed this person at risk through the unsafe use and management of medicines. This meant there had been a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked people and their visitors whether they felt there were enough staff available. One person said, "No, they need more staff for their sake." Another person said, "It depends on what is happening." A third person said, "I think so." One visitor said "There are never enough staff" and another visitor said "No, they are pulled from pillar to post." We also asked staff about how they found staffing levels within the home. One of the care workers we spoke with said "Staffing levels can be quite low particularly at night when there are only two carers on." Another care worker said, "It can be hard at times if we aren't fully staffed, there have been day shifts were there are only two care workers and one senior." A third care worker said they thought the staffing levels were fine.

On the first day of the inspection, we found night time staffing levels were not safe. The registered manager told us that for a number of months, two care workers had been working the night shift, following a fall in the number of people living in the home to 15. This posed challenges for staff as the home was spread over three floors and the nature of risks on the ground floor meant that a staff member should always be present in this area of the home. The night time rota did not routinely include a senior care worker therefore medicines had to be given before the night shift came on. Without a senior care worker on the night shift, if a person needed medicines for any reason during the night they would not be able to receive it. Night time staffing levels had not been reviewed in line with an increase in the number of people living at Barley Brook to 23 people.

On the second day of the inspection, we discussed this with the registered manager who told us they thought the staffing levels at night were too low. They told us they had decided to increase night time staffing and had brought in an additional agency care worker for the night before and intended to continue with an agency member of staff until they could recuit another care worker to nights. Following the inspection, the area manager and the registered manager developed a dependency tool to review their staffing levels.

A lack of kitchen staff on the first day of the inspection meant care workers had to cover this role, which took them

Inadequate

Is the service safe?

away from being able to directly provide care and support to people using the service. We asked the manager about this and found that when a previous cook had left, one of the kitchen assistants had been promoted to a cook and this had left a vacancy for a kitchen assistant that had not been filled. The registered manager told us the area manager had just authorised recruitment to this post.

Arrangements were in place within the home for identifying and responding to any safeguarding concerns. We found the home had a safeguarding policy in place that detailed how to make a safeguarding alert. A copy of the policy was available for staff on the ground floor of the home, alongside the local authority safeguarding procedure and contact numbers. However, at the time of the inspection this was in an area of the home that was not routinely being accessed by staff due to one area of the home being refurbished. We spoke with two members of staff about their understanding of safeguarding, both had a good understanding of what abuse was and were able to clearly describe how they would respond if they identified potential abuse. On checking staff training records we found that two thirds of staff employed by the service had received safeguarding training.

The registered manager demonstrated an understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). The MCA is legislation that was designed to protect people who are found to lack the ability to make certain decisions for themselves. We spoke with a further three care workers, all of who had a good understanding of how to support people with day to day decision making and an understanding of the MCA.

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. At the time of the inspection, one of the 23 people living at Barley Brook had a DoLS authorisation in place. During the inspection, we found another person had been making repeated efforts to leave the building. On reviewing the person's care records it became apparent that an urgent application for a DoLS order should have been made on admission and this had not taken place. We spoke with the manager about this, and highlighted the importance of DoLS applications being made. The manager completed a DoLS application for this person during the inspection. The failure to correctly refer meant there was a breach of Regulation 11 (2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the recruitment records of two members of staff. Recruitment checks were undertaken before each staff member began work. We found evidence of identification taken, references received and evidence that a Disclosure and Barring Service (DBS) check was carried out prior to the new member of staff working in the service. (The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults). Both people had a signed contract of employment within their files.

Inadequate

Is the service effective?

Our findings

People told us they liked the food. One person said, "I like the food, all of it." Another person said they liked the food "half and half" and that they were given biscuits when they had drinks. The recent resident and relative survey undertaken in November 2013 also had positive responses about the food. One relative had responded "I have regular discussions with the cook regarding my relative's special diet."

The menu for meals at Barley Brook was displayed in the hall on the notice board but not in the dining room itself. None of the people we spoke with were aware there was a menu displayed in the hall. However, staff told us they asked people about what they would like to eat that day in the morning. They also said they would always look for another alternative if somebody changed their mind about what they wanted or if they didn't like their food. One person said to us, "They would find us something different if we didn't like it." There was a file in the kitchen that contained guidance for the kitchen staff about people who had specific dietary requirements and this also contained information about people's preferences.

We observed lunch on the first day of the inspection. The food looked appetising and people appeared to enjoy it. Staff wore protective clothing such as aprons. Some people had special cutlery and others had adapted crockery to eat with. This showed staff responded to people's individual dietary requirments.

The dining / room lounge felt very crowded and noisy over the meal time period and there wasn't enough tables and chairs to seat everybody in the dining area so some people sat in chairs in the lounge. People started sitting down for lunch at 12.25pm and the food was brought out at 12.50pm. The delay appeared to be the time it took staff to move people to a different seat who required hoisting or to find small tables for people to sit in their chairs to eat. The registered manager told us the lack of space and seating had also been raised by relatives and would be rectified when the new communal space was finished and became available for people to use.

Two people required assistance to eat their food. One person did not have consistent support during lunch time, and was assisted by three different people throughout the meal. This could have had a detrimental effect on their experience of their meal.

People's nutritional requirements were being assessed and monitored within the home. We checked five people's care records and found an up to date nutritional risk assessment and care plan was in place for all five people. We saw within one person's care records that a referral had made to the Speech and Language Team (SaLT), which had let to the person receiving a softened diet. At a later date the SaLT had revisited and the care plan had been reviewed and updated to reflect the person had gone back to a regular diet.

The registered manager told us that supervisions took place every three months. We reviewed the supervision matrix and found staff had been receiving supervisions up until the last few months. There had been some slippage in the delivery of supervisions due to the recent loss of senior carers. We looked at two recent supervisions and found these to have been undertaken in a positive way that focused on supporting and developing staff. Staff appraisals had not been taking place, with the exception of the registered manager's appraisal. Following the inspection, we were sent a copy of a new appraisal matrix that had been set up. All the rest of the staff employed had been scheduled to have an appraisal by the end of July 2014. This meant staff would then be given the opportunity to receive support and guidance about their work and to discuss any training they needed to undertake.

We looked at staff training records to see what training people had received. Staff that had been employed by the service for longer than six months had received training in key areas such as food hygiene, fire safety, and moving and handling. However, seven members of staff that had started in the last six months had only received a basic induction and moving and handling training whilst employed by the service. The registered managed acknowledged this and said they were looking to book people on training as soon as possible. This meant there had been a breach of Regulation 23 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff ensured people received appropriate support from healthcare professionals. We saw evidence in people's care records of contact with a range of healthcare professionals.

Inadequate

Is the service effective?

For example, one person had received visits from the district nurse for pressure areas on their heels. In addition, we saw evidence of people's mental health needs being reviewed by professionals. Staff we spoke with were able to tell us how they would respond if somebody's health deteriorated. One vistor told us their relative had been in hospital and that staff had called for medical assistance "at the right time." They went on to say "I always feel better about things when he is being cared for at Barley Brook, rather than in hospital as the staff know him better." All of the people using the service who were able to talk to us said that if they weren't well the staff would do something about it. One person said if they had a headache the staff would "bring them a tablet."

The design and layout of the home was not optimal for the support of people with a diagnosis of dementia. Whilst there was some signage such as for the bathroom and toilets this was limited. For example, people had their names and a picture of a flower on their doors but nothing specifically memorable to them. The registered manager told us they were looking to review signage throughout the home and to add a sign to people's doors that would be meaningful to them. There was no use of accent colours, art or signage to support people to find their way downstairs from their bedrooms using the lift. In addition, there was no use of areas within the home to support the maintenance of life skills or to encourage reminiscence. Throughout our inspection of the home we found the layout of the home made it challenging for staff to observe people to ensure they were not accessing areas of the home that posed a risk to them.

Requires Improvement

Is the service caring?

Our findings

Overall, people felt that the staff at Barley Brook were caring. Comments made about the staff during our conversations with people who use the service reflected that people were supported to be as independent as possible. For example, people told us they got dressed and undressed and washed with support if they were able to do this. Everybody we spoke with told us their privacy was respected and that if they were receiving care or if a healthcare professional was visiting they would be seen in their room.

During the inspection, we spent time observing care in communal areas and found the interactions between people who used the service and staff to be respectful and caring. People and visitors were regularly offered hot and cold drinks. However, there were also a number of missed opportunities for communication and staff interactions with people who use the service, particularly those that were less mobile. For example, on two occasions we observed staff using a hoist to move people. The staff members did not speak to people either when they approached them or during the task. However, later when another person was moved the staff did talk and engage with them throughout.

Barley Brook provides care and support to a number of people with a diagnosis of dementia. Due to this, the majority of people living at the home were unable to tell us verbally about their views and experiences. We spent time observing how people were supported by the staff and made use of the Short Observations Framework for Inspection (SOFI). This tool is used to help us evaluate the quality of interactions that take place between people living in the home and the staff who support them.

We undertook our SOFI observations, on the second day of the inspection, in the communal lounge / dining area on the ground floor, for a 20 minute period in the mid afternoon. Staff levels were higher on the second day of the inspection than they would be usually due to a mix up with the rota, which had meant an extra member of staff had come into work. The atmosphere in the lounge at this time was pleasent and relaxed with people sitting chatting to each other and to staff. The majority of interactions we observed were very positive.

We observed one set of interactions that caused a person using the service visible anxiety. One care worker started to play catch with a soft ball with people using the service. One person got caught on the shoulder by the ball when another person missed it and said “Don’t throw them at me. I can’t see them coming.” The care worker didn’t appear to hear this and said “But you always play.” The person responded “No, don’t throw, I can’t see.” Again the care worker did not respond to this and turned away and started to throw the ball to another person. A couple of minutes later the deputy manager came into the room with this person’s glasses and assisted the person to put them on whilst explaining about their eye sight. The person was visibly happier once they had their glasses. This highlighted that the care worker was not aware of the person’s vision impairment, and as such had tried to engage them in an inappropriate activity that had made them anxious.

Later in the observation period, a visitor came into the home with a PAT therapy dog, who was specially trained to visit care homes, so people could have the opportunity to spend time with a dog. They told us they came every Wednesday afternoon. We observed a number of people using the service were delighted to see the dog and came and stroked him and started talking to each other about the dog.

People had been given opportunities to raise their views about the care and support offered by Barley Brook. We found meetings had been held for people who lived in the home and their relatives to give people chance to provide feedback about the home and to raise suggestions. A survey had been sent to people using the service and relatives and the results were displayed on the home’s notice board.

Inadequate

Is the service responsive?

Our findings

All the people at Barley Brook were living wih a diagnosis of dementia, which for some people affected their mental capacity to make certain decisions about their care, treatment or daily lives. We asked five people who were able to talk to us about whether they had been involved in their care plan. However, nobody was able to tell us about whether they had been involved. We found evidence of involvement of some people's families in their care plans. The registered manager told us about how they had used the best interests process and worked with a number of professionals to come to the decision to administer one person's medicines covertly. We checked the person's care records and found this had been handled well and the person's friend had been fully involved in the process.

We looked at five people's care records. We found information was present about people's needs. However, there was limited information about people's life histories and background including personal preferences. Overall, we found there was a lack of consistency in both the completion of records and staff's understanding of people's individual interests and preferences. The registered manager told us care plans were reviewed monthly. On review of the care records we found reviews took place. However, we did not see evidence of people and their families being routinely involved in the review process or any changes or updates to people's care plans.

We asked one of the care workers about how they supported people to have a bath or shower. The care worker said that each staff member was linked to specific people to support them to have a bath or shower. We asked the care worker who they had last supported to have a bath or shower and they replied that they had been on leave but that other members of staff would have supported the people they were linked to in their absence. They went on to say there was a bath book they would have to complete and showed us this. On reviewing these records we found that for a number of people they appeared to have a bath or shower infrequently with some people having no bath or shower for a number of weeks. The registered manager told us this would not be the case and that it was instead poor recording and that people would have received a bath or a shower.

We tracked one person, within their daily records to attempt to establish when they were last offered or supported to have a bath or shower. It was not possible to find out from the care records when they last had a bath or shower because the daily records only referred to personal care needs being met. For this person, there was limited information about their preferences for bathing and how often they liked to have a bath or shower. In other care records more detailed information was available. This meant there had been a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager acknowledged the need for more personalised care planning. The area manager told us they were already aware that further work was required to reflect people's individual preferences and told us they had already got a date planned for delivering training in person centred care planning. On the second day of the inspection, the registered manager told us they had removed the use of the bath book and were planning on reviewing all people's care plans. They had spoken with staff about directly recording in the person's daily records when they were offered or were supported to have a bath or a shower.

Of the five people whose care we reviewed, we found concerns about the care and welfare of two people. One visitor told us they were unhappy with the care their relative had received. They said they were able to use the toilet with prompting and yet was wearing a continence pad. They felt this was detrimental to their relative retaining their ability to use the toilet independently. They also said they had been left in bed all morning and had not received either any food or their medication. On checking the person's records and on speaking to staff we found this to be the case.

Another person prior to admission had a hospital care plan that identified they were at risk of absconsion. We looked at the person's pre admission assessment and found this had not been fully completed. The risk of them attempting to leave the building had not been identified. When the person's care plan was put in place steps taken to manage risks relating to them trying to leave the building were minimal. An urgent DoLS application had not been made at the time as would have been expected if this information had been identified. The care plan put in place on admission stated "Sometimes I may try to go outside and I am not aware of my safety."

Inadequate

Is the service responsive?

We found that shortly after admission the person had left the building by breaking a chain on a ground floor window that had not been secured with a solid window restrictor. Suitable steps had not been taken to prevent this reoccurring, such as putting in place observations and assessing the environmental risks. The person's care plan was not updated to reflect how the person would try to leave the building. In addition, risk assessments were not undertaken to consider the potential areas were the person would try to leave the building. We found within the person's daily records that just prior to the inspection, there had been a further incident and the person had been able to access the room being decorated and had again been able to break a window chain and leave the home through a different ground floor window. This incident was referred to the local authority under safeguarding procedures during the inspection by the registered manager and is currently being investigated. The failure to ensure the welfare and safety of the two people identified meant there had been a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home did not employ an activities co-ordinator and there were no plans in place to do so in the future. The manager told us staff spent time with people and engaged people with activities. During the first day of the inspection activities were limited and care was focused around a routine of delivering personal care. A television was on in the lounge. We saw one staff member play a memory game with one person and two people on work experience colouring with another person. On the second day of the inspection, we saw more engagement between staff and people who used the service. In the afternoon, a PAT therapy dog was brought into the home. The dog's handler told us they had been coming to the home for many weeks and people really enjoyed seeing the dog.

The home had a complaints policy and procedure in place. The policy outlined the timescales for the complaints procedure so people could understand how long they would wait for a response. The registered manager said there had been no recent written complaints. They said people had raised concerns about the carpet within the lounge, which had since been replaced. There had also been verbal concerns raised about the amount of space available in the home. The manager told us they had responded to this by refurbishing an additional space, which would double the amount of communal living space in the home. This work was ongoing at the time of the inspection.

None of the people using the service or their relatives we spoke with were aware of the home having a complaints policy. However, people told us they didn't have any concerns but if they did they would raise these with the care staff.

Inadequate

Is the service well-led?

Our findings

The manager of Barley Brook had registered with the Care Quality Commission in May 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. One person told us they thought the registered manager was very approachable and always listened to them if they raised any concerns or had any queries.

We found there was a system in place to assess and monitor the quality of care at Barley Brook. However, overall we found this was not effective in identifying, assessing and managing all the risks relating to the welfare and safety of people using the service. This meant there had been a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We are taking enforcement action for this area and information relating to this can be found at the back of the report.

Prior to the inspection, we were aware of an incident in late 2013 where a person had been admitted to the home and within a couple of hours had left the home unnoticed by staff, fell and sustained serious injuries. This was investigated via the local authority safeguarding procedures and it was concluded that institutional abuse had occurred and that this incident had been preventable. Following the outcome of the safeguarding investigation a number of actions were required focusing on the risk management of the environment. The actions taken were followed through with the input of the fire service and environmental health. An external company was brought in to develop new environmental risk assessments and these were shown to us by the registered manager during the inspection.

Overall, we found that although the home, had responded to the incident that had been investigated through safeguarding, the learning from this had not been extended to identify other environmental risks within the home. There were no environmental checks in place to ensure the windows were secure. In addition, adequate measures were not in place to ensure people could not access areas of the home that posed a risk to them. The measures used primarily relied on staff being present to divert people. The layout of the building made it difficult for staff to manage these environmental risks with the staffing levels in place. This meant risks to the welfare and safety of people using the service had not been effectively assessed and managed.

Care plans had been audited routinely in the past, however this system had lapsed and the number of care plans recently audited was limited. The registered manager told us this system required updating as most of the auditing had been completed by the previous deputy manager who had left a couple of months earlier. The registered manager said that following the inspection they would start auditing eight care plans per month. During the inspection, we found care records were not always fully and accurately completed, and that care was not always planned and delivered to meet the needs of people using the service. This had not been identified through the quality assurance process.

An overarching provider audit was completed by the area manager, which included medication. The last medication audit was in July 2014; this was clear and included action points were improvements were required.

We found safeguarding concerns had been identified and reported to the local authority safeguarding team and the Care Quality Commission. We found accidents such as falls were being appropriately reported. We saw evidence of a fall in a person's daily notes and checked the accident book. We found this had been recorded accurately. Incidents and accidents including those relating to behaviours that may challenge the service were being recorded and there was a system for collating information about these, and which bodies had been notified on a monthly basis.

We spoke with staff at all levels of the organisation who told us they enjoyed working for Barley Brook and felt well supported within their roles. One care worker said "I love working here, I am really enjoying it." Another care worker said "It is alright here. It is nice and friendly. We work as a team and we get things done." Staff meetings took place and minutes were taken. The last staff meeting had taken place in March 2014, and another had been due to take place in June but had been rescheduled to other commitments. The registered manager said they planned to organise another staff meeting imminently.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Proper steps were not taken to ensure each service user were protected against the risks of receiving care that was inappropriate or unsafe. Regulation 9 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Suitable arrangements were not in place to protect service users against control measures being unlawful or otherwise excessive. Regulation 11 (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not protect service users against the risks associated with the unsafe use and management of medicines. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person did not protect service users against the risks associated with unsafe or unsuitable premises. Regulation 15 (1).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person did not ensure that an accurate record was maintained in relation to the care and treatment provided to each service user. Regulation 20 (1) (a).
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that all staff had received appropriate training and were supported through appraisal to deliver safe care and support to people. Regulation 23 (1) (a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers An effective system was not in place to identify, assess and manage all the risks relating to the welfare and safety of people using the service. Regulation 10 (1) (b).

The enforcement action we took:
<Action we have taken>