Festival Care Homes Ltd

Barleycroft Care Home

Inspection report

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23 February 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 22 and 23 February 2017. Barleycroft is a purpose built 80 bed care home providing accommodation and nursing care for older people, including people living with dementia. When we visited, 47 people were using the service.

The service does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A new manager has been in post since 12 December 2016 and has started the registration process.

At our comprehensive inspection on 19 and 20 July 2016, we found that people's healthcare needs were not consistently met, some care plans contained contradictory instructions or were not sufficiently detailed and management systems had not ensured that required improvements had been made. At this inspection, we found action had been taken and people's healthcare needs were monitored and addressed. Action had also been taken with regard to care planning and quality improvement. New quality monitoring systems were gradually being embedded, some care plans were more detailed and plans were in place to review and improve the remainder. Further work was needed to fully meet the breaches in regulations identified at the comprehensive inspection and there was an action plan in place to do this.

Staffing levels were sufficient to meet people's needs.

People told us they felt safe at Barleycroft and that they were supported by kind, caring staff who treated them with respect. One person told us, "Yes, I do feel safe, the staff always come and cheer me up."

Systems were in place to ensure that equipment was safe to use and fit for purpose. People lived in an environment that was suitable for their needs. In one unit, the carpets had been replaced and redecoration was taking place.

Staff received training and support to carry out their duties and felt that this was the right training for the job they did. Not all staff training was up to date but this was being addressed by the manager.

Systems were in place to ensure that people were not being unnecessarily or unlawfully deprived of their liberty. However, evidence was not always in place to support that decisions were made in people's best interests.

People were supported by kind, caring staff who treated them with respect. Relatives had written positive comments including, "Thank you so much for looking after our [family member] so well. It's a great comfort to know they were in such caring hands."

People were encouraged to do things for themselves and staff provided care in a way that promoted people's dignity.

People were happy with the food provided and their nutritional needs were met. If there were concerns about their eating, drinking or weight, this was discussed with the GP and support and advice were sought from the relevant healthcare professional.

The arrangements for administering medicines were safe and people received their medicines as prescribed.

Systems were in place to safeguard people from abuse and staff were aware of how to identify and report any concerns about people's safety and welfare.

Staff were trained to identify and report any concerns about abuse and neglect and felt able to do this.

The provider's recruitment process ensured staff were suitable to work with people who need support.

Social and recreational activities and events were available and most people were happy with the activities offered.

A complaints procedure was in place and relatives knew how and who to complain to when needed.

Staff provided caring support to people at the end of their life and to their families. This was in conjunction with the GP and the local hospice.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service provided was safe. People received their medicines safely.

Systems were in place to safeguard people from abuse.

People were protected by the provider's recruitment process which ensured staff were suitable to work with people who need support.

The premises and equipment were appropriately maintained to ensure they were safe and ready for use when needed.

There were sufficient staff on duty to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective. Systems were in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We have recommended that decisions regarding the use of bed rails be reviewed to ensure that they are in the person's best interest.

Systems were in place to provide staff with training that enabled them to provide people with the support they needed and wanted. Action was being taken to ensure that staff training was up to date.

People were happy with the food and drink provided and were supported by staff to eat and drink sufficient amounts to meet their needs.

People's healthcare needs were identified and monitored. Action was taken to ensure that they received the healthcare that they needed to enable them to remain as well as possible.

The environment met the needs of the people who used the service.

Is the service caring?

Good

The service provided was caring. People were treated with kindness and their privacy and dignity were respected.

People received care and support from staff who knew about their needs, likes and preferences.

Staff provided caring support to people at the end of their life and to their families.

Is the service responsive?

Requires Improvement

The service provided was not consistently responsive. The staff team were aware of people's needs but care plans did not always provide detailed or consistent information about these.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for.

Activities and entertainment were provided and two activity workers were in post to support this.

Complaints were taken on board and action taken to address any concerns or issues.

Is the service well-led?

Requires Improvement

The service was not consistently well led. There was not a registered manager in post.

Management had not been consistent with three different managers in post in less than a year.

Systems were in place to monitor the quality of service provided. New quality monitoring systems were being embedded into the service and improvements were being made. Actions identified during monitoring visits were followed up.

People were consulted about changes to the service and the provider sought their feedback on the quality of service provided.

Staff told us that they felt supported by the manager.

Barleycroft 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 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 inspection took place on 22 and 23 February 2017 and was unannounced. The inspection team consisted of two inspectors, a specialist nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed the information we held about the service. We contacted commissioners of the service, local authority quality monitoring officers and Havering Healthwatch to get their feedback on the care provided.

During our inspection we spent time observing care and support provided to people in the communal areas of the service. We spoke with 15 people who used the service, eight relatives, the manager, the regional manager, 10 members of care and nursing staff, an activities coordinator, the chef, the administrator and the handyperson. We looked at eight people's care records and other records relating to the management of the home. This included three staff recruitment records, duty rosters, accident and incidents, complaints, health and safety, maintenance, quality monitoring and medicines records.

Good

Is the service safe?

Our findings

People and their relatives told us Barleycroft was a safe place. People's comments included, "I feel safe here yes, the carers make me feel safe," "Oh yes, I do feel safe, staff really good and helpful" and "I am very safe here." Relatives said, "My [family member] is really safe here, we all think that," "I am sure my [parent] is safe here" and "[family member] is very safe here, no reason why not."

Medicines were kept safely and securely in locked medicines trolleys which were stored in locked 'treatment' rooms on each unit. The 'treatment rooms' were air-conditioned and we found that the temperature was maintained within the recommended range for medicines to remain effective. The person responsible for the administration of medicines kept the keys with them during their shift. Controlled drugs (CD) were stored safely in a separate cupboard and a controlled drugs record was kept. We checked the controlled drugs and found that the amount stored tallied with the amount recorded in the register. In line with good practice opening dates were recorded on liquid medicines, drops and creams to ensure that they were not used after the expiry once opened period.

Medicines requiring cold storage were kept within a locked fridge. Minimum and maximum temperatures of the medicines fridge were checked and logged every day, providing evidence that these medicines were also kept at safe temperatures to remain effective. Any unwanted or unused medicines were recorded, safely stored and disposed of.

People who received their medicines without their knowledge (covertly) were appropriately managed. The covert administration of medicine had been approved following best interest meetings held with relatives and the necessary professionals, as it was deemed necessary for the person's health and wellbeing. Advice had been obtained from the pharmacist and was being followed. Medicines had been changed to a liquid or dispersible form to support the process and to alleviate the need for medicines to be crushed.

Some medicines taken 'as needed' or 'as required' are known as 'PRN' medicines. We saw that PRN protocols were in place, with the necessary information for staff to follow to administer these safely and effectively. We also noted that pain assessment tools were used when administering pain relief medicines, especially for people living with dementia. People's ability to take their medicines and how they took them was documented. For example, ability to swallow tablets independently.

Systems were in place to ensure that people received their prescribed medicines safely. Medicines were administered by nursing staff and senior care staff who had received medicines training. They completed the necessary records to confirm that medicines had been given. Medicines Administration Record (MAR) charts were correctly completed and up to date. They included people's photographs to check that medicines were given to the correct person. There was an accurate record of the medicines that people had received. Allergies were also indicated.

Medicines received from pharmacy were recorded in the MAR charts and the quantity reconciled with the administration record. A system of daily and weekly medicines audits were in place and these were

monitored by the manager and the regional manager.

Staff were aware of the risks to people and took action to minimise these. For example, by the use of bed rails, pressure relieving or moving and handling equipment. However, although risk assessments were completed, reviewed and updated there was not always a care plan in place relating to minimising the risk identified. However, staff were able to tell us the action they had taken.

Staff had received safeguarding training and were aware of the safeguarding policies and procedure in order to protect people from abuse. They were aware of different types of abuse and knew what to do if they suspected or saw any signs of abuse or neglect. Staff were clear they would report anything of concern to the manager and confident that action would be taken. The provider had notified us about potential safeguarding incidents and had worked with the local authority. The provider had taken action to make sure people living at the service were protected from risk of harm or abuse. The service held monies for some people to pay for hairdressing, chiropody and other small items. We saw that monies were securely and individually stored and access was restricted. The provider carried out random audits to check monies held. We checked the monies and records for four people and found the amount of cash held tallied with the record. People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

The provider's recruitment process ensured staff were suitable to work with people who needed support. This included prospective staff completing an application form and attending an interview. We looked at four staff recruitment files. Two of the four files showed that necessary checks had been carried out before they began to work with people. This included proof of identity, two references and evidence of checks to find out if they had any criminal convictions or were on any list that barred them from working with people who need support. However, although other checks were on file, there were not copies of references for the other two people. The office manager had audited staff files to ensure that they contained the necessary information and had been following up on missing paperwork. We saw evidence of this as in one file a copy of an original reference had been obtained. The issue was related to staff recruitment during a short period of time when manager and office staff changes occurred. Recruitment files checked during the inspection in July 2016 had contained the necessary information. Nurse's registration with the Nursing and Midwifery Council was also checked to ensure that they were allowed to practise in the United Kingdom. When appropriate there was confirmation that the person was legally entitled to work in the United Kingdom. People were protected by the provider's recruitment process.

Staff had received emergency training and fire marshal training was booked to take place shortly after the inspection. There was a fire risk assessment and staff were aware of the evacuation process and the procedure to follow in an emergency. During the inspection, the fire alarm was activated and we observed that staff followed the correct procedure. Each person had a personal emergency evacuation plan which provided information about their needs to assist the emergency services in the event of an evacuation. Therefore, systems were in place to keep people as safe as possible in the event of an emergency arising.

Providers of health and social care have to inform us of important events which take place in their service. Our records showed that the provider had told us about such events and had taken appropriate action to ensure that people were safe.

The premises and equipment were appropriately maintained and systems were in place to ensure they were safe to use and fit for purpose. Records showed that equipment was serviced and checked in line with the manufacturer's guidance. Gas, electric and water services were also maintained and checked to ensure that they were functioning properly and were safe. The records also confirmed that appropriate checks were

carried out on hoists, pressure relieving mattresses and fire alarms to ensure that they were safe and in good working order. There was a handyperson in post and they carried out some repairs. Appropriate external contractors were used for more specialised repairs and maintenance. There were some outstanding repairs but the necessary replacement parts had been ordered.

No concerns were raised about staffing levels and people and their relatives felt that staff were available to provide support when needed. People said, "I don't need to call my bell too many times and staff come to help me, they do alright here," "I do think staff help a lot and there is enough in my opinion" and "There are enough I think, I don't wait for a long time". Relatives commented, "[Family member] has no complaint whatsoever and doesn't have to wait for anything" and "I see plenty of staff around." Staffing levels were sufficient staff to meet people's needs.

The environment appeared clean and there were no unpleasant odours. During the visit the carpet was being replaced in one of the units as this had been identified as contributing to a smell of urine. The domestics carried out daily tasks from a cleaning schedule and kept records of the work they had completed. In addition to daily cleaning there was also a schedule for deep cleaning.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection on 19 and 20 July 2016 we found that people's healthcare needs were not consistently met. Concerns were raised about missed hospital appointments and people did not always have plans in place in relation to their healthcare needs. At our focussed inspection on 8 November 2017, we were satisfied progress was being made to address the shortfalls and breach of regulation. During this visit we found that action had been taken and people's healthcare needs were being met.

People were supported to access healthcare services. The GP visited weekly and opticians, podiatrists and dentists also reviewed people. People saw professionals such as dietitians, tissue viability nurses and speech and language therapists when needed. Files contained records of healthcare professional's visits with a summary and any recommendations made. People had 'Hospital Passports' providing an overview and essential information about the person should they be admitted to hospital. People responded positively about the care provided. One relative told us, I don't think my [family member] would be here if I thought there was a problem." Another said, "I am sure staff know when to help my [family member]."

People's healthcare needs were monitored and addressed to ensure they remained as healthy as possible. Blood sugar levels were checked and monitored as were people's weight and blood pressure. When there were concerns about the blood sugar levels for a person with diabetes a referral had been made to the diabetic nurse. Another person needed a restricted fluid intake and records showed that they were supported to keep within this target. They received twice daily mouth care to prevent their mouth becoming dry. Staff were aware of the signs that might indicate a person was becoming unwell and then arranged for them to see the GP. For example, that if a person became more confused it could be as a result of having a urinary tract infection.

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 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 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.

Records showed that most staff had completed MCA and DoLS training. Staff were clear that people had the right to and should make their own choices as far as possible and understood the importance of seeking consent when supporting people. The manager was aware of when and how a DoLS application should be made. For people with DoLS in place, these had been agreed by the relevant supervisory body. Applications had been made for other people. The manager was waiting for responses for these.

Systems were in place to ensure that people were not being unnecessarily or unlawfully deprived of their

liberty. However, when people required bed rails to keep them safe there was not always the necessary confirmation that this was in their 'best interest or that a less restrictive way of managing the risk had been considered. For example, the use of a high- low bed. We recommend that decisions regarding the use of bed rails be reviewed to ensure that they are in the person's best interest, necessary to prevent harm to the person and a proportionate response to the risk. Also that the decision making process be clearly reflected in the persons case notes and care plan.

People were provided with a choice of suitable nutritious food and drink. The chef developed a four week menu based on their knowledge of people's likes and dislikes and from feedback they had given. The chef confirmed that most food was homemade and that the service was able to cater for a variety of dietary, cultural or religious needs. For example, diabetic, gluten free and Halal food. Therefore people were able to have meals that met their cultural, religious and health needs. We looked at the menu and saw there was a choice of main meals each day plus a selection of alternatives that were always available. People chose their main meal the day before but could change their mind at any time. They could ask for specific meals in advance or on the day and as far as possible, the chef prepared these. For example, one person requested a specific food each day and the chef prepared this on a daily basis. People were happy with the food provided. Comments included, "Food is lovely for me, I like the easy and traditional food," "Nothing to complain about. The food is really good, and of course they know what I like" and "Oh yes, I really like the food here."

People were supported to be able to eat and drink sufficient amounts to meet their needs. When there were concerns about a person's weight or dietary intake, advice was sought from the relevant healthcare professionals. For example, one person had been losing weight and a referral had been made to the speech and language therapist. Following advice from them, the person had then gained weight. Staff monitored and kept records of the dietary and fluid intake for people with specific dietary requirements as a result of a medical condition or other need.

At lunchtime we observed that staff asked people what they wanted to eat and gave them the support they need. Some people ate independently and others needed assistance from staff. People were not hurried and staff gently encouraged people to eat. One person said they did not want lunch but wanted a cup of tea and staff made this for them. Staff offered the person a dessert later and sat with them and supported them to eat this. We saw that some people required a pureed diet and each food was pureed and served separately to enable them to enjoy the different tastes.

The environment met the needs of the people who used the service. There was a lift and the building was accessible for people with mobility difficulties. There were adapted baths and showers and specialised equipment, such as hoists, were available and used when needed. A programme of decoration was in place and all ground floor bedrooms had recently been 'refreshed'.

There were systems in place to provide staff with the necessary training to support people who used the service but this had not been robustly enforced. At the inspection in July 2016 there was a plan in place regarding staff training. This was to address outstanding updates and also to train staff who had been recently employed. The target for completion was the end of December 2016 but with the changes in management this target had not been reached. However, the manager and regional manager had taken action to address this. Some recent training had taken place, such as behaviour that challenges, pressure area prevention and stroke awareness and further training was booked. In addition, the manager had identified training that was outstanding and had given staff details of the e-learning they still needed to complete. The training matrix showed that most staff had completed the required training but there were some staff whose training was very overdue or had not been completed. The manager was formally

addressing this with those concerned.

Staff told us they were happy with the training they received, that it was the right training for the job that they did and was a mixture of e-learning and face to face training. Training included manual handling, fire safety, infection control, safeguarding, dementia awareness, Deprivation of Liberty Safeguards and the Mental Capacity Act. One staff told us, the manager encouraged training and continuous personal development.

Staff received supervision (one-to-one meetings with their line manager to discuss work practice and any issues affecting people who used the service) approximately every three months. This included individual and group supervision. Staff said they felt supported by the manager and by other staff they worked with. One staff told us, "Staff support each other and there's a really good team." Systems were in place to share information with staff including staff meetings and handovers between shifts. People were cared for by staff who received support and guidance to enable them to meet their assessed needs. A relative said, "They [staff] do a very good job, I don't think [family member] has anything to worry about."

Good

Is the service caring?

Our findings

People were positive about the care and support they received. They told us staff were kind and caring. They said, "Yes, they [staff] are caring, and very polite," "Very caring, kind and compassionate towards me" and "I don't have complaints, they are very caring." Relatives also felt that staff were kind and caring. They told us, "I am sure my [family member] thinks the staff caring," "Yes, I have seen good caring levels" and "Oh yes, they [staff] are caring." In a thank you card, one relative had written, "Thank you for all the time and care you took with [family member]. We will never forget your kindness." Another relative had written, "Thank you for looking after our [family member] so well during their time at Barleycroft. You were always so kind and patient, treating them with dignity and always so cheerful. It was a great comfort to us to know that they were so well cared for by you all."

Staff were gentle and supportive. They listened to people and showed genuine interest in what they spoke about. They responded to them in a friendly and patient way. We saw cards and thank you letters written by people's relatives. One said, "Thank you for your care and love over the years [person's name] has been in Barleycroft. They loved having you look after them and we were so glad you did." Another had written, "Thank you for all the love and care you showed to [person's name] while they were at Barleycroft. You became their second family and it was wonderful for us to see them interact and to respond to you all even though it was a very difficult time in their life."

Staff knew the people they cared for. They told us about people's personal history, preferences, interests and how they supported them. People told us that staff treated them with respect and their privacy and dignity were maintained. One person said, "Oh yes, staff respect my privacy and dignity, they always knock and close the doors." Another told us, "They do respect my privacy and dignity, they always close the door and the curtain." This was supported by relatives who commented, "Oh yes, they always knock" and "Yes, I have to say yes because I have seen it."

Staff supported people to make daily decisions about their care as far as possible. We saw that people made choices about what they did and where they sat. For example, staff asked people where they wished to sit at lunch time and supported them to do so with care. 'Residents' and relatives' meetings had taken place.

People confirmed they were encouraged to remain as independent as possible and to do as much as they could for themselves. One person told us, "I feed myself you know, I am in good condition." Another said, "They just help when we need it." We saw care staff encouraged those who could walk to do so.

Staff provided caring support to people at the end of their life and to their families. This was in conjunction with the GP and the local hospice. Most staff had received training in end of life care. We saw a bereaved relative had written, "Thank you for all you did for [family member] while they were at Barleycroft and for the absolute professional care you gave to them during their final weeks. You could not have done more for them or for me to see us through those final days. I will always remember and be grateful to you for the care you gave them." People benefitted from the support of a caring staff team.

Requires Improvement

Is the service responsive?

Our findings

People who used the service and their relatives were positive about the way the staff responded to their needs. One person told us, "Very satisfied to be honest, couldn't ask for anything else." Another said, "I think we could all be pleased with their [staff] efforts." A relative had written a card saying, "Thank you all for caring and loving ways. Thank you for trying so hard for my [family member]."

At our inspection on 19 and 20 July 2016, we found that people were placed at risk of receiving inconsistent care that did not safely meet their needs. This was because care plans were not always reviewed each month and did not always give sufficient detail to ensure people received care and support that fully met their current needs.

At this visit we found some areas of progress but this was not consistent or robust and people were still placed at risk of receiving inconsistent care that was not responsive to their needs. Care plans were reviewed each month and updated when necessary. Although people's needs were identified and reviewed there was not always a care plan in place in relation to that need. However, in some cases new care plans had been added in relation to changing or additional need. For example, one person had a new care plan to support them to recover from a chest infection.

Care plans were not always detailed or personalised. For example one person's mental wellbeing care plan said that they sometimes became withdrawn, anxious and uncooperative. The care plan did not indicate how staff should address this or what might enhance their sense of wellbeing. For a second person their care plan said to encourage good fluid intake but there were no details as to how this should be done or what constituted a good intake. However, for the same person there was a detailed nutrition plan that clearly outlined how to support them.

We saw that repositioning, food and fluid charts were completed when required and that these were up to date. However, for fluid charts we saw that staff recorded when people had received a drink and how much. However, there was not a target amount and the amount given was not totalled or reviewed. The charts did show that people received fluids throughout the day.

The manager and regional manager had identified that there was not a consistent care planning format. This was partly due to a lack of management stability and each new manager making changes. One staff told us, "The care were plans done in one way and then another manager says no they need to be done in a different way. Staff get confused and need to get used to new ways again. This takes time and can be stressful. We put in a lot of work, but it is not very effective." The organisation had a care plan format and the manager's plan was to use this throughout the service to support consistency.

Staff knew and understood the concept of personalised care and were able to tell us about people's needs and how they supported them in an individual way. However, this was not always reflected in care plans. In one unit we saw that a nurse had created a wall chart highlighting with different coloured pens people's care needs.

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

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for. When able, they chose where to sit, what to eat and what to do. One person told us, "Yes, I am given choice." Another said, "Yes, at all time, if I want to stay in bed or not." A relative commented, "I am sure that choices are provided at all times".

Arrangements were in place to meet people's social and recreational needs and two activity workers were in post to support this. Activities, outings and entertainment were arranged including some at weekends. Most activities were held in the lounge for groups of people but the activity workers did do some one to one activities particularly with people who needed or chose to stay in their room. An activity worker told us that they would be doing life history work with people as part of one to one time.

There was a range of activities and these included, prize bingo, a weekly film afternoon, music, reminiscence, quizzes and discussions. A musician visited every two weeks and people sang and danced. The service had access to a minibus and some people had been to the seaside last summer, out for Christmas shopping and also to the theatre. On the day of the visit people were engaged in discussion with the activity worker about topics linked to their travels and countries they had visited. There was also a quiz which people seemed to enjoy as they were interacting and responding well.

Feedback about activities was mixed with some people saying that there were enough activities and others saying there were not. When asked if there were enough things to do one person responded, "Honestly it depends, sometimes we have more activities than other days. We have the kids from schools over here to entertain us, and the activity girls, they do raffles and stuff like that." Others said, "I like some of the activities," "I like to read and do sing along" and "Well, there is not much to do, we do quizzes, sing along and staff reads us books. Feedback from relatives was also mixed. Comments included, "From what I have seen, I think they have enough activities," "I think there is a lack of activities here," "I have seen a few but nothing wow, if you know what I mean" and "It's a difficult one, because some people don't want to do it and also people have different likes and dislikes."

People used a service where their concerns or complaints were listened to and addressed. The service's complaints procedure was displayed on a notice board in a communal area. One person told us, "I don't have any problems but I think it would be dealt with accordingly." Another said, "I don't have any concerns to be honest." People also told us that if they had a complaint they would possibly tell staff but most would tell their family. Relatives informed us they would speak to the manager if they had any concerns. A record was kept of any complaints and what had been done in response to these. There had not been any complaints since the current manager had been in post.

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection on 19 and 20 July 2016 we found systems were in place to monitor the quality of service provided but had not ensured the quality of the service had improved or that regulations relating to the governance of the service had been met. At our focussed inspection on 8 November 2016, there was a new manager in post and we found improvements were being made. However, another new manager started work at Barleycroft on 12 December 2016. This meant that Barleycroft had three different people managing the service within a six month period. In addition, there had also been changes in regional management and in December 2016, the third regional manager within the same period of time had been employed. The new manager had started the process for registration.

There were clear management and reporting structures. There was a manager in overall charge of the service. In addition to care staff and nurses, there was a deputy manager, unit leaders and senior care staff on each floor. People were positive about the new manager and staff felt they were a good leader. One staff told us, "The manager works in a calm, controlled way and is keen to develop the service. They are not bossy but clear. They have standards and the changes are working, there is more patient focus." However, staff were concerned about the lack of management stability. One member of staff told us, "The new manager is brilliant, but in the year I have been here this is the 3rd one." Another said, "A manager that stays would be wonderful. You need that support and it's hard to get consistency and trust. In the last year, the instability has affected the service a lot. For example, care plans and paperwork."

Daily short meetings were held with the manager, deputy manager, the leads of each unit and of ancillary services. At this meeting information was shared about issues, what was happening in each unit and what was happening with regard to ancillary services. This enabled the management team to be aware of the current situation in the home and of any issues affecting people who used the service. We attended one of these meetings and found that the manager was clear about what needed to be done.

The manager and regional manager had introduced quality monitoring systems and these were gradually being embedded in the day to day operation of the service. This included a daily walk around, increased medicines audits and a programme of weekly and monthly checks. One staff told us, "The unit walks are good and check everything." Senior staff were carrying out checks in units other than their own to encourage greater objectivity and a more robust system of monitoring. The weekly and monthly reports were sent to the regional manager for review and comment and were monitored by the registered provider. The regional manager visited at least once each week to provide support and based themselves to the service if the manager was absent for any reason. They also carried out unannounced visits to check quality of service provided. From these visits, a report was written and any actions needed were followed up at their next visit. There was also an overall action plan that indicated what was needed to improve the service provided and what action had been taken.

The overall governance and quality of the service had improved and was more robust. The manager was clear on what needed to be done to ensure that people received a good quality of service. Further work was needed to fully meet the breaches in regulations and areas for improvement identified at the

comprehensive inspection in July 2016 and during this inspection.

Therefore there remained a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sought feedback from people who used the service and stakeholders by means of an annual quality assurance questionnaire. The last 'residents' survey was in December 2016 and the manager told us that a relatives questionnaire would be sent out after some planned changes and improvements had been made so that they could get feedback about the effectiveness of these. In addition people's opinions were sought at 'residents' and at relatives meetings. At the relatives meeting in January 2017 the new manager introduced themselves, relatives gave feedback about the service and the manager updated them regarding safety of the home and staffing. In 'resident' meeting minutes we saw that people had been asked about meals, activities, trips they wanted to do and to feedback on events that had already happened. To facilitate decorations and practical improvements, it was planned for people in one unit to stay in another unit for a short time, whilst work was being carried out and we saw that people affected by this had been consulted before arrangements made. This meant people used a service where their views sought and taken into account when changes to the service were being considered.

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 9 HSCA RA Regulations 2014 Person-centred care The lack of consistent and specific information about people's needs placed them at risk of not receiving the care that they required. Regulation 9 (1) (a) & (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not adequately assess, monitor and improve the quality and safety of the services provided .Regulation 17 (1) and (2) (a) (b).