Care Quality Commission

Byron Court Care Home Limited

Byron Court Care Home

Inspection report

Gower Street
Bootle
Merseyside
L20 4PY
Tel: 0151 922 0398
Website: www.byroncourt.co.uk

Date of inspection visit: 2 September 2015
Date of publication: 10/11/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service responsive?	**Requires improvement**

Overall summary

Situated in Bootle, located close to public transport links, leisure and shopping facilities, Byron Court is registered to provide accommodation for up to 52 adults, who require nursing or personal care. There is a separate unit for seven people with dementia. The building is a large three storey property, which is fitted with a passenger lift. There were 47 people living in the home on the day of the inspection.

The manager for the home was registered with the Care Quality Commission (CQC). 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.

The inspection took place on 2 September 2015 and was unannounced.

We received information of concern prior to this inspection regarding poor standards of care in the home. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to this. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Byron Court Care Home on our website at www.cqc.org.uk .

The home training programme showed that 75% of the nursing staff had not received training or updates relating to catheter care whilst working at Byron Court. The training matrix showed a number of gaps in mandatory training for care staff.

Summary of findings

We found people's nursing care needs were not being effectively monitored. Nursing staff over relied on information supplied by care staff to inform their decision making and review of people's care. This information was not always effectively communicated or recorded.

People received food and drinks which met their dietary requirements. Some people needed their food and fluid intake recorded when concerns had been raised. We found this was not always done consistently.

People's physical and mental health needs were monitored and recorded. However we found this was not consistently carried out. Most of the time staff recognised when additional support was required and people were supported to access a range of health care services. We found one person's weight loss had not been noted and acted upon by staff.

Some people were not weighted regularly in accordance with their plan of care. Weights were not always recorded.

Plans of care did not always record an accurate picture of peoples health needs. Some plans of care and risk assessments in relation to pressure area care and nutrition had not been reviewed recently or on a regular basis. Therefore people's health was put at risk of being compromised.

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 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 always safe.

Although we didn't see examples of poor care being provided, current assessed levels of risk for people were not accurate as they had not been regularly reviewed. Risk assessments for pressure ulcer and nutrition required updating.

Requires improvement

Is the service effective?
The service was not always effective.

The home training programme did not support nursing staff to receive appropriate training and updates to support and develop their role at the home. The training matrix showed a number of gaps in mandatory training for care staff.

People's nursing care needs were not effectively monitored in relation to dietary and nutrition needs, catheter care and pressure ulcer care.

People's food and fluid intake was not consistently recorded when required.

Requires improvement

Is the service responsive?
The service was not always responsive.

People's physical and mental health needs were monitored and recorded. However we found this was not consistently carried out.

Some people were not weighted regularly in accordance with their plan of care.

Plans of care did not always record an accurate picture of peoples health needs. Some plans of care had not been reviewed recently or on a regular basis.

Requires improvement

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.

The inspection took place on 2 September and was unannounced. The inspection team consisted of two adult social care inspectors. The inspection was in response to concerns that had been raised.

We were not able to review a Provider Information Return (PIR) before the inspection. The 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 this prior to the inspection. We reviewed other information we held about the home.

We were able to speak with three people living in the home. We spoke with two of the nursing staff, three care staff, the chef and the registered manager. We also spoke with the district nursing team.

We looked at the care records for four of the people living at the home, seven nursing staff recruitment files and staff training records. We undertook general observations and looked round the home.

Requires improvement

Is the service safe?

Our findings

We received information of concern prior to this inspection regarding poor standards of care in the home. We were informed by community health care professionals that people with pressure area care had not received the correct treatment in a timely manner.

We found during our inspection that people were assessed for any risks regarding their health care needs. The quality and consistency of these assessments varied. Risk assessments had been carried out to assess people's risk of developing a pressure ulcer and risk assessments for nutrition. Dietary needs and nutritional requirements had also been recorded and assessed routinely using an appropriate assessment tool. There were examples where some assessments required updating and monitoring. For example, a risk assessment for nutrition was out of date as it required review in May 2015; the current level of risk for the person was therefore not assessed. Another person had a pressure area which was last reviewed on 27 May 2015. We looked at the wound care management of four people and did not find any concerns. However, the lack of review did not mitigate this risk. Lack of review and monitoring places people at risk of their health deteriorating.

These findings are a breach of Regulation 12 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

Prior to our inspection we received information of concern regarding poor standards of care at the home. We were informed by community health care professionals that nursing staff were unable to carry out nursing procedures as they had not received specific training to do so. This was in relation to catheter care. We were also informed that people with pressure area care had not received the correct treatment in a timely manner.

We looked in detail at the training received by the care staff and registered nurses. The provider had eight nurses employed to work at Byron Court. The training matrix we were given showed that not all nurses had consistently attended training courses provided. For example two nurses had completed catheterisation training in 2014, three had completed infection control training in 2011/ 2012, one nurse had completed safeguarding adults training in 2012 and only one nurse had completed Mental Capacity Act training in 2012.

We looked at the training received by are staff. We found that 93% of all care staff had completed a health and social care qualification at level 2 or above. The training matrix we were given showed a number of gaps in mandatory training for care staff.

One nurse who had recently started working at Byron Court had very little experience working in a general nursing home setting. Since they began in May 2015, they told us they had not received any mandatory training from the provider. We saw from the training matrix that mandatory training included moving and handling, infection control, safeguarding vulnerable adults, fire safety and medication administration. No record of an induction plan was shown to us or was found in the nurse's recruitment file. No record of any previous training for this nurse was recorded by the service.

We saw from the training matrix that nursing staff had not received any additional training regarding tissue viability and wound care management during their time of employment at Byron Court. We spoke to the registered manager about our concerns during our inspection. The registered manager confirmed that wound care training and catheter care training had been arranged for October 2015. Since the inspection the registered manager confirmed that all nursing staff and two senior care staff had attended the wound care training. We also asked the registered manager to send us an accurate training matrix to enable us to see what training had been completed since this inspection. To date this information has not been supplied.

These findings are a breach of Regulation 18 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014.

We found there was a lack of communication between care staff and nurses. Care staff we spoke with told us they did not look at and were not involved at all with care planning. We found that nurses relied on care staff to monitor people's needs and report information to the nurses rather than the nurses being proactive and reviewing people in the home themselves on a daily basis. For example, a person who lived in the home who was discharged from hospital only the previous night but had not been reviewed by the nurse in charge on the day of the inspection. The nurse told us they relied on the care staff reporting any issues. In this case the person required particularly close monitoring following their treatment in hospital.

Some people required food and fluid charts to be maintained to help inform staff of their daily intake. We found that these charts were not consistently maintained to record what people had eaten and drank each day. We found some charts recording intake of fluids and food showed that a record had not been kept of their intake for six days. Staff we spoke with could not explain why this had occurred. This meant that staff could not accurately monitor people's progress. We found care staff, when asked on the day, were aware of people's food and fluid intake but had not yet formally recorded this on their chart.

We reviewed care plans and saw that some people needed to be weighed regularly to maintain good health. One person's care plan stated that they had lost weight and needed to be weighed each week. We found that this was not happening. We found that this person had lost a significant amount of weight recently and that none of the staff in the home were aware of this. A recent evaluation of this person's care records did not reflect this. At the time of the inspection we asked that the person be weighed and the weight recorded and to be informed of this. We contacted the registered manager for the information. We were informed that since the inspection this person had been referred to a dietician and was being weighed each week. They had started taking food supplements on the advice of the dietician and had since gained weight.

Requires improvement

Is the service effective?

Another person was not weighed according to their care plan; the last recorded weight was in February 2015, when they should have been weighed each week. After the inspection we contacted the registered manager and were informed that this person was now being weighed each week.

The care staff we spoke with told us they were responsible for weighing people and passed the information to the nurses. The nurses were responsible for entering the weights in peoples care records. We found this had had not happened. Nurses had not recorded the weights in people's care records. We asked for the generic / communal records used by care staff to record weights. Nursing staff found these difficult to locate. When they were produced they showed weights being recorded only sporadically. The registered manager told us people were weighed but was unaware of the inconsistent recording of people's weights.

We found care staff were unaware of alternative methods of recording people's weight if they could not use scales.

These findings are a breach of Regulation 9(3) (b) & (h) HSCA 2008 (Regulated Activities) Regulations 2014.

We spoke with the chef. We found they had a good knowledge of people's individual dietary requirements as well as their likes and dislikes and meal preferences for each day. The chef and kitchen assistant were aware of people who required dietary supplements and those who required food to be mashed or liquidised and fluids to include a thickener, to help reduce the risk of choking. This helped to ensure people received food and drinks that met their assessed health needs for eating and drinking.

Requires improvement

Is the service responsive?

Our findings

We looked in detail at the care received by some of the people living at Byron Court. This was because we received information of concern prior to this inspection regarding poor standards of care in the home.

People had plans of care for health care needs where staff support was required. The quality and consistency of these care plans varied. We looked at the care record files for four people who lived at the home. We found that two care plans and records were individualised to people's preferences and reflected their identified needs but two did not. For example, one care record did not record a complete medical history and omitted a current diagnosis as well as any current medical treatment, monitoring and symptoms to be aware of. We found another care record lacked detail regarding a person's catheter care. Records did not specify how much fluid the person should be encouraged to take. Fluid charts to record the amount of liquid people took throughout each day were not consistently completed by staff. Care plans lacked guidance for staff informing them how to respond to issues such as bladder retention.

We found examples were staff had not updated care plans and records as care needs had changed. For example we found a person with catheter care issues had not had their care plan updated for over 12 months, although It had been sporadically evaluated. Another person, who had lost weight and was taking dietary supplements and not had their care records reviewed between April and September 2015. We also found examples where care planning had not been individualised with respect to people's individual care needs. For example, one care record contained statements such as, "lost weight, needs to be on a food chart" and "needs encouragement at times and assistance." A nutrition assessment for this person was incomplete and not dated or signed.

We looked at the care of a person who required support and monitoring with a catheter. We found care plans were basic and did not contain specific details to direct staff when any issues or difficulties arose from the catheter. Plans had not been rewritten for over 12 months. One care plan did not include a person's current health issues to help and guide staff to support the person in this particular area of care. The registered manager sent us a copy of the person's updated care plan after the inspection which included all their health issues and detailed the support they required. The registered manager informed us that care plans were in the process of being written in a new format for all people living in the home, but the process was not yet completed.

These findings are a breach of Regulation 9(3) (a) HSCA 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People who use services did not receive appropriate care and treatment to meet their needs.** Regulation 9 (3) (a), (b) & (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who use services were not protected against the risks associated with receiving inappropriate or unsafe care because assessed levels of risk were not accurate.** Regulation 12(2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Persons employed by the service did not receive appropriate training as is necessary to enable them to carry out duties they are employed to perform.** Regulation 18 (2) (a)