

Hillersdon Court

Bybuckle Court

Inspection report





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Seaford
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Ratings

Overall rating for this service	Requires Improvement 
Is the service safe?	Requires Improvement 
Is the service effective?	Requires Improvement 
Is the service caring?	Good 
Is the service responsive?	Good 
Is the service well-led?	Requires Improvement 

Summary of findings

Overall summary

Bybuckle Court is registered to provide residential care for up to 17 older people. There were 14 people living at the home at the time of the inspection.

People required a range of help and support in relation to living with short-term memory loss, dementia and assistance with personal care needs.

The home is a converted building with a large communal room used as a lounge/dining area. The home has a passenger lift and wide staircases with handrails to assist people to access all areas of the building.

This was an unannounced inspection which took place on 9 and 10 March 2016.

Bybuckle Court had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

The registered manager was in day to day charge of the home. People living at Bybuckle Court spoke highly of the registered manager and told us that they were always around if they needed them. Staff told us that the registered manager had a good overview of the home and knew everyone well.

People's safety had not been maintained, we found that legionella and fire safety risk assessments had not taken place by an appropriately trained professional. Infection control systems needed to be more thorough to ensure all areas of the home and equipment used regularly were clean, tidy and safe to use.

Medicines were kept in a trolley located in the main lounge/dining area. Daily temperature monitoring had not been maintained and staff were not clear on safe temperatures for medicines to ensure they were appropriately stored.

Mental capacity assessments had not been completed to show how decisions around people's capacity and ability to consent to care and treatment had been made. However, staff had received training around MCA and DoLS and were able to demonstrate a good understanding around capacity and choice for people.

Safe recruitment processes were in place and there were enough staff to meet people's needs and staff had time to provide care to meet people's individual needs. New staff completed an induction and were supported by experienced staff. There was a programme in place to ensure staff received appropriate training. Staff were encouraged to attend further training, with a number having achieved National Vocational Qualifications (NVQ) or similar. Staff received regular supervision and support. Meetings took place, these included resident, relative and staff meetings to ensure people's views and opinions were sought and listened to.

Staff understood their roles and responsibilities. All staff displayed a good understanding around recognising and reporting safeguarding concerns.

We received only positive feedback from people, staff, relatives and visiting professionals. Everyone told us that the registered manager was really keen to make positive changes and cared about making sure people received the best care possible. This was supported by clear up to date care documentation which was personalised and regularly reviewed.

People's nutritional needs were met. With special dietary meals and alternative meals provided for people who had specific health needs. Meal choices were available and people were encouraged to maintain a balanced healthy diet.

Staff knew people well and there was clear affection between people and staff. Staff interacted with people and encouraged them to interact and participate in activities throughout the day. When people required support this was provided with patience and understanding. If people became unwell referrals were made to other health professionals if needed.

Care documentation was person centred and aimed to support and encourage people to remain independent as much as possible. Referrals were made appropriately to outside agencies when required. For example GP visits and community nurses. Visiting professionals told us the registered manager and staff were responsive and followed instructions given to maintain people's health.

Systems were in place to continually assess and monitor the service. A number of these had been implemented by the registered manager and were being reviewed and amended to ensure they were effective.

Notifications had been sent when required to CQC or other organisations.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Environmental risk assessments including legionella and fire had not been completed to ensure people's safety was maintained.

Infection control systems needed to be more thorough to ensure all areas of the home and equipment used regularly were clean, tidy and safe to use.

Temperature checks to ensure medicines were correctly stored had not been maintained.

Individual health risks to people were identified and monitored. Safe recruitment processes were in place.

There were enough staff to meet people's needs. Staff had time to provide care to meet people's individual needs.

Staff displayed a good understanding around recognising and reporting safeguarding concerns.

Requires Improvement ●

Is the service effective?

The service was not consistently effective.

Mental capacity assessments had not been completed to show how decisions around people's capacity and ability to consent to care and treatment had been made.

Induction and training systems were in place to ensure staff were adequately trained and supported to meet people's needs.

Staff felt supported by the manager and received regular supervision.

People's nutritional needs were met. Meal choices were available and people were encouraged to maintain a balanced healthy diet.

Requires Improvement ●

Is the service caring?

Good ●

The service was caring.

Staff knew people well and displayed kindness and compassion when providing care.

People were involved in day to day decisions and given support when needed.

Staff treated people with patience and dignity.

Is the service responsive?

Good ●

The service was responsive.

Documentation was personalised and included specific information about people's care and support needs.

Clear information was in place for staff. Care plans had been written for people's identified care needs. Care plans and risk assessments were regularly reviewed and updated.

People's independence was supported and encouraged.

Daily activities were provided for people to allow them to spend time doing things they enjoyed.

People were encouraged to share their views. A complaints procedure was in place and displayed in the main entrance area for people to access if needed.

Is the service well-led?

Requires Improvement ●

Bybuckle Court was not consistently well led.

The provider had not ensured all systems and services had been maintained.

Systems had been implemented to assess and monitor the service.

There was a registered manager in place who was supported by the registered provider.

Staff and people living at Bybuckle Court spoke highly about the registered manager and the positive improvements made.

Bybuckle Court

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 which took place on 9 and 10 March 2016 was unannounced and was undertaken by two inspectors.

The last inspection took place in March 2013 where no concerns were identified.

Before the inspection we looked at information provided by the local authority. We reviewed records held by the CQC including notifications. A notification is information about important events which the provider is required by law to tell us about. We also looked at information we hold about the service including previous reports, safeguarding notifications and any other information that has been shared with us.

Many people living at Bybuckle Court were able to tell us about their experiences of living at the home. For people who were unable to talk with us we carried out observations in communal areas, spoke with staff and looked at care documentation to understand their experiences of living in a care environment.

We looked at care records for three people and daily records, risk assessments and associated daily records and charts for other people living at Bybuckle Court. All Medicine Administration Records (MAR) charts and medicine records were checked. We read diary entries and other information completed by staff, policies and procedures, accidents, incidents, quality assurance records, staff and resident meeting minutes, maintenance and emergency plans. Recruitment files were reviewed for three staff and records of staff training, supervision and appraisals.

We spoke with four people using the service and five staff. This included the registered manager, care staff, cook and other staff members involved in the day to day running of the service.

We spoke with three visiting health professionals who visited the home on a regular basis. We received only

positive feedback from everyone we met and spoke to.

Is the service safe?

Our findings

People told us they felt safe living at Bybuckle Court. People felt that they were well looked after and staff knew how to care for them appropriately. One told us, "Staff keep an eye on me; they remind me to eat the right things and always let the nurse know if I need them to check anything," and, "I was at home but I was not able to look after myself, I am safer here as I need help with things." Despite this positive feedback we found that there were some areas which needed to be improved to ensure peoples safety was maintained at all times.

Despite this positive feedback we found that some areas needed to be improved to ensure people remained safe. Environmental risk assessments had not been completed to ensure people remained safe. A fire risk assessment had not been carried out. This meant that environmental risks and specific risk factors for the building had not been identified; this could leave people at risk in the event of fire as potential fire risk factors had not been identified.

Water safety checks for the prevention of legionella had not been done. Although water temperature checks were being carried out by the maintenance employee these did not include all taps in the building, for example sluice taps in the laundry room were not included. No overall risk assessment had been completed by a suitably trained professional to assess the risk of water contamination. This meant that people may be at risk due to unchecked water systems. We discussed these concerns with the registered manager during the inspection and they contacted the registered provider.

The registered manager had a risk assessment in place for their small dog as they brought this to the home. People spoke positively about how much they enjoyed having the dog around as it reminded them of home. The registered manager had a portable dog crate which was used when the dog needed to be safely secured. However, we saw that on a number of occasions people living at Bybuckle Court let the dog out of the crate and the dog was unsupervised by staff. This was not an issue in relation to people's safety as the dog was friendly and well behaved. However, the dog did access a hallway and we later found a small amount of dog faeces in the hallway. This was immediately cleared and no one had accessed this area. We also noted that the outside veranda area accessed through the lounge, which although not being used by people in winter was clearly visible from the dining area had a lot of dog faeces on the ground as this was where the dog was let out during the day.

There was one domestic employee responsible for cleaning the home. The registered manager confirmed this person worked Monday to Friday and care staff were responsible for cleaning certain areas when the domestic employee was not working. We found that areas of the home required more attention to detail and a more thorough clean was needed. For example, we saw areas in the lounge where items of rubbish remained on the floor over both days of the inspection and part of a Christmas decoration was still attached to the ceiling. The laundry room was untidy and in people's rooms we found commodes which needed to be cleaned or thrown out as they were no longer suitable for use due to areas of rust which could pose an infection control risk. The registered manager removed the damaged commode instantly and a replacement was provided.

The above issues meant that people's safety and welfare had not been maintained. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at Bybuckle Court had a range of care needs including slight memory loss, dementia and personal care needs. These were assessed and reviewed monthly to ensure that the home could provide safe care. Everyone was mobile, some used walking aids and required minimal care and support. Whilst others needed help with all aspects of personal care and required guidance and prompting by staff to orientate them to their surroundings. No-one currently required the use of moving and handling lifting equipment, although these were available if required.

Policies and procedures were in place to support the safe administration and management of medicines. Medicine fridge temperatures were monitored daily to ensure they remained within appropriate levels; however, the medicine trolley kept in the lounge had not had daily temperatures checked since February 2016. We asked staff why this had not been completed and were told that they needed a new sheet to record them on. We saw that previous temperatures documented were above appropriate expected levels. However, no action had been taken in relation to this. Staff responsible for medicines were unsure what safe levels for the storage of medicines should be, this meant that medicines may not be properly stored at all times.

Protocols for administration of medicines were in place. This included guidance for 'as required' or PRN medicines. PRN medicines were prescribed by a person's GP to be taken as and when needed. For example pain relieving medicines. PRN guidance was written onto people's front sheets within the medicine administration record (MAR) folder and clearly identified what the medicine was, why it was prescribed and when and how it should be administered. For two people who had moved into Bybuckle Court in recent weeks, we saw that front sheets and photographs had yet to be completed, however staff knew people well so the impact of this was minimal. The registered manager confirmed these would be in place promptly. These areas needed to be improved. We recommend that the provider consider current guidance on storage and administration of medicines and take action to update their practice accordingly.

Care staff responsible for giving people medicines had completed medicine training and updates when required. Medicines were regularly audited to ensure that medicine procedures were maintained. We observed medicines being administered and saw that this was done appropriately. No-one currently self-administered their medicines, but if needed a policy was in place to regarding this. Medicines were labelled, dated on opening and stored tidily within the trolley. Medicines were ordered when required and medicines which were out of date or no longer needed were disposed of appropriately. The medicine storage cupboard currently located in the registered manager's office was very small. The registered manager confirmed this was not currently in use and if required a larger locked cupboard may be needed for safe storage of specific medicines.

Incidents and accidents were documented in people's records and staff completed accident/incident forms. These were then given to the registered manager to ensure they had oversight of any incidents/ accidents or falls that had occurred. No overall analysis had been completed in relation to accidents/incidents or falls. This meant that systems were not in place to identify trends or themes with regards to people's health and welfare. By identifying areas of concern steps can be taken to help prevent issues from re-occurring and ensure open and transparent recording and reporting. This was an area that required to be improved to ensure people's safety was maintained.

There were systems in place to ensure the safety and maintenance of equipment and services to the building. Equipment checks had taken place with certificates available to confirm this. Staff told us that any

serious maintenance issues were addressed promptly. There was a maintenance book for staff to report minor concerns. We saw that this had been signed by the maintenance employee when actioned and countersigned by the registered manager to confirm when things had been completed.

People's care and health needs had been considered in relation to evacuation in the event of an emergency. Staff received regular fire safety training. Fire alarm checks had been completed and the emergency lighting had recently been upgraded. Personal emergency evacuation plans (PEEPS) were in place with plans of the building, fire safety and evacuation information.

Personal risk assessments were in place for all identified health risks for people. However, we found that one person who had moved into the home approximately six weeks prior to the inspection did not have risk assessments completed. Staff told us that care plans were clear for this person and risk assessments would be written at the next review as this gave staff time to fully assess the person and any specific risks in relation to their safety.

We looked at staffing rotas for the week of and prior to the inspection. This included information regarding all staff including the manager, head of care and senior care staff. This meant that staff knew who was the senior person during each shift. Despite some staff absence due to sickness cover had been arranged to ensure that people's care needs continued to be met. Staff told us that most people only required minimal care and support. On the odd occasion that a staff member called in sick or was on annual leave other staff were happy to cover and or the registered manager had covered a care shift, but generally staffing levels were appropriate to meet people's needs. Staff said, "We could have more staff but it runs smoothly without. If someone is ill it can be tricky as there are no extra staff but we have managed, the manager will come on the floor if there is sickness and we usually cover it in house. If we are desperate we use agency at night but rarely. We did have two long term sick but we rally around we are not overly stressed." Staff told us that an increase in staffing at night from one to two care staff had made a positive impact and ensured people received care in a timely manner at night as well as in the day. The registered manager confirmed that they felt continuity of care was important for people. On the odd occasion that they had worked a care shift they had used this as an opportunity to assess that people were receiving the support they needed and check things were running as they should. Staff confirmed that if on occasion things got busy, for example if someone suddenly became unwell, the registered manager would assist staff.

A visiting health professional who regularly spends time in the home told us they received only positive feedback about the home from people and call bells were always answered promptly. People told us that they had call bells they could use in their rooms and in toilets and bathrooms. People in communal areas told us that there was always someone within ear shot. We saw that there was generally a member of staff in the lounge/dining area at most times and if not the kitchen was next to the lounge and people could always indicate when they needed assistance.

Staff demonstrated a clear understanding around recognising and reporting safeguarding concerns. Staff were aware of the safeguarding policy and contact numbers and were able to outline the different types of abuse and what to do if this was suspected.

Recruitment information was available in staff personnel files. We looked at staff recruitment files; these included the staff file of a newly employed staff member. All files showed relevant checks which had been completed before staff began work. For example, disclosure and barring service (DBS) checks, a DBS check is completed before staff began work to help employers make safer recruitment decisions and prevent unsuitable staff from working within the care environment. Application forms included information on past employment and relevant references had been sought before staff were able to commence employment.

Staff had access to relevant and up to date information and policies, including whistleblowing and safeguarding. Policies were reviewed and updated when changes took place. Staff told us they knew where policies were stored and that they were asked to read them when changes occurred to ensure they were aware of correct working procedures.

Is the service effective?

Our findings

People we spoke with told us that they found the home to be comfortable and homely, although people did comment that areas of the home appeared, "Tired," and, "In need of a bit of a spruce up in some places." The registered manager had identified areas of the home which required some improvement; we saw that redecoration was taking place in empty bedrooms and an on-going plan was in place for redecoration. Staff told us that they felt the registered manager was trying to make necessary improvements to the way the home looked and this was a positive improvement.

The training schedule identified that the registered manager and all care staff had completed Mental Capacity Act (MCA) training. However, we found that people's care documentation did not include any information in relation to mental capacity assessments for specific areas. This meant that it was unclear how decisions around people's capacity had been made, who had capacity to make decisions and who else may be legally entitled to make decisions on their behalf. Supporting documentation including MCA and Deprivation of Liberty Safeguards (DOLS) policies and procedure information was available for staff although we found that some information did not include most current guidance around DoLS. We discussed this with the registered manager who confirmed that they would source current guidance and protocols in relation to this. This was an area that needed to be improved to ensure decisions around consent and capacity was clear. The impact of this was minimal as staff demonstrated a good understanding around MCA and were able to tell us how this was the ability of the person to make individual decisions on a day to day basis. For example choosing what to wear, how to spend their day and what to eat. The registered manager had a good working understanding of DoLS. One DoLS application was in progress with a number of other applications in the process of being submitted. The registered manager confirmed they were currently in contact with the DoLS team to ensure they were meeting requirements.

A training schedule was in place for all staff training, this included information in relation to required and further training. A number of staff were in the process of completing or having completed National Vocational Qualifications (NVQ) level 2 and two staff (including the registered manager) currently in the process of completing NVQ level 5. Staff told us the training they received enabled them to understand people, for example safeguarding and moving and handling. Staff displayed a good working knowledge of memory loss and dementia and when people became anxious or upset support was provided appropriately.

New staff had a period of induction. The registered manager told us this was an 'in house induction programme' and all staff were enrolled on the National Vocational Qualification (NVQ) programme. An induction checklist was available which was signed by a supervisor and the employee and this included; reading of policies such as fire, emergency numbers, care plans and other relevant requirements. Staff told us that they had received an induction which included receiving details of their job description, a tour of the home and the fire evacuation plan. They also looked at policies, rotas and shadowed an experienced carer for at least three shifts during the induction period until they felt competent and confident to work alone.

A robust structure was in place for regular staff supervision. Supervisions were documented and included a

number of key areas for discussion. We saw that supervision records detailed actions and when these had been achieved or actioned. Staff told us that supervision was, "A two-way process where they were able to raise issues with the manager and request training as needed." Staff told us, "Since the new manager has been in post things have really improved," and, "Communication is good; the manager is always available if needed." Staff felt involved in the day to day running of the home, telling us any changes were discussed and information shared at meetings and handovers. Staff told us feedback was listened to and suggestions taken seriously, this made them feel involved and encouraged to continually improve the service. Staff understood their roles and responsibilities. The head of care told us that she was responsible for, "Making sure the work was done and that there was good communication with staff and residents."

People told us they felt involved in decisions about their care. Telling us, "Staff always ask me what I want to do before they do it." We observed staff talking to people throughout the day, orientating them to time and place and reminding them what was happening that day. For example, one person had a health professional visiting and staff were seen to remind them of this and sat with them to explain what the meeting was for. Staff described how they would ask for people's permission before giving support, and what they would do if someone declined the support offered.

People were supported to maintain a balanced and nutritious diet. People's weight and nutritional intake were monitored. Staff told us when someone did not eat their meal or appeared to be unwell this would be fed back to staff at the handover and monitored and if this continued then a GP would be called. The dining area was in the main lounge and people were able to choose to sit at the dining table or in the lounge or their room if they preferred. Tables were set, with paper napkins, placemats and condiments. People were offered drinks and accompaniments and these were served to them at the table. One person liked to have an alcoholic drink with their lunch and we saw that this was provided.

People told us they enjoyed the food provided and that meals were good. The cook had information regarding people's dietary requirements. This included soft diets, diabetic meal requirements, likes and dislikes. The cook provided specific meal choices for diabetics. This included separate cakes and puddings which were low in sugar to ensure that people had meals they enjoyed.

People were offered meal choices, with alternatives available if required. We saw that staff clearly knew people's likes and dislikes and how they liked their meals presented. One person's care plan included information that they liked small meal portions as large plates of food put them off their meal. We saw that staff were aware of this and meal portions were smaller. Meals looked very appetising and well presented. People who needed assistance with eating their meal had this provided in an unhurried supportive manner. Staff spoke kindly to people explaining what the meal was and offering help as needed. At lunchtime we saw that people were offered a choice of drinks and water. Hot and cold drinks were offered throughout the day and could be requested at any time. Water and refreshments were also seen in people's rooms.

Is the service caring?

Our findings

Feedback from people living at Bybuckle Court, staff and visiting professionals was positive. People told us, "I am very happy here, staff are wonderful," and "They are so kind." One person told us, "I wish I could live at my own home, but I know that's not safe as I need help, but I cannot fault it here, they look after me so well."

We observed staff being kind and attentive throughout the day, It was clear they were very knowledgeable about the people and their individual needs and behaviours. Staff sat and chatted to people, striking up conversations about films being watched, stories in the newspaper or general chat about the day and what people were doing. This included sitting with or kneeling next to people sat in chairs to ensure that eye contact was maintained and support provided on the same level as them. Staff were quick to notice if someone did not appear their normal selves and this was responded to quickly. When a person became anxious or appeared disorientated staff quietly approached the person and spoke to them calmly offering support and distraction to ease their anxiety.

People's care documentation was kept confidentially. Care files were safely stored in a locked cupboard in the hallway. We saw that staff were discrete when discussing people's support in communal areas.

People received care which ensured their dignity was maintained and supported at all times. Staff had a good knowledge on how to provide care taking into consideration people's personal preferences and people's independence was encouraged and supported whenever possible.

When people had memory loss or dementia we saw that staff treated them with patience and offered support appropriately. Staff told us that they respected people's privacy and dignity telling us, "We make sure that doors are shut during personal care and that we don't bellow to other staff across the lounge," and, "We knock and wait before going into their rooms." People were prompted regarding their continence needs and this was done in a hushed tone to maintain privacy and dignity. When people needed to have their clothing changed, they were supported to do so by staff in a timely manner. People were supported to maintain their appearance in a way that they wished. For example, one person told us they loved to wear jewellery. We saw that they were wearing the earrings of their choice and other items they had asked staff to assist them with.

People told us they could have a bath or shower when they chose. Although there was a list for staff detailing who had baths or showers which day, staff and people confirmed this was flexible and could be changed if they requested it.

A number of health professionals visited the service; this included a visiting optician to ensure people's vision was appropriately monitored. A hairdresser visited the home regularly and people told us they had their hair cut or styled when they wanted and this was something they enjoyed. One lady told us, "I always had my hair done regularly at home, so it's nice that can carry on now I live here."

Is the service responsive?

Our findings

People told us the manager and staff were responsive. People living at Bybuckle Court felt they were kept well informed about any changes and reminded when appointments or visits were arranged. For example, one person told us, "I have a daily visit by the nurse, staff always check I know when they are coming and I am ready." A visiting health professional told us, "All the staff here are brilliant they know the residents well and the home runs itself. And a staff member said, "The residents are fantastic and I love its homeliness, it is not clinical it is small and personal."

People with specific health needs had information in the care plans to inform staff how to provide effective care. Staff gave us an example of personalised care, telling us about one person who has dementia and can get increasingly agitated dependent on their mood. "We carry out personal care in their room and give them time to choose what to wear. We put out options of clothes and let them show us what they would like to wear." Care plans also included information to encourage and support people to remain as independent as possible. Individualised information was included about things people were able to do themselves and areas which may require prompting or minimal support. For example, one person was able to wash independently but needed help and support when dressing.

We saw that staff were responsive to people's needs and were seen to instigate activity or discussion with residents such as playing games or having a 'sing song'. There was a lot of laughter and banter and people clearly enjoyed the interaction with staff. We saw that care staff responded to non-verbal cues from people, picking up on body language for example when a person was in pain or needed to go to the toilet.

People were given choices about how they spent their day. People told us they got up and went to bed when they chose. Staff confirmed that one person did not usually get up before 11.30am. This was their personal choice and staff supported this routine. Others told us they got up early and that staff would come and give them a cup of tea when they woke up and they got out of bed when they were ready.

There was a clear system in place to assess, document and review care needs. Care files included personalised care planning and health related risk assessments. Information had been sought from people, their next of kin or significant people involved in their care. This meant that documentation was very individualised. There was clear information in care files to support staff to provide appropriate care and support.

All care documentation and risk assessments were reviewed by the registered manager and senior care staff to ensure information was relevant and up to date. These included regular checks to ensure high standards of documentation were maintained. Any changes to people's health or care needs were promptly updated and information shared with staff at handover. All staff told us they read care plans and care documentation regularly and were aware of any relevant information about people. Visiting community nurses confirmed that the manager and staff always responded to concerns and acted on information given by the community nursing team. For example, when feedback was given regarding monitoring a person's blood sugar staff followed these and contacted them immediately if they had concerns.

Activities took place throughout the day. There was no designated activity employee, the registered manager told us all staff were involved in providing activities for people and there were also visiting entertainers to the home. We saw that the home had a lively feel and people were occupied by a variety of activities throughout the day. We observed staff giving residents choice for example whether they wanted to watch a film or play a game or listen to music. We saw some people chose to read books or newspapers. Some listened to music and joined in with staff singing. Whilst others chose to sit quietly or remain in their rooms. Homemade musical instruments were given out to accompany the music. Games were played and in the afternoon people chose a film to watch. People told us they felt entertained when they wanted to do something. There was an outside area with lovely views to the seafront; staff told us people used this area in good weather. Some people went out regularly with family or friends, and those who chose to spend their time in their rooms were reminded when activities were taking place and encouraged to participate if they chose.

People had the opportunity to share their views and give feedback during resident and relatives meetings. For example, there was a winter and summer menu and before the menu changed over a meeting took place to seek people's views about new meal choices to go onto the menu.

A complaints policy and procedure was in place and displayed in the entrance area. People told us that they would be happy to raise concerns and would speak to staff or management if they needed to. There were no on-going complaints at the time of the inspection. The registered manager understood the importance of ensuring even informal concerns were responded to appropriately. Everyone we spoke with told us the registered manager had an 'open door' policy and people confirmed they would be happy to raise any concerns with the manager if they needed to.

Is the service well-led?

Our findings

People spoke very highly of the registered manager. One said, "She is lovely, always checking I am OK." Staff told us, "I love working here we have had three managers and this manager is brilliant, everyone respects her. She has an open door policy and we can go to her anytime with anything. Everyone feels comfortable and her knowledge is excellent." We spoke to a visiting health professional who told us, "This is a nice home we come here all the time and it is very well run. The residents are always well dressed and the staff are very kind, we've never had any issues."

The registered manager had been in post for just over a year. The previous registered manager had been off sick for some time prior to the new manager's registration, therefore the current manager had not received any handover of processes and systems when they took over the manager role. There were some systems which the provider had not ensured were in place and suitably maintained during this period of absence. This included environmental risks and maintenance of equipment and services to the building including legionella, gas and fire risk assessments which not being maintained and reviewed. This is an area which is required to be improved.

The registered manager demonstrated a clear understanding of their role and responsibilities. Care was person centred, with a real emphasis on always putting the person first and foremost. This was seen during observations between staff and people and further supported in the way people's care records were written. The manager worked full time at the home and told us they worked varying hours to ensure they had a clear picture of how the home ran at all times. The registered manager demonstrated a good knowledge and understanding of people, their needs and choices. They promoted an open inclusive culture and told us the focus of the service was to ensure people received person centred care, which supported them to maintain independence and dignity at all times. They strove to ensure the service was open and transparent and welcomed comments and suggestions from people and staff to take the service forward and make continued improvements.

People at Bybuckle Court required care and support, but people's independence was encouraged and supported. For people whose care needs were higher staff were trained and supported to provide appropriate care. The registered manager was aware when it was appropriate to support people to move to nursing care when needed.

There were systems in place to assess and monitor the quality of the service. A number of these had been started by the registered manager and were being reviewed and amended as time went on to ensure they were effective. This included domestic, maintenance, kitchen and medicine spot checks and audits. There was a maintenance book for staff to report minor concerns. We saw that this had been signed by the maintenance employee when actioned and countersigned by the registered manager as part of their regular auditing. A future care plan audit was to be implemented but currently the registered manager wrote all care plans for people so they had clear oversight of peoples care needs and when changes occurred. The provider visited the service regularly and met with the registered manager to discuss processes and systems. Policies and procedures were currently being reviewed and updated. The registered manager also worked

varying shifts and assisted in the care role to enable them to get a complete picture of the home and the way care needs were being met.

Accident, incidents and falls were reported to the registered manager and completed forms given to them to review. This meant they had oversight of these and were aware when incidents had occurred. However, no analysis of these had been completed to identify trends. The registered manager discussed with us how this would be implemented in the near future to ensure everyone was aware of when incidents or falls had occurred and to show how learning had been taken forward after the event to help prevent them from re-occurring.

Residents and relatives meetings took place. Residents meetings usually took place to discuss any changes for example new menus, or to discuss trips out. Staff told us that there were residents meetings where relatives were invited but rarely came. Staff felt this was because people who visited regularly just spoke to staff or the registered manager when they were there so they did not feel they needed to come.

Staff meetings had taken place; one was scheduled and took place during the inspection. We saw this was well attended by staff and staff told us this had been a positive experience. One told us, "There's usually staff meetings three monthly and issues such as there not being enough time to carry out things are talked about and it was dealt with and the routine was changed."

Policies and procedures were available for staff to support practice. There was a whistle blowing policy and staff were aware of their responsibility to report any bad practice. The manager was aware that they needed to access information in relation to the new methodology and regulations including duty of candour. Staff were aware of the policies and were aware that these underpinned safe practice. Policies and changes to procedure were discussed during supervision and at meetings to ensure everyone was aware if changes occurred.

All of the registration requirements were met and the manager ensured that notifications were sent to us and other outside agencies when required.

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 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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for people. Regulation 12 (1) (2)(a)(b)(d)(h)