Barleystone
Care Home Service

Westquarter Avenue
Westquarter
Falkirk
FK2 9RY

Telephone: 01324 717 400

Type of inspection:
Unannounced

Completed on:
15 April 2026

Service provided by:
HC-One Limited

Service provider number:
SP2011011682

Service no:
CS2011300644

About the service

Barleystone is a purpose-built care home for up to 60 older people. It is located in Westquarter, a small village on the outskirts of Falkirk. Local transport is easily accessible to and from the home.

The building has two storeys, with smaller seating areas, lounge and dining rooms on both floors. In general, the people living on the ground floor are living with a diagnosis of dementia and the home class this floor, as their dementia unit. On the first floor, more people are physically frailer with some also having a dementia diagnosis.

All bedrooms are single rooms with en-suite toilet facilities. The corridors are wide and both floors are spacious, allowing people a lot of space to walk around. There is a good variety of seating areas and in most areas a good amount of natural light.

Garden areas surround the home and an enclosed patio area can be accessed from the door out of the dining room.

At the time of our inspection, 55 people were living in the home.

About the inspection

This was an unannounced inspection which took place on 7, 8 9 April 2026 between 09:00 and 18:30 and 12 April 2026 between 18:00 and 19:30. The inspection was carried out by two inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with ten people using the service
- spoke with eight relatives
- spoke with 18 staff and management
- observed practice and daily life
- reviewed documents
- obtained feedback from two external health professionals
- spoke with a social worker.

Key messages

Care plans should evidence that people's preferences, choices and routines stipulated in their care plans are being met.

Food and fluid recording should be clearly evidenced for people.

Reviews of staffing levels, staff deployment and staff relationships need to be reviewed.

The home environment was clean and fresh with housekeeping staff visible throughout the home.

To drive improvement, identified corrective actions within audit findings needs to be undertaken consistently and within specified timescales.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	2 - Weak
How good is our leadership?	2 - Weak
How good is our staff team?	2 - Weak

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses.

People should expect to receive baths and showers in line with the preferences set out in their care plans. However, from the records sampled, this was not consistently achieved within the stipulated frequency. Several relatives we spoke with expressed concern about this. We found in some plans, there were considerable gaps in the day where no interventions from staff were evident. People who required regular repositioning to maintain skin integrity did not always receive this support within the specified timeframes. This increased risks of people becoming uncomfortable, experiencing pain or becoming dehydrated for example. As a result, we made a requirement to address this (see Requirement 1).

During our morning walkarounds, we observed all residents' bedroom doors were closed. This meant that people who were unable to summon help independently were at risk of not being adequately supported during the morning routine at the time it was needed. Care plans were therefore required to be reviewed where required and to ensure people's morning routines, preferred privacy and individual preferences were clearly identified. We were unable to see for some people the most recent six monthly care plan review (see requirement 1).

Observation of the lunchtime dining experience identified delays in residents receiving their meal, with some people waiting for a considerable period of time in one particular area identified for dining. No staff members were available during the time people waited. One resident needed support to promote dignity. Residents expressed dissatisfaction with this experience. Staff presence and availability is explored further under 'How good is our staff team?'

Meal options were offered verbally, and in some cases choices were made for people. The use of plated choices was identified as a way to better support decision making. Staff attended to more than one person at a time who needed support to eat and drink and did not always perform hand hygiene in between. We did not see residents being supported with hand hygiene prior to their meal. Feedback on food quality and choice was mixed, although the staff were observed to make efforts to offer and provide alternatives when residents declined the main options. Opportunities for residents to contribute feedback on menus and preferences were limited.

Recording of food and fluid intake for people was inconsistent, making it difficult to provide assurance that people were receiving adequate nutrition and hydration throughout the day. Food intake monitoring was not always fully completed for those who required it, and weight measurements were recorded inconsistently. While some care staff may have been providing appropriate support, the lack of consistent documentation meant assurance could not be established. We have made a requirement to address this. (see Requirement 2).

People should not experience obtrusive noise within their living conditions. Throughout the inspection, call buzzers were frequently heard going unanswered for longer than expected, resulting in people waiting longer than appropriate for staff support. During our inspection, at times we found we had to look for staff to respond. Loud music was played in communal areas during the day, and this was not always in line with residents' preferences. We highlighted this during the inspection.

Feedback from professionals involved with the service was mixed. We could see for some people that follow up actions to support wellbeing was in place, however we saw this was not in place for others.

Some family members raised concerns about a lack of meaningful activity and social opportunities. Staff reported that limited time prevented them from supporting residents with activities. While dedicated activity staff were observed to make efforts to provide structured and meaningful engagement, there was an identified risk of social isolation for some people. The activity timetable was displayed in small print and was not easily visible, limiting awareness and accessibility (see Area for Improvement 2).

Requirements

1.
By 9 June 2026, to support good hygiene, skin integrity and monitoring of health, the provider must.

a) ensure people's preferences and frequencies as stipulated in their care plan are met for personal care including repositioning

b) ensure that care and support interventions throughout the day are evidenced

c) ensure support at different times of the day is offered where there are repeated refusals to accept care

d) ensure that care plans are formally reviewed once in every six month period.

This is to comply with Regulation 4 (1) (Welfare of Users) of the Social Care and Social Work (Requirements for Care Services) Regulation 2011 (SSI 2011/210) and SSI 2011/210 5(2(b) (iii) Personal plans.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices ' HSCS (1.15).

2.
By 9 June 2026, to ensure people are not at risk of malnutrition, the provider must evidence consistent and clear records for food and fluids that are provided to people. In order to achieve this, the provider must:

a) evidence a time line throughout the day when meals/drinks have been provided
b) evidence detailed recording of nutritional and fluid intake if weight loss is a concern or if the dietician has recommended this
c) evidence consistency in the recording of weights for people who have concerning weight loss.

This is to comply with Regulation 4 (1) (Welfare of Users) of the Social Care and Social Work (Requirements for Care Services) Regulation 2011/210 4 (1) (a) Welfare of Users.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state 'My meals and snacks meet my cultural and dietary needs, beliefs and preferences.' (HSCS 1.37).

Areas for improvement

1. People should be able to spend their day in a way which is meaningful to them and be supported to do so.

This is in order to ensure that care and support is consistent with the Health and Social Care Standards which state "I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors (HSCS 1.25).

How good is our leadership? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses.

The service had established a range of governance and quality assurance processes, including incident and accident recording systems, audits covering falls, infection prevention and control, choking and housekeeping, a home improvement plan with named leads and risk ratings, and a complaints tracking system.

Despite these structures, significant gaps were identified in management oversight of incident reporting and statutory notifications. Several notifiable incidents had not been reported to the Care Inspectorate in line with guidance, which were only identified when leaders were prompted to review records during the inspection (see area for improvement 1). This reduced assurance that risks were being effectively reviewed, learned from and reported, and increased the risk of regulatory non-compliance.

Audit tools and templates were detailed and capable of identifying risks and practice issues such as staff compliance, training gaps and environmental concerns. Leaders demonstrated awareness of areas requiring improvement, which was reflected in the issues recorded within the home improvement plan. A learning forum approach was in place through Home Learning Meetings, supported by a comprehensive template, which had the potential to promote reflective practice and service improvement.

Audits identified corrective actions in several areas; however, these actions were not consistently progressed, lacked clear timescales and did not always identify who was responsible for completion. Issues previously highlighted through audits, such as gaps in post-falls observations, continued to occur, indicating that learning was not embedded and improvements were not sustained (see requirement 1).

The home improvement plan was well structured and demonstrated awareness of service challenges; however, it lacked clear target completion dates and measurable actions. Many actions were marked as "off track with plan to recover" without clear explanation or recovery plans. Oversight and monitoring arrangements were unclear, and some actions lacked specificity, focusing on intention rather than defined improvement activity. There was limited evidence demonstrating how improvement actions translated into improved safety or experiences for residents. This weakened assurance that improvement activity was being effectively driven, monitored and evaluated (see requirement 1).

Night staff reported that they had not met the manager, contributing to feelings of disengagement. Some staff described experiences of limited accessibility to the leadership team, including reports of 'closed door' management and openly critical communication. Combined with frequent changes in leadership and a historical lack of communication, this impacted staff morale, team cohesion and motivation.

Several relatives reported that they had to repeatedly follow up concerns they had raised due to limited communication and lack of timely information. This led to dissatisfaction and reduced confidence in how concerns were managed.

Complaints tracking was in place but many entries lacked sufficient detail, and it was unclear which complaints had been resolved, remained ongoing, or had been escalated. There was limited evidence of learning from complaints, and themes identified mirrored issues raised in previous inspections, indicating that learning had not been consistently embedded (see requirement 1).

Staff feedback highlighted limited management walkarounds and an absence of whole staff or cross team meetings. Some staff described divisions between teams, indicating that leadership oversight of team cohesion required strengthening. The lack of visible leadership reduced staff confidence, limited opportunities for early problem solving and weakened organisational culture (see requirement 1). This is discussed further under 'How good is our staff team?'.

Requirements

1.
By 9 June 2026, peoples' experiences of care should be a result of continuing improvement demonstrated by leadership. In order to achieve this, the provider must

a) ensure that the approach to quality assurance, including audits and observations, is reviewed and improved

b) ensure that the development of clear action plans, detail the areas for attention, staff responsible, and timescales for action

c) ensure that complaints received are fully investigated within 20 working days (or shorter period as may be reasonable) and inform the complainant of the action (if any) that is to be taken.

This is in order to comply with the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/2010) Regulation 3 - Principles; Regulation 4(1)(a) - Welfare of users and SSI 2011/210 18 (3) and (4) Complaints.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I can be meaningfully involved in how the organisations that support and care for me work and develop (HSCS 4.6) and 'I am supported to give regular feedback on how I experience my care and support and the organisation uses learning from this to improve' (HSCS 4.8).

Areas for improvement

1. People should be safeguarded where identified and have their needs responded to after an incident or accident. The provider should improve their reporting and sharing of information with the Care Inspectorate and other relevant departments or organisation in line with current guidance.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that 'I benefit from different organisations working together and sharing information about me promptly where appropriate, and I understand how my privacy and confidentiality are respected'(HSCS 4.18).

How good is our staff team? 2 - Weak

We made an evaluation of weak for this key question. Whilst we identified some strengths, these were compromised by significant weaknesses.

We found staff to be pleasant, hardworking and demonstrated kindness and patience towards residents. Relatives and professionals told us that they were concerned about the use of agency and temporary staff cover that resulted in at times, inconsistency of care provision. Relatives told us they preferred to engage with staff they knew well. A statement we heard from relatives with regard to care and support was "this depends who is on duty." Some relatives and staff members felt that some staff members did not make sufficient effort to get to know their family member or provide person-centred care.

Concerns were identified regarding staffing levels, deployment and availability. During the inspection, particularly on the first day, there was a lack of staff visibility. As previously highlighted, call buzzers were frequently heard going unanswered for extended periods, indicating delays in staff response. Staff were observed multitasking during breakfast, with insufficient support available to meet residents' needs. We heard from some staff who were providing care and support to people that at times they had to stop doing this to then provide tea and snacks. Care staff were assigned to the bain-marie, while some residents experienced prolonged waits for support with their meals. The deployment of tasks and priorities of duties should be re-visited. We saw residents waiting for staff intervention, only for the staff member to be redirected to another task. This meant people were waiting longer than they should due to interruptions. More than one nurse told us that medication rounds could take significantly longer than they should due to interruptions they faced.

During our inspection, inspectors and housekeeping staff were required to seek out care staff to respond to unanswered buzzers, further demonstrating limited staffing availability and ineffective deployment. This had a direct impact on people's experiences of timely support. Housekeeping staff advised they were often approached by relatives looking for available staff. .
We heard from staff and relatives there was confusion among staff regarding "assigned residents," with one relative being told, "not my resident." This created frustration for families and reduced confidence that staff took shared responsibility for residents' care. Relatives and visiting professionals we spoke with reported difficulty finding staff when needed.

Staff themselves described feeling overwhelmed, rushed and under constant pressure. They reported low morale, feeling persistently criticised and unsupported. Concerns were raised about staff interactions, including reports of disagreements during prolonged morning flash meetings and disagreements taking place in front of residents. These reports were corroborated by a relative, an agency nurse and permanent staff. Disharmony was described across staff groups, including day and night staff, housekeeping and care staff, and between local and overseas staff, indicating widespread team cohesion issues.

Information provided to us with regard to staffing levels was inaccurate with further information being provided. We could not be assured that these reflected actual staffing levels or that that sufficient staff were consistently deployed to meet residents' needs.

Overall, while there were isolated strengths linked to individual staff members, these were outweighed by significant and systemic weaknesses in staffing deployment, leadership oversight, team cohesion and staff wellbeing, all of which adversely affected people's experiences of care (see requirement 1).

Requirements

1.
By 9 June 2026, the provider must ensure that there are, at all times, adequate numbers of skilled and competent staff on each shift, to meet service users' health, safety, and wellbeing needs. In order to achieve this, you must:

(a) Gather accurate information about service users' needs and use it to assess how many nursing and care staff with the right skill mix are required on each shift and in each unit during the day and night.

(b) Demonstrate that you are able to anticipate and respond to changes in service users' needs amending staff numbers accordingly when required. This includes monitoring the impact of new and agency staff.

(c) Ensure sufficient staffing to provide meaningful interaction and regular social events, as stated in people's care plans and recorded outcomes.

(d) Establish a clear leadership structure outlining roles and responsibilities. This structure must be communicated effectively to all staff to promote positive team working and peer support.

(e) Ensure that staff wellbeing supports the provision of safe and high-quality care.

This is in order to comply with section 7(1)(a) of the Health and Care (Staffing) (Scotland) Act 2019.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My needs are met by the right number of people' (HSCS 3.15).

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To meet people's needs and promote their wellbeing, the provider should ensure that all care and support plans and related recording tools are accurate, contain sufficient information and people's personal hygiene is supported in line with their personal plan. To do this, as a minimum, the provider should ensure:

a) Records are kept and evaluated to detail the care and support provided to people. This should include, but is not limited to, personal care records.

b) People living in the service are offered a bath or shower regularly, and staff clearly record if this is refused.

c) People are offered oral care a minimum of twice daily and staff clearly record if this is refused.

d) People are offered nail care as required and staff clearly record if this is refused.

e) Staff only record a task has been carried out when they are sure it has been completed.

f) There is a system in place to evaluate support plans, risk assessments and daily records of care at agreed intervals or as people's needs change. Any actions identified should be implemented.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My needs, as agreed in my personal plan, are fully met, and my wishes and choices are respected' (HSCS 1.23).

This area for improvement was made on 24 July 2025.

Action taken since then

We did not see clear evidence to meet this area for improvement. This area for improvement has been replaced by two requirements within 1.3 'How well do we support people's wellbeing?."

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Detailed evaluations

How well do we support people's wellbeing?	2 - Weak
1.3 People's health and wellbeing benefits from their care and support	2 - Weak

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement is led well	2 - Weak

How good is our staff team?	2 - Weak
3.3 Staffing arrangements are right and staff work well together	2 - Weak

To find out more

This inspection report is published by the Care Inspectorate. You can download this report and others from our website.

Care services in Scotland cannot operate unless they are registered with the Care Inspectorate. We inspect, award grades and help services to improve. We also investigate complaints about care services and can take action when things aren't good enough.

Please get in touch with us if you would like more information or have any concerns about a care service.

You can also read more about our work online at www.careinspectorate.com

Contact us

Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY

enquiries@careinspectorate.com

0345 600 9527

Find us on Facebook

Twitter: @careinspect

Other languages and formats

This report is available in other languages and formats on request.

Tha am foillseachadh seo ri fhaighinn ann an cruthannan is cànain eile ma nithear iarrtas.

অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

یہ اشاعت درخواست کرنے پر دیگر شکلوں اور دیگر زبانوں میں فراہم کی جاسکتی ہے۔

ਬੇਨਤੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

هذه الوثيقة متوفرة بلغات ونماذج أخرى عند الطلب

本出版品有其他格式和其他語言備索。

Na życzenie niniejsza publikacja dostępna jest także w innych formatach oraz językach.