Byron Court Care Home Limited

Byron Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

A responsive inspection took place on 21 and 25 April 2016 and was unannounced. This inspection was to follow up on concerns raised by the Local Authority following recent events at the home. This inspection was also to follow up on concerns that were identified at our last inspection in December 2015.

During this inspection we found that little improvement had been made, and there were still concerns which compromised the health, safety and welfare of people living at Byron Court.

Byron Court is a care home proving personal care and nursing care. It is registered to provide accommodation for up to 53 adults who require nursing or personal care. There is a separate unit for people who have dementia. The building is large three storey property. A passenger lift provides access to all areas of the home.

There were 48 people living at the home during the time of our inspection.

A registered manager was in post and was available for us to speak to for the first day 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.

During our last inspection in December 2015 we found the provider was in breach of regulations relating to medication, risk assessments, staffing, person centred care, failure to display ratings, and governance. The home was rated as 'inadequate' overall and placed in special measures.

During this inspection we found there were some audits in place around the cleanliness of the building and medication; however we found a lack of auditing systems around service provision. The current auditing system had failed to highlight the concerns we picked up on during our inspection.

We were told by staff that the staffing provision was not sufficient, and staff felt they could not spend time with people. There was no formal mechanism for determining what the staffing numbers should be based around people's needs We observed one person was shouting for help and the staff did not come in a timely manner. . There was no staff presence in the lounge on occasions to ensure people's safety and comfort.

During our last inspection in December 2015, we found the provider was in breach of the regulation associated with the management of risk for people who lived at the home. During this inspection we saw that some risk assessments were in place to help keep people safe from harm.

People were not always receiving care in accordance with their plan of care. Some people were not being weighed regularly, and other clinical tasks that people needed were not always being completed. Some

people's care plans did not contain information such as MUST scores and some information was difficult to find.

There was a process in place for gathering feedback from stakeholders and family members.

Equipment was in place to help support people with their personal care, and this was being regularly checked in accordance with national guidelines, however we saw the weighing scales were not always fit for purpose. One person's weight was not documented accurately, and another person could not be weighed because the type of scales the home used were inappropriate.

We observed on more than one occasion, that a fire door was wedged open, which presented a risk to people living at the home and others in the event of a fire.

We found the laundry room, a store room and a cupboard were left unlocked and unattended. One contained substances which could be ingested or swallowed by people with dementia by mistake. An area of the home was being used to store wheelchairs which could pose a risk if people had to be evacuated quickly from the building.

Most of the staff we spoke with were aware of abuse. They knew what constituted as a safeguarding and how they would report this; however, we found that one alleged safeguarding incident had not been reported.

We found that the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not always being used appropriately. There was conflicting information recorded concerning the capacity of some people, and we found the best interest processes had not always been followed. We did see some forms of consent documented in care plans and we heard staff asking for peoples consent at some points during our inspection.

People told us they had enough to eat and drink, however we could not see any evidence of choice around mealtimes. There was no menu in place, and people told us they only knew what they were having on that day.

We found that referrals were being made to other professionals when they needed to be, although the action taken was not always documented.

There was a complaints' policy in place. There was not a complaints log to check if appropriate action had been taken to address complaints.

Staff we spoke with were knowledgeable regarding people's needs. The interactions we observed between staff and people who lived at the home were positive.

We saw some confidential information displayed in corridor which we highlighted to the deputy manager at the time. The deputy manager removed this information.

During our last inspection we saw the ratings from our last inspection in June 2015 were not being displayed as required. At this inspection the ratings from the December 2015 were displayed so that people were aware of how the service was performing. The provider was no longer in breach of the regulation.

During our last inspection in December 2015, we found people were not always protected against the risks

associated with medication. We found during this inspection that improvements had been made and the provider was no longer in breach of this regulation.

People told us they liked the staff and felt safe living at Byron Court.

Staff were recruited appropriately and the relevant checks were undertaken before they started work to ensure they were fit to work with vulnerable people.

During our inspection we raised some concerns regarding how the service was being managed whilst we were present in the home. The provider took acceptable steps to address these concerns.

The overall rating for this provider is 'inadequate'. This means that it has been placed into 'Special measure' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in Special Measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We will report on any action we have taken once this has been completed.

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 were not always protected against risks which might cause them harm, as some risk assessments were not completed or contained inaccurate information.

There was a lack of staff presence in some areas of the home. Staff told us they were short staffed.

Measures were in place to regularly check the safety of the environment and equipment. However, the service did not always ensure effective fire safety measures were adhered to.

Staff understood how to recognise abuse and how to report concerns or allegations; however one incident had not been reported.

Is the service effective?

Requires Improvement

The service was not always effective.

Care and support was not always provided in accordance with the Mental Capacity Act 2005 (MCA).

Staff training was up to date; certificates were in place to confirm training had taken place.

People had access to medical professionals when they needed them.

People got plenty to eat and drink, the food was freshly prepared. People did not have a menu to choose from and their food and fluid intake was not always being recorded for people who required support with this

Is the service caring?

Requires Improvement

The service was not always caring

We did observe some positive interactions and staff knew people well. However there were quite of number of times when people

were left on their own and staff presence was minimal.

Confidentially was not always protected Some personal information was displayed in a communal place.

People told us that some of the staff were caring, and we received positive comments about staff from families

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not always in place for people who required them. Some care plans contained conflicting advice. Documentation which was needed to keep people safe was either not completed or was missing from care files.

We found that referrals were being made to other professionals when they needed to be, although the action taken was not always documented.

There was a complaints policy in place; however, there was no complaints log so we were unable to check if appropriate action had been taken to address complaints.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of leadership in the home. Some staff expressed that the management had not always been approachable.

The provider did not have a robust system in place to regularly assess, monitor the quality of the service. Staff however spoke positively about the new providers of the home, and there were plans in place to improve the home.

There was a whistleblowing procedure in the home; staff confirmed they understood what whistleblowing was.

The home had a process in place for gathering the feedback of people who
lived at the home.

Byron Court 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 21 & 25 April 2016 and was unannounced.

The inspection team consisted of three adult social care inspectors and a specialist nursing advisor.

Before our inspection we reviewed the information we held about the home. This included the Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We had not requested a PIR for this service. We also looked at the notifications and other intelligence the Care Quality Commission had received about the home. We had received information of concern before this inspection had taken place; this inspection was conducted in response to those concerns. In addition, during our last inspection in December 2015, we found the provider was in breach of multiple regulations to the Health and Social Care Act 2008 Regulated Activities (Regulation's) 2014. This inspection was also to check if the provider was still in breach of those regulations.

We spoke to 11 staff, including the registered manager, 12 people who live at the home, and two relatives. We looked at seven care files and four staff recruitment folders as well as other documentation relating to the running of the home. We looked around the building, including bathrooms, lounges the dining room and some people's bedrooms.

Inadequate

Is the service safe?

Our findings

During our last inspection in December 2015, we found breaches in relation to medication, safe care and treatment and staffing. This domain was rated as 'inadequate.'

During this inspection we found the only improvement made was in relation to medication. We also found additional breaches.

During our last inspection in December in 2015, we found that not all risks assessments reflected people's needs. We found the provider was in breach of this regulation. During this inspection we looked at risk assessments relating to people's care and checked to see if risks associated with their safety had been assessed. We saw risk assessments were in place. We saw people had been assessed in areas such as falls, mobility and nutrition. Some of these risk assessments were comprehensive and contained information to help mitigate risk. However, there were still concerns around gaps and accuracy. We found some conflicting information which meant that the risk assessments were not being completed accurately or were not being reviewed when people's needs changed. For example, one person had a mobility risk assessment in place. This person was scored as being able to walk with the support of carers. We saw in some of their other documentation that this person was a wheelchair user, which would have given them a different score. We found this had been the person's original score when they had entered the home. The records had not been updated to reflect that they were now using a wheelchair for all mobility needs.

The staff could not always clearly evidence the process they had followed to address risks to people. For example, one person had their medications, food and fluid through a PEG [Percutaneous endoscopic gastrostomy]. PEG feed is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. We observed the person's PEG tube was discoloured and had become flattened on one end. We were concerned, as the staff told us the PEG was 'sometimes difficult to get water through'. We asked to see if this matter had been referred to a specialised nurse for assistance to ensure the PEG was still functioning appropriately. There was no risk assessment which indicated the concerns around PEG, and the only referral we saw was twelve months prior to our inspection. No other action had been taken. When we spoke to the staff, they confirmed they had pursued this as they felt the person was at risk, though details of the action they had taken was not documented anywhere in the person's records. Another example of this was for one person who had been assessed as being at risk of falls. Their records indicated that they had fallen twice. The nurse on duty told us that this person had been referred to falls clinic; however there was no supporting documentation in the person's records to indicate that a referral had been made. Conversations with staff indicated they were aware this person was at risk and were monitoring them.

This is a breach a breach of regulation 12 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the deployment of staff within the home. During our last inspection in December 2015, staff told us there was not enough staff on the middle floor of the home. We also found there was no formal

dependency tool used to access whether staffing numbers were determined in conjunction with people's accessed needs. During this inspection we found that little improvement had been made. Different staff told us there was not enough of them on the middle floor to complete peoples routines. One staff member said "I don't know how we do it, but we get the residents sorted." The same member of staff told us that if someone needs to go to the toilet the nurses will come and find the care staff to take them because they 'don't have time'. Another member of staff told us that staffing levels need to be improved.

Staff we spoke with said that staff rotas were often handed out late. There was no formal tool in place which assessed people's dependencies so that the service could determine the number and skill mix of the staff needed to care for them. We observed the lounge areas of the home, and found there were long periods of time when people were left without staff presence. In the dementia unit, there were nine people sitting in the lounge having breakfast. There was one staff member in the lounge who told us they were not usually in this section of the building so they were unfamiliar with the people who lived there. There was a risk therefore that they did not know how to support people safely and in accordance with their individual need.

On the second day of our inspection we did observe one member of staff painting someone's nails. The staff member told us this was a 'one off' because us the Care Quality Commission were here, and there were more staff on duty due to our inspection. The member of staff said they did not usually get the time to sit and talk to people. A staff member told us there was no continuity of care as staff were required to work on different floors. They gave an example of this when caring for a person who had recently passed away at the home. and staff were dependant an accurate record keeping to know if for example, a mark or pressure area is worsening or not. Another member of staff told us moral had been low in the home due to staff shortages.

We observed a person shouting from their room, their voice didn't have volume so was difficult to hear. Their legs were half off the bed and they said they needed help. We raised the alarm and pressed the call bell there was no staff walking around up/down to have heard the person calling for help.

This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection we observed fire doors were wedged open, both external, and the internal laundry room. Retaining fire doors in an open position means they are not able to close automatically which places people at risk in the event of a fire. We brought this to the attention of the registered manager who took action to rectify this. Later on during our inspection we found this door was open again, and had to bring this to the attention of the registered manager for a second time.

On the first floor we saw a store room was unlocked which contained soaps and other cleaning products. We brought this to the attention of one of the staff on that floor

This is a breach of Regulation 12(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most areas of the home were clean and tidy. On day one of our inspection we observed a downstairs bathroom in the dementia unit was left open and there were various toiletries, including a razor left within reach of people. We brought this to the attention of one of the staff on the unit. Twenty minutes later, the bathroom was still not attended to; we had to find the staff member again to alert them to the possible risk of harm this could cause to someone with dementia due to ingestion of the soaps and shampoos by mistake. We observed, on the ground floor there was an open door inside a bathroom with a 'high voltage' sign on the front. The lock was broken on this door, and there were various electrical switchboards inside.

We brought this to the attention of the registered manager who engaged the help of the maintenance person to fix the lock.

This is a breach of Regulation 15 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed safeguarding with the staff at the home. We saw that there was a safeguarding policy on display which incorporated the local authorities safeguarding procedure. Staff we spoke with were able to explain what safeguarding was and what they would report to the manager. The training matrix showed that recent training had been undertaken in safeguarding; however one member of staff told us they had not received any training. During our discussion with one person who lived at the home they informed us they had recently reported an incident to the staff regarding a possible theft. When we asked the deputy manager about this, they were not aware and we were informed that the incident had not been documented or reported. The registered manager visited the person straight away to make further enquires. Following discussions with the person concerned the registered manager was able to provide assurance that a theft had not occurred and further actions were not required. We were however concerned that the incident had not been reported initially or documented. This had the potential to leave the person at risk of abuse as robust safeguarding procedures had not been adhered to...

This is a breach of regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe living at the home. Comments included "Very safe living here". Also "Very pleased with the care here."

We looked at how medications were managed in the home. During our last inspection in December 2015, we found the provider was in breach of this regulation. During this inspection, we found that improvements had been made, and the provider was no longer in breach. Medication was stored in separate trolleys for each of the three floors in the home, along with a separate trolley for night time medication. The trolleys were locked securely in a designated room. The medication policy in the file was dated 2012. When we highlighted this to the registered manager, they informed us that the policy had been updated; it was on the computer system and had not been printed yet. The manager rectified this.

There was a covert medication policy in place however no one was taking covert medication at the time of our inspection. Covert medication is when medication is disguised in food or drink. We looked at medication administration records (MARs) for seven people and found most contained correct information. We saw that one person's MAR, who has medication administered via a PEG tube, was missing some instruction with regards to whether a tablet needed to be crushed. We raised this with the registered manager at the time who contacted the pharmacy for this information to be added. We looked at the storage of medication. We saw that medication requiring cold storage was stored in the fridge and the temperature was regularly monitored. Controlled drugs (CDs) were stored correctly in line with the legislation in a locked cupboard. These are prescription medicines that have controls in place under the Misuse of Drugs legislation.

The nurse in charge showed us the procedure for returning medication and the delivery of medication to the home. The pharmacy checked all delivered medications were correct, and this was subsequently checked again by the nurse on duty.
We checked to see what safety checks were undertaken in the environment. We saw a range of assessments and service contracts which included fire safety, gas, electric, and legionella. Procedures were

in place for responding to emergencies and in the event of a fire. Everyone who lived at the home had a personal emergency evacuation plan (PEEP) which was personalised to include the level of support each person would require if they had to be evacuated from the building.

We reviewed three files relating to staff employed at the service. Staff records viewed demonstrated there were robust systems in place to ensure staff recruited were suitable for working with vulnerable people. Full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person, two references and police check on file prior to an individual commencing work.

Requires Improvement

Is the service effective?

Our findings

During our inspection in December 2015, we found the home to be in breach of regulations relating to staff training. We saw during this inspection that training had been completed and the provider was no longer in breach of this regulation, we did find new additional breaches. The home was rated as 'requires improvement' in this domain, and although improvement has been made in relation to staff training, the home was found to be in breach of other regulations.

We looked to see if the home was working within the legal framework of The Mental Capacity Act 2005. 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 decision's and are helped to do so when needed. When they lack mental capacity to make 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 to see whether the home was working within the principles of the MCA, and whether the conditions identified in the authorisations to deprive a person of their liberty were being met. We saw that the home was not always working in accordance with the principles of the MCA. For example, capacity assessments had been conducted on people at different stages during their stay and there was different levels of capacity determined which was confusing. One person, who was deemed to not to have capacity, had information recorded in their care plan which stated that their capacity varied, so we could not determine what decisions this person could make for themselves and what they require support with. Some capacity assessments were not completed with the involvement of the person's next of kin (if legally empowered to do so). We saw examples of when the 'best interests' process should be followed for people; however we saw no evidence of best interest meetings taking place. For example we saw that a person who was prone to nail infections needed their finger nails cut, however, they refused because their family member would usually do this task, however they had not been in to visit for some time. The person's nails were very long and were digging into their palm. We asked the registered manager if they had considered a best interest processes. They said they had not considered it for this person.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told there had been a best interest meeting arranged for another person. Two of the staff we spoke with told us they had MCA training, however they did not know what 'best interests' was. We saw DoLS applications had been made to the Local Authority to keep people safe, and had been authorised. We had received the required statutory notifications.

We looked at the provision and planning of food. We saw that the menu for each day was written on a board in the dining room. There was no planned menu for food, the meals were centred around what was

available in the kitchen on that day, rather than consultation with people around what they would like served.

The chef told us they would always cook something different for people if they did not like what was offered. One person who we spoke with told us the food was very nice, though there was no choice. We saw that a food allergy was recorded for one person, and there was a list of people who required fortified diets recorded. We did not see any lists of people who required a diabetic controlled diet, there were people with diabetes in the home. . We were told the staff informed the kitchen staff.

During our last inspection in December 2015 we found there was poor monitoring of people's food and fluid intake, which put people at risk. We found during this inspection, even though some improvements had been made, fluid and food charts for people who required them were still not being completed accurately. For example, during day one of our inspection we observed one person had two untouched drinks in their room. One was a cup of tea, which had gone cold, and the other was juice. We looked at this person's fluid and food chart, the last drink documented was early evening the day before. When we checked this person's care plan, it stated the person required assistance with eating and drinking. We highlighted this to the registered manager as we were concerned this person had gone a long time without any drinks. When the registered manager asked the staff, we were informed this person had had breakfast and a drink that morning, but the staff had forgotten to document it down in their chart. We also saw other examples of gaps in food and fluid charts. The registered manager told us sometimes staff 'forget' to fill them in. This meant that people may be at risk of dehydration, weight loss or weight gain as their diet was not being monitored

We saw staff regularly bringing people drinks throughout the day, and there was a machine in the main lounge which contained fruit juice. We saw people helping themselves to this.

This is a breach of Regulation 14(4)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a staff supervision and appraisal schedule at the home. The supervisions were in the process of being changed to encompass a competency checklist for nurses as part of their clinical supervision. This change was in response to recent concerns raised about the competency of the nurses when dealing with pressure care and skin viability. We saw that all of the nurses had recently attended wound care training. Staff told us they had an induction in line with the Care Certificate, and most staff were enrolled on professional qualifications (QCF level 2/3). QCF stands for Qualification and Certificate Framework which replaced NVQ's. People told us they felt the staff had the skills to support them. One person said "Staff are very good." And "Very pleased with the care here."

The home had equipment in place to help people with transferring and personal care. We found this equipment was being checked in accordance with national guidance. We did however; observe the scales used in the home to weigh people were not appropriate for their needs. We had also received a concern from a community professional around the use of these scales. The registered manager during day one of our inspection told us new scales had been ordered.

There was a lift which people used to gain access to the upper floors of the home. We found people had call bells in their rooms, however on two occasions we observed the person's call bell was not within their reach. Bedrooms were personalised with people's own choice of bedding, and people had photographs displayed in their rooms. At the corner of one of the corridors, just outside someone's room, we saw that this area was being used for storing wheelchairs. We highlighted this to the registered manager at the time as these items could be an obstruction if people needed to leave the building quickly. The deputy manager assured us they

would be moved.

We saw that people were supported to maintain their physical health and appropriate referrals were being made. We spoke to two healthcare professionals who told us the home had made 'timely' referrals. One visiting professional spoke positively about the staff and the care they had provided to one person in particular. The home was part of the CHIP (care home innovation programme) which is a commissioned service by the CCG (clinical commissioning group). This means there is a laptop available in the home where staff and people who live at the home can partake in video calls with trained nurses and doctors out of hours if they are feeling unwell or need to obtain advice regarding an injury or medication.

Requires Improvement

Is the service caring?

Our findings

During our last inspection we had rated this domain as 'good'. However we saw during this inspection that staff were not always proving a caring service for people.

Most people, and relatives with the exception of one spoke positively about the staff. Comments included "Staff go above and beyond for the residents", "Staff are their families" and "Staff are very good." One person, however, commented that there are too 'many different faces.'

Some of our observations throughout the inspection showed staff interacting kindly with people, and people appeared to be treated well. We did observe in some areas of the home, there was less staff engagement, and staff did not appear to be close by. One member of staff in the dementia unit did not know people's names or anything about them, and they told us this was not the place they usually worked in the home. This meant that staff faces were not always familiar which is important for consistency when supporting people with dementia.

We observed staff attending to a person in a discreet and kind manner when asking them if they wanted some help to sit down. People told us staff would knock on their doors before entering and spoke with them in a respectful manner. On day two of our inspection we saw some confidential information was displayed in the corridor on one of the floors of the home. We highlighted this to the deputy manager at the time.

Discussions with people indicated that they had been involved in their care planning, however this consent and involvement was not always documented in people's care files. We saw that some people had consented to the use of bedrails and this was documented; some care plans were signed by people.

The registered manager informed us that residents' meetings take place every few weeks. The last one took place on 24 March 2016. The home also published a regular newsletter for people who lived at the home and their families, which included a 'resident of the month'. We viewed one from a previous month. The person appeared in the newsletter, which included small biography about them and a photograph. The person had consented to this taking place.

For people who had no family or friends to represent them contact details for a local advocacy service were available. People could access this service if they wished to do so. We saw that no one was accessing these services during our inspection.

Inadequate

Is the service responsive?

Our findings

During our last inspection in December 2015, we identified concerns around people not always receiving care which was based around their individual needs. We found the provider was in breach of this regulation. During this inspection, we found that little improvement had been made and the provider was still breach of this regulation. We also found an additional breach of regulation. During our last inspection in December 2015, we rated this domain as 'inadequate'.

We saw that some people at the home were being nursed in bed and some others had complex clinical needs. When we looked at care plans for these people we saw that some documentation relating their care was missing or not in place. For example there was no MUST being used in the home. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers. The MUST tool is also a key element in identifying people who are at risk of developing pressure ulcers.

We saw that people were being weighed; however there was conflicting information in people's care files in relation to this. For example, we asked staff to weigh one person because their weight chart indicated that they had a lot of weight recently and we were unable to see a referral being made to the dietician. When the person was weighed by staff the scales gave a different recording which indicated the person had actually gained weight. We queried this with the registered manager, as the person's records were not accurate. The person was weighed again using different scales and this gave another reading. Due to this different information we were concerned people's weights were not being monitored appropriately. We highlighted our concern to the registered manager and asked them to take action to address this. The person's records were updated straight away.

We could not locate weight charts for one person who had lost a lot weight recently. These had also been requested by the dietician. When we asked the registered manager where they were the registered manager told us they were archived so we were not able to view them during this inspection.

We observed one person who required regular position changes through the day and night to ensure pressure relief. This person did not have a pressure ulcer, however, when we saw this person's turn charts there were gaps which indicated that they had not been turned in accordance with their plan of care.

We saw for another person that they did not have important information recorded in their plan of care which corresponded to advice given from a medical professional. This involved the purpose of piece of equipment and why it was important this person had access to it.

We saw that the staff has been requested by a diabetic nurse that for one person their blood glucose was to be monitored at certain points during the day for a number of consecutive days to aid a medication review. We saw gaps in this recording and found further correspondence from the diabetic nurse which stated the medication could not be reviewed at that time as the glucose monitoring had not been undertaken as

requested. We saw that since this had happened the staff had followed this instruction and the person has been reviewed.

One person's care notes indicated they had a blister on their skin. When we checked the rest of this person's information we could see no further mention of the blister, or a body map containing details of what the blister looked like or any action that was taken. When we highlighted this to the nurse on duty we were told that this person did have a blister and a dressing applied. There was no wound treatment plan for this person. We also saw advice from a medical professional who suggested a series of medical checks the staff needed to have completed for this person to improve their overall health and wellbeing. We could not find any documented evidence that these checks had been completed. When we spoke to the nurse they gave us a verbal account of this person's current condition, including the requested checks, which had been actioned. We informed them that the records for this person did not offer this information.

This is a breach of regulation 9 (1)(a)(b)(3)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health care professionals responded positively when we asked about the responsiveness of the staff in relation to recognising when people were unwell or a referral was needed.
We looked at the complaints procedure in place in the home. We were able to view a complaints policy, and people told us they knew how to complain. The policy was displayed in the communal areas of the home. We asked to see the complaints' log but this could not be located during our inspection. The deputy manager was unsure if there had been any complaints. Therefore we were unable to track the complaints procedure from beginning to end.

This is a breach of Regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at how social activities were organised within the home. There was an activities coordinator in post, who was at the home during day two of our inspection. The activities coordinator role included supporting people to plan outings, there were knit and natter sessions, and sing along. The activities coordinator also provided 'one to one' time with people. We were unable to speak to the activities coordinator because they were supporting someone to visit their relative in hospital. Two people told us they felt bored during the day and said they thought there should be more for people to do. There was an activity planner on display in the home.

Inadequate

Is the service well-led?

Our findings

During our last inspection in December 2015, we found the provider was in breach of regulations relating to the governance of the home. During this inspection we saw that some improvement had been made in relation to the auditing of medication, however auditing in other areas was poor, and the provider was still breach of this regulation.

During our last inspection we found that the ratings from our previous inspection were not displayed as required by law in the home. We saw during this inspection that the ratings from December 2015 were displayed in the communal areas of the home.

We found there were mixed responses with regards to the leadership and management of the home. One staff member told us the registered manager was not approachable, and another staff member commented negatively about the way in which management had spoken to them in the past. Someone else told us they felt management had not been approachable, and would not feel comfortable discussing any information of concern with them. We were told during day one of our inspection that staff morale was low.

We saw that various audits were taking place around the cleaning of the home, including a 'deep clean' schedule. Medication audits were also taking place every month. The shortfalls we saw in people's care plans had not been identified. There was no audit which suggested that care plans and other documentation, such as risk assessments, were being regularly checked. Therefore the service had not picked up on any of the concerns we found on inspection. With the exception of medicines management, It was apparent that little if any improvement had been made since our previous inspection. In addition to this new breaches of regulation had also been identified. Robust audits are important because they highlight the gaps and actions needed to improve practice.

There was a registered manager in post who was available during the first day of our inspection. After our first day of inspection we informed the provider that we were concerned with the overall management of the home and also highlighted other areas of concern we had identified. The provider took immediate action to address these concerns. We conducted our inspection with the deputy manager on the second day of our inspection

This is a breach of Regulation 17 (2)(b)(c)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the week prior to this inspection, the two directors for the provider had resigned from their posts and had been replaced by a new board of directors. Because the new directors had been in place for a short period of time it was too early to assess whether their proposed changes had been effective or not.

We met two of the directors during our inspection. Staff we spoke with were complimentary about the new directors and told us they had been at the home regularly to advise and support the staff

A process was in place to gather the views of family members and people living at the home. We saw a survey was sent to people asking about their experiences of living in Byron Court. We saw the results of this survey had been analysed and people were generally happy with the care they received.

Staff meetings were held to share information about the service and for staff to raise any issues. The most recent meeting had taken place on 21 April 2016. The minutes had not yet been typed up.

The home had policies and guidance for staff to follow. For example whistle blowing, dignity, independence, respect, equality and safety. Staff were aware of these policies and their roles within them.