CareTech Community Services Limited

Byron Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Bryon Court is a residential care home providing accommodation and personal care to 7 people. The service was supporting 7 people in total who were living with a learning disability or autism.

The service has not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and autism to live meaningful lives that include control, choice, and independence. People using the service did not receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The home was a large domestic style property. There were two identifying signs at the front of the home that it was a residential care home. A poster displaying the rating by the food standards agency was near the front door by the doorbell. The office had a large window at the front with a broken office blind at this window. When the lights were on it was obvious it was an office to a service. This is not in line with the values and policy of Registering the Right Support.

The service did not apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons.

People's experience of using this service and what we found
This was an institutionalised service which did not always provide a safe, person-centred service for people which promoted their independence and rights.

There was ineffective leadership at the home. The registered manager was often not present, and the provider had not responded to this. There were clear failings at the home in terms of managing people's safety, promoting a quality experience, and giving people opportunities in their lives. The provider's own quality monitoring systems were inadequate at identifying the shortfalls of the leadership of the service and taking action to correct these.

These leadership failures led to a poor culture amongst the staff team, where people were not being put first. There had been an event when a member of staff had harmed a person. They eventually returned to work with no clear monitoring or oversight by a manager or the provider. Concerns had also been raised about a potential bullying culture in the staff team. Staff did not feel supported or valued by the leadership, which included the provider.

People's safety was not routinely being considered with action taken to monitor their needs, to ensure they

were safe. Risk assessments and plans for staff to follow had not been created when people experienced new risks to their safety and well-being. Action to seek health professional input or to try and push appointments for earlier dates was not happening. Staff were not seeking out the advice from professionals to support people's needs before referrals were made or before a scheduled appointment took place to keep people safe. We needed to raise two safeguarding referrals during this inspection to the local authority because we were concerned about a person and the shortfalls in their care.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support good practice. People did not have capacity assessments to check they consented to important aspects of their lives.

People's independence with food and the promotion of healthy eating was not explored with them.

Staff spoke with people in direct unfriendly tones. Staff did not encourage friendly banter or conversations with people. Staff and the provider did not promote the environment as people's homes. They did not involve them in making the space their home.

People's interests and ambitions were not being explored or promoted at the home. People's relationships were also not being supported in a safe way. Staff lacked an awareness of the importance of this.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 16 June 2017). At this inspection the service had deteriorated significantly from which has resulted in multiple breaches of the regulations.

Why we inspected
This was a planned inspection based on the previous rating.

You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Byron Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Byron Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. They were not present during our inspection. On the second day the providers representative was available to answer our questions.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed notifications the registered manager had sent us, which they must do so by law. We also spoke with the local authority to gain their views of the service. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who lived at the home, five members of the care staff and the providers representative the locality manager. We had spoken with the registered manager before the inspection regarding a safeguarding event at the home.
We looked at four people's care records - including three people's medication records and two staff personnel records. We completed many observations and reviewed safety records.

After the inspection
We looked at the training records for staff and reviewed an action plan the provider had sent us. We formally requested a further response to our findings at the inspection under our powers of the Health and Social Care Act 2008.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● A recent safeguarding event had taken place when a member of staff had harmed a person. A safeguarding process was followed. However, when we inspected the home on 5 December 2019 we found this member of staff in charge with no management presence. There was no plan from the provider to manage this situation safely. We needed to ask the provider's representative to take immediate action.

● During our inspection we raised two safeguarding referrals to the local authority because of the concerns we had about a person's safety. Some of their health needs had not been identified with a clear plan in place to support staff to meet those needs safley.

Assessing risk, safety monitoring and management

● People did not have full risk assessments in place, which identified the risks which people faced with a clear plan for staff to follow. This could put people at risk of harm. One person had a serious skin complaint which was not explored in a risk assessment.

● Risks associated with people's health and care needs had not been fully assessed. With an accompanying plan to support staff to manage these needs. This placed people at further risk of harm.

● We saw a person had been sleeping in a very wet riser reclining chair, due to incontinence issues. No action had been taken to see if the chair was safe to sit and sleep in. We needed to ask the providers representative to take action about this immediately. Before the new chair had been ordered, no one had considered seeking professional advice about the suitability of the new chair and temporary replacement chair in use, to check it was suitable. We advised them to consult with an occupational therapist.

● Incidents and accidents were not being monitored to review what happened to try and prevent these from happening again. Staff told us they were not involved in any reviews of incidents to consider what lessons could be learnt for next time.

● We found many harmful substances about the home which were not secured. We needed to ask for these to be made secure. We also identified items such as work man's tools and items in the garden which were accessible and could harm people. A person had become upset this year and threated to use an item to harm people. This event had not promoted safer storage of harmful items.

Using medicines safely

● One person was taking additional medicines bought over the counter to help them sleep at night. Staff had not checked with the person's GP or the pharmacist these were safe to take alongside their prescribed medicines. Staff were not recording when these were being administered. No one was auditing these medicines. This placed a person at risk of harm.

● Staff told us this person slept a lot during the day. They were asleep most of the day we first inspected the home. On their medication record it said certain prescribed medicines could make them sleepy. Staff had

not requested a review of their medicines or considered if the additional sleeping medicines were causing this behaviour.
● A person's creams were being stored in their room, but staff were not monitoring the temperature of this room as per the manufacture's guidelines. This had the potential to undermine the effectiveness of these medicines, if the room got too hot.

Preventing and controlling infection
● The kitchen was grubby; the cooker hood was stained and dirty. One person had cob webs in their bedroom by their bed and laminated posters in their room, were layered in dust. Fans were dirty with heavy dust on the blades. These were next to people's beds. This placed people at risk of becoming unwell.
● People's wet rooms had pools of water in them which remained throughout the day. This caused an aroma of stale water at times and was a risk to people slipping and hurting themselves. One person had a rusty metal runner on the ground, they said to, "Stop the water going into their room, I jump over it." Another person had a rusty shower chair. We saw mould on shower curtains. These are infection control risks.
● One person's en-suite and living space smelt of urine. We asked a member of staff what they were doing to address this, they said, "We put things in the air." There was not a plan in place to try and manage this person's continence needs and promote the hygiene of their room.

Learning lessons when things go wrong
● There were no systems in place to learn from situations to improve people's experiences at the home.

We found no evidence that people had been harmed however, but there was a real potential that people could be harmed. This placed people at risk of harm. These were all breaches of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staffing checks were in place to ensure staff were suitable to work at the home, when they joined the service.
● We saw there were appropriate levels of staff to support people and meet there needs.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff did not have the skills or knowledge to manage some people's needs who expressed challenging behaviour. We saw three examples when staff did not know how to reduce these escalating situations. One person was agitated and upset, staff suggested taking them out for a walk. They agreed, but as they were going out still distressed the member of staff invited another person to come too. The distressed person then ran ahead in the street screaming. They had also been assessed to say they needed a member of staff with them when they left the home.
- Staff had given a person money to attend a health appointment. When they did not attend, staff wanted this money back. This person became very upset about this for most of the afternoon. This showed effective techniques were not being used to support people.
- Staff told us they did not feel supported by the registered manager.
- Staff did not have regular supervisions, there were large gaps in these taking place. We were told by the providers representative these should happen six times a year, but they did not. One member of staff had told their line manager they did not feel supported and the workload was too great. There was no action taken about this. Another member of staff had raised issues about, "Staff sitting about a lot." No investigation or action was taken about this.
- Staff competency, with the exception of medicine administration, was not being checked and assessed at the service. We saw examples of poor staff practice and a limited connection with people at the home. This had not been identified before by the management and the provider.

We found no evidence that people had been harmed, however, staff received poor support to do their jobs well. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had some assessments in place, however staff considered these to be out of date and they told us they did not look at these or people's care plans. Care plans were not written in line with guidance to promote people's safety. Some people did not have risk assessments and care plans about their key needs.

Ensuring consent to care and treatment in line with law and guidance

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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- The registered manager and provider were not compliant with the MCA. People who were living with cognitive conditions did not always have capacity assessments in place. Staff told us one person was having a sexual relationship and staff had taken this person to a clinic to access contraceptives. No one had assessed their capacity to consent to sex. This placed them at risk of potential abuse and actual harm.
- Other people did not have capacity assessments about managing their money. Their finance plans showed staff managed their money. The provider was using individuals own money to pay for the individuals' yearly holidays. People were also signing a consent form to pay for staff lunches and drinks when they were out with staff. However, they may not have had capacity to consent to their money to be used in these ways.
- Staff were restricting people's access to food without any assessed reason.
- Clear and strong systems were not in place to protect people's rights, with consenting to care and support.

We found no evidence that people had been harmed, however, people's consent was not being obtained in an accurate and meaningful way. This placed people at risk of harm and was a breach of their rights. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- Staff had identified one person was at risk of choking in October 2019. No action had been taken to seek input from a specialist professional at this time. Staff and the registered manager had instead waited until a planned health review on 5 November 2019 to raise this with professionals. When a referral was made to a specialist food team, the registered manager and staff had not asked what they should do in the meantime, before a professional from this team assessed this person. This placed them at constant risk from choking.
- We saw this person being supported to eat. At times it did not look safe. They made a coughing noise after eating. We needed to tell the providers representative to take action about this quickly.
- Healthy foods were not promoted by staff. One person wanted to lose weight. When they asked for unhealthy foods a healthier alternative was not suggested and the unhealthy option was given to them.
- Food which had limited nutritional value was being given to people. Lunch was tinned macaroni and cheese, tinned sausage and beans, or wafer-thin ham on white bread. There were no fresh fruit or vegetables accessible to people. There were some bananas and pears, but these were in a padlocked cupboard in the kitchen. When we asked why, we were told that it was where the knives were also stored. No one had thought about bringing the fruit out for people to snack on.
- Staff did not show concern about whether people enjoyed their meals. When preparing a person their lunch a member of staff said, "Oh, that doesn't look that loose normally, oh well." They did not ask the person whose lunch it was, if this was okay for them.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support

● The registered manager and staff had not been proactive at working with health and social care professionals to help support people and meet their needs. One person's continence needs had changed, no action was taken to respond to this.

● Timely action was not taken to respond to some people's health needs. One person needed to see the GP because staff had found a sore area of their body. They were given an appointment in three weeks' time. No staff had tried to challenge this or seek an earlier appointment. Even though this person could not communicate with people, lacked capacity, and regularly touched the affected area.

● Staff did support people to go to health appointments. However, one person had a lot of appointments on one day. The impact of this on this person had not been considered.

Adapting service, design, decoration to meet people's needs

● There was some redecoration taking place and some new items were going to be purchased for the service by the provider. However, people were not allowed to be involved in choosing items and colour schemes. A member of staff told us, "We were given the choice of grey and white or brown and white. The manager spoke with the provider, but they said we couldn't have any other colours."

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity.

Ensuring people are well treated and supported; respecting equality and diversity

- Two members of staff spoke to one person in a kind and caring way during the inspection. However, staff generally spoke in direct non-friendly tones to people. One person was expressing challenging behaviour and a member of staff spoke at length in a shouting tone at them which did not calm the person down.
- Another person was preparing their lunch, they were putting spread on their toast on a plate. A member of staff said in an authoritarian way twice, "Can you put that on a chopping board, thank you." The tone was not friendly, it was direct, an order. They did not explain to the person the reason or importance of using a chopping board instead of a plate.
- Staff did not show concern for people's wellbeing. A person was sleeping and resting in their wheelchair in the staff office. Two different staff made continuous loud noises trying to find items in the filing cabinet next to them. We needed to ask a member of staff to be respectful as this person was resting. Nor had any consideration been given to supporting the person to be in a different environment or take them out.
- A person told us about their diverse wishes and needs. They told us staff had said it was "Okay," but they had not offered practical support or made plans to support this person to explore this need in a protected and caring way.

Respecting and promoting people's privacy, dignity and independence

- One person's door was open, and they were fast asleep. Their bedroom was next to the front door. We were told staff could not close the door as the door way had been recently painted. But staff could have closed the door to their actual bedroom, to promote their privacy, but they did not.
- Staff and the provider did not respect the building as people's own home. The provider did not give people choices with decorating their bedrooms and the communal parts of the home. One person referred their room to looking like a "Prison cell," due to its colour.
- Staff were seen to hang out in the lounge watching TV when people were in the room. One member of staff vaped in the lounge. We spoke with this member of staff we asked if they had asked people if this was ok, they told us they had not. Nor had any consideration been given to this potentially upsetting a person or causing harm to them.
- Broken furniture had been left outside, some items had moss growing on them. In the lounge, some curtains needed to be replaced, but when they arrived they were too small, so a member of staff said they were returned. However, the old curtains were not put back. This room faced into the back garden, but staff had not tried to create a homely environment. The room was going to be redecorated but no thought had been given to people's experience before this time.
- Confidential information was not stored securely at the home. As people's files with their names and

pictures on them were on a book shelf. The office had a large window over looking a suburban street, with a broken blind at the window.

● The registered manager and staff were not promoting people's independence. For example, one fridge in the kitchen had a bolt and padlock on it. A member of staff told us it was because milk was stored in that fridge, and people may use the most recent bottle of milk rather than milk which needed to be used up. No attempts were made to teach this domestic skill to people.

We found no evidence that people had been harmed however, people were not being treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

● Some people told us they spoke with their key worker at the end of each month to review what had happened that month. Some people said they looked at their care plans, others said they did not and were not supported to. Most people's care records were not in formats they could understand.

● In many aspects of people's care, managing their money, relationships, and care needs, people were not involved in the planning and managing of these needs.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The planning of people's care was not person-centred and there was not a culture in the staff team to do this. People had care assessments in place written some time ago. Staff told us they did not look at these. People's care plans lacked details about people's actual situations, so staff knew how to support people. For example, a person had struggled with their mental well-being earlier in the year. There was no assessment or plan about this to try and address and manage this going forward. Some people had needs which were not reflected in their assessments and care plans at all such as, risk of self- harm, a breakdown to their skin, and supporting their diverse needs. This placed people at risk of physical and emotional harm.
- Reviews lacked purpose. Often there was a statement saying, "No change", when there had been changes in people's needs.
- Consideration and thought was not given to improve people's experiences. One person was trying to get fit. A member of staff took them swimming each week but told us this person often did not engage with this activity. They said, "[Name of person] might do so, if I could swim and get into the pool with them, but I can't." Plans had not been made to ensure a member of staff who could swim went with this person and got in the pool with them.
- Staff told us one person was reluctant to go out or spend time in the lounge. They told us what this person's interests were. They had not considered promoting these interests in the lounge. For example, playing a type of music they liked or putting programmes on the TV about their interests. We needed to make this suggestion. Nor had they thought about related events outside of the home.
- Another person who could not communicate with others was often left without any form of engagement. They had two items in their hands at one point which a member of staff said they enjoyed holding. One of these items was their mobile phone. It had a broken screen which was sharp to touch and could hurt them. This phone did not work. Despite having one to one care often the staff who supported them just watched TV. Thought was not being given to make their time stimulating or interesting.
- People's rooms were not always personalised. One person had various slings of different sizes stored in their room with a poster telling staff how to use the hoist. We were told this person liked the colour orange, this was not promoted.
- The home was cold. People were wearing coats and many layers at times. This had been reported but no quick action or follow ups had been made until the provider's representative directed a member of staff about this. Staff routinely opened windows even though it was cold. One person wearing a coat inside said, "I'm always cold in here."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them

● People were not encouraged and supported to maintain relationships with people that mattered to them. One person had a partner who lived at another home. Staff told us their partner was not allowed to come to the home as staff at Byron Court did not have training on how to manage a particular need of theirs. No plans or actions had been made to enable this person to see their partner in their own home.

● People's compatibility living together was not being reviewed. The appropriateness of people's placements was not being considered.

● There was a lack of promoting people's goals and aspirations. People did go out into town and to some organised clubs. However, they did not do anything different. The culture of the service was not trying to develop people's experiences or expand their interests.

● Staff did not routinely chat and engage with people in a social friendly way.

We found no evidence that people had been harmed however, people were not being cared for in a way which promoted their interests, considered their futures and provided them with person centred experiences. These were all breaches of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● There was information about people's communication needs in their care records. Although, people's written documents were not in a format people could easily access or understand.

End of life care and support

● People had basic end of life plans in place. Often about funeral arrangements only. These plans did not include their wishes or what was important to them.

Improving care quality in response to complaints or concerns

● A complaints process was in place. A person told us they had made a complaint and spoken with the registered manager about this. They said the response was, "Okay."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant failures in the leadership of the service. Leaders and the culture they created did not assure the delivery of high-quality care.
Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There had been failures at both management and provider level to assess the quality of this service and make improvements.
- We found issues with most elements of service provision. Had meaningful checks been completed by persons who knew what good quality care looked like, these issues would have been identified, but they had not.
- We needed to raise urgent issues throughout our two day inspection to the providers representative. We needed to tell them to take action to ensure people were safe. We also raised concerns with the safeguarding team at the local authority. These are all signs the service was not being well managed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a poor culture at the home. People were not being put first and treated in a way which promoted their rights and needs.
- Staff felt they needed the registered manager to be present more in the home. They did not feel involved in managing people's needs.
- Staff had a limited opinion of the provider. One member of staff said, "It's just a business to them [the provider]."
- There were concerns about the culture of the home, identified by the registered manager, which included staff bullying and how some staff treated people. The provider had not responded to these. There was a lack of strong leadership at the service which contributed to the poor culture of the home.
- We identified numerous examples of people not receiving person centred care and good outcomes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People were not routinely involved in the development or management of the service. Staff and the management team were not promoting or championing people's rights in this way.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

- The provider started to take action when we inspected the home and raised our concerns with them. However, the provider's own quality monitoring systems and understanding of what good care looked like had not identified the failures of this service.

● There was no culture of working with others to identify and make improvements for people living at Byron Court.

We found no evidence that people had been harmed however, there was a poor culture and leadership at the home. There were inadequate systems which assessed the quality of the service in a thorough and meaningful way. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider had not ensured that care and treatment was always provided in a person centred way. Regulation 9 (1) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The leadership of the service and staff did not always promote people's dignity and respect. Regulation 10 (1) and (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager had not ensured that people's consent to care was assessed, monitored and promoted at the service. Regulation 11 (1).

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 not ensured that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks. Regulation 12 (1) and (2) (a) (b) (e) (g) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of effective systems to ensure quality care was always provided. Regulation 17 (1) and (2) (a) (b) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff had the information, knowledge and skills to do their jobs well. Regulation 18 (1) (2) (a).