Mrs D J Webster

Barnfold Cottage Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection of Barnfold Cottage Residential Home took place on 18 April 2017. Located in a residential area and near to local facilities, Barnfold Cottage is registered to provide accommodation and personal care for up to 14 older people. There were 13 people living in the home at the time of this inspection.

Because the registered person is an individual, under current legislation there is no requirement to have a manager registered with the Care Quality Commission to manage this service. The registered person has responsibility for the day to day operation of the service. They have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However the registered provider told us they had asked the deputy manager to take over much of the day to day running of the service and therefore intended that this person would apply to register with CQC as manager of the service.

Our previous inspection was undertaken in December 2014 when we identified two breaches of regulations; this was because the registered provider has failed to notify CQC of certain reportable events. Following the inspection the registered provider wrote to us to tell us the action they intended to take to ensure they met the relevant regulations. During this inspection we found the registered provider had fulfilled their legal responsibility to submit required notifications.

During this inspection we identified five breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. This was because medicines were not always safely managed, proper infection control procedures were not followed and action had not always been taken to mitigate identified risks. In addition people's rights had not always been protected when they were unable to consent to their care in Barnfold Cottage. The lack of formal documented audit processes had led to the shortfalls identified during this inspection. You can see what action we told the provider to take at the back of the full version of the report.

We identified shortfalls in the management of medicines. This was because we found evidence that people had not always been given their medicines as prescribed. Discrepancies were found between the stocks of medicines and the records held for two people who used the service. In addition the system for managing controlled drugs was not sufficiently robust to ensure these medicines were not misused.

Proper infection control procedures were not followed in the home. Laundry facilities did not meet required standards. No system for colour coding cleaning equipment was in place which increased the risk of cross infection. Two large areas of peeling plaster in the main lounge area meant these areas could not be thoroughly cleaned.

Although risk management plans were in place for people, we noted one person had experienced seven falls between February and April 2017. We could not find any evidence that consideration had been given to

additional strategies which could be put in place, such as the use of a pressure/sensor mat to alert staff if the person tried to move independently, in order to help minimise the risks of future falls occurring.

The registered provider and deputy manager did not have a thorough understanding of the Deprivation of Liberty Safeguards (DoLS). There was also no system in place to review whether people remained able to consent to their care in Barnfold Cottage. During the inspection the deputy manager identified one person who potentially lacked capacity to consent to live at the home; the lack of any legal safeguards for this person meant there was a risk their rights had not been properly protected.

There was a lack of robust quality assurance processes in the home. Although the registered provider had distributed satisfaction surveys to people who used the service and their relatives, the responses to which had been largely positive, the lack of formal documented audits had led to a number of shortfalls being identified during this inspection. In addition there was no system in place to review themes and trends from accidents and incident which had occurred.

People told us they felt safe in Barnfold Cottage and that staff were kind and caring. We found people were cared for by sufficient numbers of suitably skilled and experienced staff who had been safely recruited. Staff had received the essential training to enable them to deliver effective care. They were aware of the action to take should they witness or suspect abuse and were confident they would be listened to if they raised any concerns with the registered provider or deputy manager.

Interactions between staff and the people who used the service were warm, friendly and relaxed. The staff we spoke with had a good understanding of the care and support that people required. Records we reviewed showed there was an emphasis on promoting the independence of people who lived in the home. All the people spoken with confirmed staff would encourage them to do as much as they could for themselves.

Staff told us they enjoyed working in Barnfold Cottage and felt they were well supported by the deputy manager and registered provider. Staff told us they were able to make suggestions about how the service could be improved and that their views were always listened to.

There was no chef employed in the service; instead care staff had responsibility for preparing and cooking meals as part of their duties. People gave us mixed feedback about the quality of the food but told us they were always able to have an alternative meal if they did not like what was on the menu. Systems were in place to help ensure people's health and nutritional needs were met.

We saw that a range of activities were provided to help maintain the well-being of people who used the service. People we spoke with expressed mixed views about the activities on offer with several stating they preferred to spend time in their room as they did not feel the activities were appropriate for them.

We saw that people had opportunities to comment on the care provided in Barnfold Cottage. People were encouraged to participate in care plan reviews and to attend resident meetings to share their opinions of the service.

There were systems in place for receiving, handling and responding appropriately to complaints. All the people we spoke with during the inspection told us they would be confident that any concerns they reported would be listened to and action taken by the registered provider or deputy manager to resolve the matter. We noted no complaints had been received at the home since 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always safely administered. Proper infection control procedures were not followed.

People were cared for by sufficient numbers of staff who knew the correct action to take if they witnessed or suspected abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Although staff had received training in MCA and DoLS, effective systems were not in place to identify and protect the rights of people who were unable to consent to their care in Barnfold Cottage.

Staff received the necessary induction, training and supervision to enable them to be able to deliver effective care.

Systems were in place to help ensure people's health and nutritional needs were met although we received mixed feedback regarding the quality of food.

Is the service caring?

Good

The service was caring.

People who used the service spoke positively about the kind and caring nature of staff. Staff told us, wherever possible, they would always promote the independence of people who lived in Barnfold Cottage.

Staff demonstrated a commitment to providing high quality care. They had a good understanding of the needs of people who used the service.

Care records were stored securely to protect people's confidential information.

Is the service responsive?

Good

The service was responsive.

Care records contained sufficient information to guide staff on the support people required. The records were reviewed regularly to ensure the information contained within them was up to date.

A range of activities were provided to promote the well-being of people who used the service.

People were encouraged to provide feedback on the care they received in Barnfold Cottage.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered provider was legally responsible for the running of the service. However they told us they had handed over most of this responsibility to the deputy manager who intended to register as manager with CQC.

The quality assurance processes in place were not sufficiently robust. There was no formal system of audits in place; this had led to the shortfalls identified during this inspection.

Staff told us they enjoyed working in Barnfold Cottage and were able to make suggestions as to how the service could be improved.

Barnfold Cottage Residential Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 18 April 2017 and was carried out by one adult social care inspector

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the home, what the home does well and improvements they plan to make. The provider returned the PIR within the agreed timeframe and we took the information provided into account when we made the judgements in this report.

In preparation for our visit, we also reviewed information that we held about the home such as notifications (events which happened in the home that the provider is required by law to tell us about). We also asked the local authority contract monitoring team for their views of the service.

During the inspection we spoke with five people who used the service and one visiting relative. We also spoke with the registered provider, the deputy manager and two members of care staff.

We had a tour of the premises and carried out observations in the public areas of the service. We reviewed the care records for five people who used the service and the medicines administration records for three of these people. In addition we looked at a range of records relating to how the service was managed; these included three staff personnel files, training records, a sample of policies and procedures, meeting minutes and records relating to the monitoring of the service provision.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe, secure and well cared for in Barnfold Cottage. Comments people made to us included, "I feel safe here; there's no danger", "I definitely feel safe; it's one of the reasons I came here" and "My room feels safe." A relative also told us, "We chose here as we wanted somewhere [name of family member] would be safe. It's very small and friendly here."

We looked at the recruitment processes in place and found they were not as robust as they should have been. We found the provider's recruitment policy lacked detail and did not meet the requirements of the current regulations. However we found there was a stable staff team with only one person having been recruited in the previous two years.

We looked at the personnel files for three staff and noted these all contained a completed application form in which applicants were required to detail a full employment history and explain any gaps in employment. All personnel files included two references and confirmation of each person's identity. Checks had also been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

We reviewed the systems in place to ensure the safe administration of medicines. We saw that there was a policy and procedure in place to guide staff regarding the safe handling of medicines. We noted all staff responsible for administering medicines had received training for this task. However there was no system in place for the registered provider to regularly assess the competence of staff to administer medicines safely. There was also no clear procedure in place for staff to follow should an error occur in the administration of a person's prescribed medicines.

We looked at the medicines administration record (MAR) charts for three people who used the service. We noticed there were errors on each of these records; these included a number of missing signatures, no record of how many tablets had been given for a variable dose medicine and handwritten entries which had not been signed or countersigned to confirm their accuracy. We also noted one staff member had signed to say they had administered a medicine on the day after the inspection which was clearly an error. In addition one person had received two doses of a medicine which was only prescribed to be given once a day; no action had been taken to ensure the person did not suffer any ill effects as a result of this error. The errors we identified meant we could not be certain people had received their medicines as prescribed. This was also confirmed by the fact that stocks of the medicines held for two of the people whose MAR charts we reviewed did not correspond accurately with the records.

We found suitable arrangements were in place for the storage of controlled drugs. Controlled medicines are more liable to misuse and therefore need close monitoring. However when we checked the records of the controlled drugs prescribed to one person we noted these did not correspond accurately with the stock of medicines held. Following contact with the supplying pharmacist we were told staff had made an error in recording the amount of medicines supplied; this error had not been identified by any of the staff who had

signed or countersigned the controlled drugs record to confirm the amount of medicines held. This meant the system for managing controlled drugs was not sufficiently robust to ensure these medicines were not misused.

There was a lack of a robust system in place for the safe handling of medicines. This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the systems in place to help ensure people were protected by the prevention and control of infection. We looked around all areas of the home and saw the bedrooms, lounges and dining room, bathrooms and toilets were clean. However we noted there were two large areas of peeling plaster on the walls at the rear of the main lounge area; this presented a risk to people who used the service as the areas could not be thoroughly cleaned. The deputy manager told us there was no system currently in place to colour code equipment and materials used in the delivery of cleaning services as advised by national guidance to help reduce the risk of cross infection. We also saw that mops were stored in bathrooms which could lead to cross infection. We noted however there had been no recent outbreaks of infection at the home.

We looked at the systems in place for the laundering of clothes, towels and bedding. We noted a washing machine was located in a central corridor of the home, directly outside the bedroom of a person who used the service. This person told us they had complained about the location of the washing machine as their sleep was disturbed when the machine was switched on early each morning. The location of the machine was in an area accessed by all people who used the service and visitors; this meant there was a risk of cross infection. There was also no workspace area to ensure a flow of soiled to clean laundry took place. .

We were told there was a separate laundry building at the rear of the premises. When we looked at this building we found it was dirty and was also being used as a storage area; any designated laundry area should only be used for this purpose in order to help avoid cross infection. Two days after the inspection we were told the laundry had been cleaned and the washing machine returned to this building.

There was a lack of appropriate measures in place to prevent and control the spread of infection. This was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risks involved in delivering people's care had been assessed to help keep people safe. Care records we looked at contained information about the risks people who used the service might experience including those relating to restricted mobility, skin integrity and nutritional needs. Risk assessments had been regularly reviewed in the care records we looked at. However, from our review of accident records we noted one person had experienced seven falls in the period February to April 2017. We could not find any evidence in this person's care records that consideration had been given to additional strategies which could be put in place, such as the use of a pressure/sensor mat to alert staff if the person tried to move independently, in order to help minimise the risks of future falls occurring. We discussed this with the deputy manager who told us they would arrange for a review of the risk assessments and any required equipment when the person returned to the home from hospital. We were advised that their hospital admission was not as a direct result of any injuries sustained during the recent falls they had experienced.

There was a failure to take action to mitigate identified risks to people's health and safety. This was a breach of Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that suitable arrangements were in place for safeguarding people who used the service from

abuse. Policies and procedures for safeguarding people from harm were in place; these provided staff with guidance on identifying and responding to signs and allegations of abuse. Information was also in display in communal areas of the home detailing the procedure to follow if abuse was suspected. Staff we spoke with told us they had received training in safeguarding adults. They were able to describe the different types of abuse and actions they would take if they became aware of any incidents. All staff spoken with said they would not hesitate to report any concerns to the deputy manager, registered provider or if necessary to the local authority.

We looked at the staff rosters and noted that sufficient numbers of staff were in place on each shift to meet the needs of people who used the service, most of whom required limited support. The registered provider told us extra staff were organised should a person become unwell and require additional support. They told us they did not use agency staff as people employed by the home were always willing to take on extra shifts where necessary. Comments people made to us about staffing levels included, "I am sure there are enough staff" and "There's plenty of staff; always someone around."

Inspection of records showed that a fire risk assessment was in place and regular in-house fire safety checks had been carried out to check that the fire alarm, emergency lighting and fire extinguishers were in good working order and the fire exits were kept clear.

Records were kept of the support people who lived at Barnfold Cottage would need to evacuate the building safely in the event of an emergency. We asked to see a copy of the business continuity plan in place. The purpose of a business continuity plan is to provide information for staff about the action they should take in the event of an emergency such as a failure of the gas or electricity supply to the premises. The document we were shown was titled 'business continuity plan' but was actually a service improvements plan, detailing how the provider intended to improve the premises. Although we saw emergency numbers were on display throughout the home, the lack of a formal business continuity plan for staff to refer to meant there was a risk they would not be aware of the correct action to take in the event of an emergency at the home.

Requires Improvement

Is the service effective?

Our findings

People who used the service told us staff knew them well and had the right level of skills and knowledge to be able to provide them with effective care. One person told us, "Staff know what I like and don't like." Another person commented, "Staff look after me well."

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

People can only be deprived of their liberty so that they can 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.

Our discussions with the registered provider and deputy manager showed they had limited understanding of DoLS. The deputy manager told us everyone who lived in Barnfold Cottage had chosen to be there but acknowledged that at least one person's mental health had deteriorated since admission to the point that they no longer fully understood their placement in the home. We found there was no system in place for people's capacity to consent to their care to be reassessed if their mental health condition changed; this meant people's rights might not be fully protected. The deputy manager told us they would ensure that a DoLS application was submitted to the local authority; this would allow for an assessment to take place to determine if any restrictions in place were in the person's best interests.

There was a failure to operate effective systems to protect the rights of people who were unable to consent to their care in Barnfold Cottage. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with who used the service told us staff always asked for their consent before any care was provided. One person commented, "Staff ask my permission before they do anything." We noted that all care records had been signed to indicate each person's agreement to the support to be provided to them.

Records showed that all care staff had completed training in the MCA and DoLS. Our discussions with two members of care staff showed they had a good understanding of the principles of the MCA. Staff told us, wherever possible, they would support people who used the service to make their own choices and decisions. One staff member commented, "We assess capacity day to day. I ask people to make their own decisions." Another staff member told us, "We always ask people if it's ok to do something."

We looked to see how staff were supported to develop their knowledge and skills. The deputy manager told us that all new staff completed an induction period which included training in the provider's policies and procedures, mandatory training and a period of shadowing experienced colleagues before they started to work as a full member of the team.

Records we reviewed showed that staff employed in the service had received training to help ensure they were able to safely care for and support people. This included areas such as infection control, moving and handling, pressure care and fire safety. The deputy manager told us that new staff who had no previous qualifications in care were required to complete the Care Certificate; the Care Certificate aims to equip health and social care workers with the knowledge and skills they need to provide safe, compassionate care.

Staff spoken with were positive about the training they received. One staff member commented, "We have plenty of training. We always try and keep on top of things." Staff also told us they received regular supervision; supervision meetings provide staff with the opportunity to discuss their responsibilities and to develop their role. However we noted the provider only maintained an annual summary record of supervision sessions held. This meant it was not possible to review what topics had been discussed throughout the year and any actions taken by managers to address issues raised. We noted that all staff employed for more than a year had received an annual appraisal of their performance.

We looked at how people living in the home were supported with eating and drinking. People we spoke with gave us mixed feedback about the quality of the food served. Comments people made included, "The food is alright. They do their best and make it as nice as they can", "The food is poor at times" and "The food is good."

We noted that the service did not employ a chef; instead care staff were responsible for making and serving meals as part of their daily duties. Staff told us they had received training in food hygiene and followed a menu which had been drawn up in consultation with people who lived in the home. They told us they had a good understanding of people's likes and dislikes and were able to be flexible to provide alternatives to meals which were on the menu. This was confirmed by one person who told us, "They [staff] have done something different for my lunch today as I don't like what's on the menu."

During the inspection we observed part of the lunchtime period. We saw that the meals served were of reasonable quality and were enjoyed by all the people we observed. None of the people we saw required assistance to eat but we saw staff provided gentle encouragement where necessary.

People's weight and nutritional intake was monitored in line with their assessed level of risk and referrals had been made to the GP and dietitian as needed. We noted risk assessments had been carried out to assess and identify people at risk of malnutrition and dehydration. A relative we spoke with told us they were pleased that their family member had put on weight since they were admitted to the home.

We found the kitchen was clean and tidy. The service had received a 5 rating from the national food hygiene rating scheme in October 2016 which meant they followed safe food storage and preparation practices.

We asked staff how they kept up to date with people's changing needs to ensure they provided safe and effective care. Staff told us they attended handover meetings at the start of each shift. Staff also told us important information in relation to people's needs was recorded in the diary to help communication across the shifts.

People who used the service had access to healthcare services and received on-going healthcare support. Care records contained evidence of visits from district nurses and GPs.

Good

Is the service caring?

Our findings

People who used the service gave us positive feedback regarding the attitude of staff. They told us staff were always kind, caring and respected their dignity and privacy. Comments people made to us included, "I've always been treated very fairly", "Staff are kind; they try and help you" and "The staff are lovely." The relative we spoke with was also complimentary about the staff team. They told us, "Staff are brilliant. They cope with her moods. They are really good with her."

Throughout the inspection we noted there was an emphasis on supporting people to be as independent as possible. Care records included information about the tasks people were able to do for themselves and the level of support they wanted from staff. People who used the service confirmed staff promoted their independence as much as possible. Their comments included, "They [staff] let me be as independent as I can be; they are very good" and "Staff let me do as much as I can for myself."

All the people spoken with told us they were comfortable in their surroundings and that staff respected their dignity and privacy. During the inspection we observed people spending time in the privacy of their own rooms and in different areas of the home. People told us they were happy with their bedrooms, which they were able to personalise with their own belongings and possessions. We noted that visitors were welcomed into the home. A notice informed all visitors that they were able to use the conservatory for private discussions with their family member if they did not wish to use the person's bedroom.

Care records we reviewed contained information about people's likes and dislikes as well as recording details about their social history and important relationships and interests. This information helps staff to develop caring and meaningful relationships with people. The deputy manager and staff we spoke with clearly demonstrated they knew people who used the service very well. They were able to tell us about people's likes and dislikes, their care needs and also about what support they required. They spoke about people affectionately and compassionately. Staff also demonstrated a commitment to providing high quality, personalised care. One staff member told us, "We try and put people first. We do what's best for them." Another staff member commented, "I treat people like I would wish to be treated."

People were encouraged to express their views as part of daily conversations, residents and relatives' meetings and satisfaction surveys. The residents' meetings gave people the opportunity to be consulted on topics such as menus, activities and the attitude of staff. We saw records of these meetings and noted that people had made positive comments regarding their care in the home. The notes from one meeting stated, "All feel at home, safe, happy and well cared for."

We spoke with the deputy manager about access to advocacy services should people require independent support to express their views about the care they received. The registered provider had information about the local advocacy service that could be provided to people and their families if this was requested although we noted the contact details for this service needed to be updated; this was actioned by the deputy manager before the end of the inspection.

We found that care records were stored securely. Policies and procedures we looked at showed the service placed importance on protecting people's confidential information.

Good

Is the service responsive?

Our findings

People told us they received the care and support they needed and that staff responded well to any requests made for assistance. One person told us, "Staff always try their best." Another person commented, "I've never been refused anything and they [staff] have never let me down." The relative we spoke with told us they considered staff had developed a good understanding of their family member's needs during the short period they had been at the home. They also commented that the care and support staff had provided meant their family member was now much more mobile and their general health had improved.

We asked the deputy manager to tell us how they ensured people received care and treatment that met their individual needs. They told us they always completed a detailed assessment of the support people required before they were admitted to the home. This was to help the service decide if the placement would be suitable and also to ensure the person's individual needs could be met by staff. Care records we reviewed confirmed this assessment had taken place.

We saw that the completed pre-admission assessment was used to develop person-centred care plans and risk assessments. These included information about people's needs in relation to personal care, mobility, health conditions, communication, medication, skin care and eating and drinking. The records we looked at provided sufficient information to guide staff on how to respond to people's individual needs. All the staff we spoke with confirmed they would regularly check care plans to ensure they were an accurate reflection of people's needs. They told us they would bring any changes they felt were required to the attention of the deputy manager who would undertake an immediate review with the person concerned.

There were arrangements in place for people's care plans to be reviewed on a monthly basis or more frequently if there was a change in need. An annual review was also completed once a person had been in the home for 12 months; this process helped to ensure people were happy with the care and support they received.

We saw that staff completed daily records of people's care which provided information about changing needs and any recurring difficulties. We noted the records were reasonably detailed and people's needs were described in respectful and sensitive terms.

We looked at the opportunities available for people to participate in activities. We looked at the log of recent activities which had taken place and noted these included yoga, arts and crafts, film nights and events to celebrate St Patrick's Day and Mother's Day. A professional singer also visited the home on a regular basis. People we spoke with expressed mixed views about the activities on offer with several stating they preferred to spend time in their room as they did not feel the activities were appropriate for them.

We asked the deputy manager about how they supported people to retain links with the local community by attending events or visiting local attractions. They told us they had tried to organise trips but that there was generally little enthusiasm from people who lived in the home.

We looked at the systems in place to enable people to provide feedback on the care they received in Barnfold Cottage. We noted information about the complaints procedure was included in the service user guide which was on display in the home. A complaints policy was also in place which provided people with information about how complaints would be responded to and investigated.

The deputy manager showed us they maintained a log of any complaints or minor concerns raised with them. We noted that there had not been any complaints received since October 2014. The registered provider and deputy manager told us that formal complaints were rare. We were told this was because the deputy manager encouraged people to alert them to any issues or concerns in order for them to be resolved immediately and informally.

People spoken with were confident that any issues or concerns they raised would be dealt with by the deputy manager or the registered provider. One person told us, "I would speak with [Name of deputy manager] if I had a complaint but I've never had cause to do so." Another person commented, "I would speak to any member of staff or [Name of deputy manager] and feel they would always listen to me."

Requires Improvement

Is the service well-led?

Our findings

People spoken with during the inspection told us they were satisfied with the way the home was run. They described living in the home as like being part of a family. One person commented, "It's small and friendly; it's lovely."

At our last inspection we found the provider had failed to notify CQC of certain reportable events. Prior to this inspection we checked records we held about the service and saw incidents that CQC needed to be informed about, such as serious injuries, had been notified to us by the registered provider. This meant we were able to see if appropriate action had been taken to ensure people were kept safe. We noted the registered provider was meeting the requirement to display their latest CQC rating.

Because the registered provider was an individual there was no requirement to have a registered manager in place. The registered provider was legally responsible for the running of the service. However they told us they had handed over most of this responsibility to the deputy manager who intended to register as manager with CQC.

We asked the registered provider and deputy manager about systems in place to help ensure people always received high quality, safe and compassionate care. They told us they sent out an annual survey to people who used the service and their relatives. We saw that the most recent relatives' survey had been completed in January 2017 with five responses; four of which were very positive. One person had written, "No issues, very good service." We asked the registered provider and deputy manager about the action they had taken to address the negative comments made by one of the relatives who had completed the survey. They told us they had not responded formally but would do so.

We saw that there had been 13 respondents to the most recent resident's survey distributed in October 2016, all of which had been positive. Comments people had made included, "I am very happy here in my home", "Everyone is very kind and friendly here; I'm glad I came" and "I'm very happy with everything here."

We asked the registered provider and deputy manager about the auditing processes in place in the service; these audits should help to monitor the quality and safety of the care people received. We were told that there were no formal documented systems in place to audit medicines, care plans, the environment or equipment used. We also noted that, although the deputy manager maintained a log of all incidents and accidents which occurred within the home, there was no analysis of any themes and trends which needed to be addressed. Our review of records showed that one person had experienced seven falls between February and April 2017, with four of these falls occurring at the same time of day. The deputy manager had failed to identify this trend and had therefore not reviewed if any action was necessary such as where/ how many staff were deployed to help prevent future occurrences.

There was a lack of robust quality assurance processes which had led to the shortfalls we identified during the inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider told us their key achievements since the last inspection had been the refurbishment of parts of the home including the dining room, kitchen and patio area. The deputy manager told us they had been focused on updating people's care plans to ensure they were person-centred.

All the staff we spoke with told us they enjoyed working at Barnfold Cottage. They told us the registered provider, deputy manager and colleagues were all approachable and supportive. They told us all staff worked well as a team to help ensure people received high quality care.

We saw that staff meetings had been held within the service. Staff meetings are a valuable means of motivating staff, keeping them informed of any developments within the service and giving them an opportunity to discuss good practice. Staff we spoke with told us they were encouraged to contribute to discussions at staff meetings and that their ideas were always listened to. One staff member commented, "We get listened to in staff meetings. We can make suggestions and they [registered provider and deputy manager] will always tell us if it is not possible and why that is."

We saw that the registered provider had maintained their Investors in People status since the last inspection. This is nationally recognised award given for meeting set standards in the management of staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to protect people against the risks associated with the unsafe use and management of medicines. Regulation 12 (2) (g) The provider had failed to fully mitigate the risks to people's health and safety. Regulation 12 (2) (a) and (b) The provider had failed to properly assess and manage the risk of cross infection in the service. Regulation 12 (2) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that effective systems and processes were established and operated effectively to assess and monitor the quality and safety of the service. Regulation 17 (2) (f)