Care Quality Commission

Byron Lodge (West Melton) Limited

Byron Lodge Care Home

Inspection report

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West Melton
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South Yorkshire
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Date of inspection visit: 15 July 2015
Date of publication: 02/09/2015

Ratings

Is the service safe?	Inadequate
Is the service caring?	Requires improvement

Overall summary

We carried out this focused inspection on 15 July 2015 following concerns raised by whistle blowers and by the local council.

Byron Lodge is a care home providing accommodation for up to 61 people. It is situated in the area of West Melton, approximately six miles from Rotherham town centre. It provides accommodation on both the ground and the first floor and has parking to the front of the building and a secure accessible garden at the rear.

The service did not have a registered manager in post at the time of our inspection. 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 2008 and associated Regulations about how the service is run.

We spoke with the deputy manager, who was covering the manager role at the time of our inspection, supported by the service manager. We were told that a new manager had been employed and would be commencing their role in August 2015.

At this inspection we found, while most people said they were happy with the home, we identified a number of concerns. Our observations and the records we looked at did not always match the positive descriptions some people gave us. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that risks associated with people's care were not always monitored, people's privacy, dignity and preferences were not always respected and the management of medicines was not appropriate. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The provider did not have appropriate arrangements in place to manage medicines. The provider's medication policy and procedure did not include instruction for the medication system that was in place at the home.

People were not protected against the risks associated with the unsafe use and management of medicines. Appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration or disposal of medicines used were not always in place and/or followed.

Care and support was not always planned and delivered in a way that ensured people were safe. We saw support plans included areas of risk. However they were not always monitored and applied effectively and therefore did not always prevent risks from occurring.

We observed staff interacting with people to ascertain if there were enough staff to meet the needs of people living at the home. On the day of our inspection there were more staff on duty due to staff working extra shifts to ensure they worked their contracted hours. Therefore it was difficult to gain a clear picture of what the staffing situation would be on a usual day. We will look at this further when we visit the home again.

We spoke with staff about their understanding of safeguarding people from abuse and what action they would take if they suspected abuse. Staff we spoke with were knowledgeable in this area and told us they would report anything they needed to straight away.

We observed staff interacting with people and we spoke with people who used the service and their relatives. Relatives felt the staff were very caring and kind. However one person who used the service felt their choices and preferences were not respected. We also observed staff to be task focused and did not always check out people's preferences.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not safely dispensed and recorded. We identified that the administration of medicines was not always accurate.

Care and support was not always planned and delivered in a way that ensured people were safe. We saw support plans included areas of risk.

We looked at the numbers of staff on duty to ascertain if there were enough staff to meet people's needs. It was difficult to gain a clear picture due to extra staff working on the day of our inspection.

We spoke with staff about their understanding of safeguarding people from abuse and what action they would take if they suspected abuse. Staff we spoke with were knowledgeable in this area and told us they would report anything they needed to straight away.

Is the service caring?

Requires improvement

The service was not always caring.

We observed staff interacting with people and we spoke with people who used the service and their relatives. Relatives felt the staff were very caring and kind. However one person who used the service felt their choices and preferences were not respected.

Byron Lodge 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 was a focused inspection following the receipt of concerning information. We inspected this service against two of the five questions we ask about services: is the service safe and is the service caring.

This inspection took place on 15 July 2015 and was unannounced. The inspection team consisted of an adult social care inspector 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 care service. Their area of expertise included older people and caring for people living with dementia.

We spoke with the local authority and commissioners. The local authority was continuing to closely monitor the service.

At the time of our inspection there were 54 people living in the home. The service consisted of four units, Shakespeare, Ruskin, Wordsworth and Byron.

We used the Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spent some time looking at documents and records that related to peoples care, including risk assessments and the recording of medicines. We spoke with six people who used the service and seven relatives.

During our inspection we also spoke with six members of staff, which included a nurse, care workers, deputy manager and the service manager.

Inadequate

Is the service safe?

Our findings

We looked at this domain following concerns received from the local council and others regarding the staffing levels and management of medicines.

The provider did not have appropriate arrangements in place to manage medicines. The provider's medication policy and procedure did not include instruction for the medication system that was in place at the home. The policy referred to the previous system and was in need of updating. We spoke with the service manager about this who agreed this was required.

Medicines were delivered on a monthly basis, however not all medication was booked in using the Medicine Administration Record (MAR) or any other record. This made it difficult to ascertain how much medicine was in the home at any one time.

There was a record available for the disposal or returned medicines to pharmacy. However we saw the record dated back to February 2015 and had not been signed by a pharmacist to indicate the medicines had been returned. We saw a large container with quite a lot of medicines in it which was to be returned to the pharmacy to be destroyed. We also saw a large box full of medicines which required returning to the pharmacy. We asked the deputy manager about this who agreed that it should be returned as soon as possible.

We looked at the MAR sheets for eight people who used the service. We saw some gaps in the charts where there were no signature and no code to say if the medicine had been given or why it was not given. We also saw some MAR sheets which recorded 'C' as a code for administering the medication. We spoke with the nurse on duty who said the 'C' is usually when creams had been prescribed and meant the carers had applied them. However, there was no indication on the MAR sheet as to what this stood for. This meant the record was not accurate.

We saw one MAR sheet which indicated that a person had been out of stock of one of their prescribed items for four days. The item was only ordered on the third day of it being out of stock, this meant there had been a delay in ordering this item. We asked the nurse on duty about this but they were unsure how this had occurred.

We found one bottle of paracetamol suspension in the medicine trolley on Ruskin unit which had no label on it. This meant that there was no name indicating who it belonged to and no dose. This meant there was a risk that the right person had not received their prescribed medicines.

This was a breach of regulation 12 (1) including (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (safe care and treatment).

Care and support was not always planned and delivered in a way that ensured people were safe. We saw support plans included areas of risk. We saw risk assessments had been devised to help minimise and monitor the risk. However, we saw one person's risk assessment identified they were at a high risk of malnutrition and had been in hospital under the care of dieticians. The care notes stated that the hospital had asked the home to commence a first line treatment plan and to review after one month. This was commenced on the 15 May 2015; however, this had not been followed up. The care notes also stated that the person should be weighed weekly. Records showed that the person was weighed on the 30 May 2015, 25 June 2015 and 11 July 2015; this indicated that the weekly weights were not taking place. Weights had been recorded on three different records and were not accurate. This meant the person's risk of malnutrition was not managed appropriately. We spoke with the deputy manager about this who said they would ask staff to weigh the person that day.

This was a breach of regulation 12 (1) including (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (safe care and treatment).

We spoke with people and their relatives and were told they didn't feel there were not enough staff to deal with the needs of people at all times of day. One person said, "It's not their (the care worker's) fault. There are just not enough of them to go round so they end up trying to help too many people at once." A relative said, "I made a complaint to the manager last week because there were only two carers on one unit and that's not enough. My family member had only just got dressed when I arrived because the two carers had to deal with so many people." Another relative said, "I know it's easy to say they need more staff, but at the end of the day it affects the care of these residents when carers are so pulled out. They never stop all day and they must be exhausted at the end of the shift because they're trying to

Inadequate

Is the service safe?

make sure everyone gets good care." Another regular visitor said, "They have been very short-staffed, but I've noticed a few more carers in the last couple of weeks so I hope that continues."

We saw that one person had severe bruises on their face. This resident explained they had fallen several times. They said, "It's my own fault. I keep trying to walk when I can't! The carers do tell me to stop trying to walk by myself."

On the day of our visit care workers told us there were more staff than usual on duty that day and this made their jobs less stressful. The deputy manager confirmed there was more staff than usual working on duty. This was due to the service having to ensure staff worked their contracted hours and this occurred sometimes. It was therefore difficult to gain a clear picture of what the staffing situation would be on a usual day. We will look at this further when we visit the home again.

However, we saw that care workers were very busy all day and they were focussed on completing care tasks, so time for social interaction with people was very limited.

People we spoke with all told us they felt safe living at the home and relatives thought their family members were safe. One relative said, "It's a relief to know family member is safe and secure. I can rest easy at night now."

We spoke with staff about their understanding of safeguarding people from abuse and what action they would take if they suspected abuse. Staff we spoke with were knowledgeable in this area and told us they would report anything they needed to straight away.

Requires improvement

Is the service caring?

Our findings

One person, who communicated with us, felt some of the care workers were very good at their jobs, but others did not perform the caring tasks as well. The person told us they would like the care workers to ask their views on how they would like the care delivered, for instance in moving and handling and personal hygiene. They also said they would like to be given the opportunity to explain preferences they had, for instance for meals and drinks. More importantly, they would like all the care workers to deliver these choices and preferences. The person wanted us to inform the manager of their concerns and we discussed this with the deputy manager who said they would look in to the matter.

We saw that one person's dignity was not upheld when they were hoisted wearing a short skirt and no other cover was provided. One of the care workers explained that they were waiting for relatives to supply longer skirts. No consideration had been made to the person's preference of wearing a shorter skirt and the possibility of preserving dignity using a cover.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (dignity and respect).

We observed staff interacting with people throughout the day including lunchtime. We saw staff were very task orientated. For example, we observed lunch and found not all people were asked or even told what was for lunch and a bowl of soup was placed in front of them. No one we observed was told what kind of soup it was. Sandwiches were served after the soup had been eaten. Staff did ask what kind of sandwiches people would prefer. However, no one was asked if they would like their soup and sandwiches served together or if they would like bread with their soup. One person did say they did not want the soup and asked for some toast which they received. People were also asked what they would like to drink and staff respected their choice. The dining areas were very quiet during lunch, no music playing in the background and there was very little conversations between staff or people who used the service. This reinforced that this was a task and not much consideration had been made to the dining experience for people living at the home.

We did not see much meaningful activity taking place on the day of our visit. In the afternoon, a group of ladies received a pampering and nail painting session in the reception cafe area, with warm drinks and biscuits. A relative/volunteer was helping with this activity and the ladies were enjoying themselves. However, other people who used the service did not receive social stimulation. In the Wordsworth lounge the TV was playing all day and no-one was watching. People were mainly asleep. The care workers in the room were mainly completing their notes and not interacting much with people. One care worker brought a few magazines for one person, but told them, "They're probably a load of rubbish, but you can look through them."

The Wordsworth lounge was not designed or adapted to be dementia friendly. There were no dementia friendly resources, rummage boxes, sensory areas or displays to stimulate people. The care workers were interacting in a limited conversational way between writing notes. There were some effective sensory decorations along the corridors, including tactile tapestry pictures and appropriate 1950's film posters, but not in the communal areas. We noted there was no colour coding in the corridors to aid orientation and no coloured doors to aid identification of rooms. Some rooms had memory boxes outside but were very sparse and did not say a lot about the person.

We noted that three of the four units had interesting tactile displays on the corridors, but the Shakespeare Unit did not. We noted that all the communal sitting areas were well decorated, but mainly plain and uninteresting.

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

We spoke with people who used the service and their relatives and most were complimentary about the care workers. People told us the care workers were kind, caring, compassionate, patient and friendly. One person said, "They're a really lovely bunch. They work so hard and I've never heard them grumble." Another person said, "They have such a lot of patience. Some of the residents can be very difficult, but I've never heard a raised voice, ever." Another person said, "I have to travel on two buses to get here, but it's worth it because these carers are so good with my relative."

Requires improvement

Is the service caring?

Relatives we spoke with told us that care workers respected their family member's privacy, by knocking on bedroom doors before entering and keeping doors closed when appropriate. We saw care workers knocking on doors before entering bedrooms. Relatives told us they had not witnessed any breaches of confidentiality.

Relatives appreciated the care that staff provided. One relative we spoke with helped the activity co-ordinator once a week with the pampering session on a voluntary basis to try and help the staff as much as possible.

The café area in reception was popular with relatives. One relative said, "The coffee area is a godsend. When I take my mum there she thinks she's gone out for a trip. It's such a good place to sit and have a chat, away from the unit."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's care did not always meet their needs and reflect their preferences. Regulation 9 (1) (a) (b) (c).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People who use services did not always have their dignity maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who use services were not always protected against the risks associated with their care and treatment. Regulation 12 (1) and (2)(a).**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have appropriate arrangements in place to manage medicines. Regulation 12 (1) including (2)(g).

The enforcement action we took:

We have issued a Warning Notice which we have asked the provider to comply with by 20 August 2015.