Byron Court Care Home Limited

Byron Court Care Home

Inspection report

Gower Street
Bootle
Merseyside
L20 4PY
Tel: 0151 922 0398

Date of inspection visit: 8 and 21 December 2015
Date of publication: 07/03/2016

Ratings

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

Overall summary

A Comprehensive inspection took place on 8 and 21 December 2015 and was unannounced. This inspection was also to follow up on the concerns that were identified at the previous inspections in June and September 2015. Although some improvements had been made, several concerns still remained and this compromised the health, safety and welfare of people that lived at Byron Court.

Byron Court is a care home providing personal and nursing care. It 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. A passenger lift provides access all areas of the home.

There were 49 people living in the home at the time of our inspection.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

Improvements to the safe management of medicines had been made however some concerns were apparent in relation to the recorded keeping and safe storage of medicines.

There were not enough staff on duty at all times to ensure people were supported safely. Staff told us they needed more staff to support people with their care needs in a timely manner.

People had their needs assessed and staff understood what people's care needs were. However, some people's care plans, health needs and risk assessments were not regularly reviewed. People had still not been weighed regularly as they should have been following specialist input. Food and fluid charts had still not been completed therefore it was impossible to tell what people had had actually eaten or drank. All of this put people at unnecessary risk of harm.

People's physical and mental health needs were monitored but not always recorded. Staff recognised when additional support was required and people were supported to access a range of health care services.

There was a lack of good governance and leadership at the home. Although the service had a quality assurance system in place it was not robust enough in order to ensure the health, safety and welfare of people was effectively assessed and monitored.

The service had not displayed the ratings to the public from either the June 2015 or the September 2015 inspections as they are legally required to do so.

There were systems in place to get feedback from people so that the service could be developed with respect to their needs.

We saw the necessary recruitment checks had been undertaken so that staff employed were suitable to work with vulnerable people. Staff said they were well supported through induction, supervision, appraisal and the home's training programme.

The building was clean, well-lit and clutter free. Measures were in place to monitor the safety of the environment and equipment. Some changes had been made to the environment of the dementia unit to help promote a positive dementia- friendly environment.

Staff sought people's consent before providing support or care. The home adhered to the principles of the Mental Capacity Act (2005). Applications to deprive people of their liberty under the Mental Capacity Act (2005) had been submitted to the Local Authority. Staff had a good understanding of the Mental Capacity Act (2005) about how the act applied in a care home setting.

People told us they received enough to eat and drink, and they chose their meals each day. They were encouraged to eat foods which met their dietary requirements.

We saw that people were involved in the decisions about their care and support, and in choosing what they wanted to do each day. They told us staff treated them with respect.

Staff we spoke with were knowledgeable and showed they had a very good understanding of the people they were supporting and were able to meet their needs. We saw that they interacted well with people in order to ensure people received the support and care they required. We saw that staff demonstrated kind and compassionate support. They encouraged and supported people to be independent both in the home and the community.

Referrals to other services such as the dietician or tissue viability nurses and GP visits were made in order to ensure people received the most appropriate care.

The home had a complaints policy and processes were in place to record complaints received. This helped ensure issues were addressed within the timescales given in the policy.

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

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

Summary of findings

• 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff on duty at all times to ensure people were supported safely.

Although improvements had been made since the last inspection, concerns with the regards to the safe management of medicines remained. Records were not always completed to support and evidence the safe administration of medicines

Risk assessment and care plans had still not been regularly reviewed and updated when required. This put people at risk of harm.

Staff understood how to recognise abuse and how to report concerns or allegations.

Recruitment checks were undertaken to ensure staff were suitable to work with vulnerable people.

Is the service effective?

Requires improvement

The service was not always effective.

People's physical and mental health needs were monitored but not always updated and recorded in the care records. People's weights were not always recorded despite the intervention of dieticians.

Staff said they were well supported through induction, supervision, appraisal and the home's training programme.

People told us they received enough to eat and drink and chose their meals each day. They were encouraged to eat foods which met their dietary requirements.

Staff recognised when additional support was required and people were supported to access a range of health care services.

Is the service caring?

Good

The service was caring.

People told us they had choices with regard to daily living activities and they could choose what to do each day. They told us staff treated them with respect.

Staff we spoke with showed they had a very good understanding of the people they were supporting and were able to meet their needs. We saw that they interacted well with people in order to ensure they received the support and care they required.

Summary of findings

We saw that staff demonstrated kind and compassionate support.

Is the service responsive?

Inadequate

The service was not responsive.

We saw that people's needs were not always regularly assessed. Care plans and risk assessments were not always regularly reviewed.

Concerns at the last inspection had not been appropriately followed up.

Referrals to other services such as, the dietician or occupational therapist andGP visits were made in order to ensure people received the most appropriate care.

People living at Byron Court were involved in the decisions about their care and support.

The home had a complaints policy and processes were in place to record complaints received.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of good governance and leadership at the home.

The service had did not have a robust quality assurance system in place with to help ensure good practice within the home.

There were systems in place to get feedback from people so that the service could be developed with respect to their needs.

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 was 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 unannounced inspection took place on 8 & 21 December 2015. The inspection team consisted of two adult social care inspectors, a specialist nursing advisor and a specialist pharmacist advisor. A specialist advisor is a person who has experience and expertise in health and social care. The specialist advisor, pharmacist and one adult social care inspector attended the home on the first day of the inspection.

Before our inspection we reviewed the information we held about the home. We looked at the notifications the Care Quality Commission had received about the service.

During our inspection we used a number of different methods to help us understand the experiences of people who lived at Byron Court. This was because the people who lived at the home were not always able to communicate their needs and we were not always able to directly ask them their views about their experiences. We undertook general observations, looked round the home, including some people's bedrooms, bathrooms, the dining room and lounges. We completed a short observation framework for inspection (SOFI) in the dementia care unit. SOFI is an observational tool used to help inspectors collect evidence about the experience of people who use services, especially where people may not be able to fully communicate or describe this themselves. It enables inspectors to observe people's care or treatment, looking particularly at staff interactions.

We spoke with eight people who lived at the home, three relatives and visitors. We spoke with the registered manager, two registered nurses, five care staff, two domestic staff the cook and the administrator. We observed the administration of medication in the home by staff to ensure their practice was safe and that people received the correct medication and in a timely way. We looked in-depth at the care records for four people by 'pathway tracking' their care and discussing their care with staff, the people themselves and their relatives. We looked at a further six care records, seven staff recruitment files, medicine charts and other records relevant to the quality monitoring of the service.

Inadequate

Is the service safe?

Our findings

At the previous comprehensive inspection in June 2015 we found that medicines were not always managed safely at the home. We conducted a focussed inspection in September 2015 in response to concerns that were received and we found concerns in relation to people's risk assessments not being reviewed/updated on a regular basis, for example nutritional and pressure area care risk assessments. The safe domain had been rated as requires improvement at the last inspection.

As part of this inspection we followed up on the concerns identified at the previous two inspections. We found that some concerns still remained and new breaches of regulation were also identified.

We looked at how medicines were managed in the home. On the whole we found improvements had been made since the inspection in May 2015 although some concerns remained.

One of the MAR chart folders (i.e. the large folder containing many charts) had a list of all persons and their allergy status at the front of the folder, but the list was out of date and did not include the two people who did not have an allergy status documented on the medication section of the MAR chart.

At this inspection we found the storage of medicines was good. The medicines storage room was locked and all cupboards were locked. The room was neat and tidy and trolleys were secured using a locked cable when not in use. The controlled drug cupboard was locked and contained appropriate medicines. The controlled drugs (CD) register appeared to be comprehensively filled-in but there was no routine check of CD quantities other than a count whenever a CD was administered. The provider's policy stated that there should be a weekly CD count. One nurse's signature was recorded on a MAR chart for the administration of controlled drugs (CDs). The pharmacy had added an extra box for a second signature on the MAR chart for all CDs but it was being used to document administration time and not used for a signature. Another MAR chart from a different medicines trolley was being used correctly and did have two staff signatures. The registered manager informed us that there were two signatures when administration was completed by the senior care staff. Registered nurses did not get another staff to countersign when administering CD's, however, we found there were always two signatures in the CD register.

The home had developed a good system with the GP surgeries and pharmacy for obtaining regular supplies of prescribed medication. All medicines were checked by a registered nurse on receipt from the pharmacy and the quantity documented on the medicine administration record (MAR) chart.

On the first day of our inspection medication administration was observed for several people who lived in the home. All medicines to be administered at the same time were supplied within a single blister for the person. The names of the medicines were printed on the top of the blister and the nurse checked the medication name and strength against the MAR chart. This was a robust system. The nurse showed patience and had a caring rapport with the people. People were asked about the need for 'when required' treatments and outcomes were documented. Any omitted medicines were documented and explained.

Two people required warfarin treatment and in both cases the documentation and administration of the daily dose was clear and complete. Warfarin is an anticoagulant (blood thinner) which reduces the formation of blood clots. The daily dose was written on the MAR chart by the individual undertaking the INR test, and the date of the next test was recorded. This helped ensure people's health and welfare were monitored.

Staff had completed medication administration training in June 2015, following the introduction of the new administration system. However we found there was no assessment of competence in the handling and administration of medicines for staff. This practice is stated in the provider's medicines policy.

The home was using the 59th edition (March 2010) copy of the British National Formulary (BNF). It was therefore very out of date. The BNF gives staff administering medicines authoritative and practical information on the selection and clinical use of medicines.

There was a thermometer in the medication room and temperatures were monitored although there were some gaps. All temperatures were below 25 degrees. The room temperature of the medicines storage room was documented most days but there were some gaps in

recording. We informed the registered manager of this on the second day of our inspection. Temperature of the fridge and medication room should be taken regularly to ensure the temperature remains within the recommended range to keep medication stored correctly for optimum benefit of its use. However there was no suggestion on the day of inspection that the fridge had been out of the desired range. We did not see any documented temperatures that were too high or low, which would have affected the performance of the medication. Medicines for destruction were documented in a destruction book and stored in specific containers. The medication fridge was unlocked (keys were kept in the lock) and there were no temperature records for 5 out of 8 days in December.

We found vials of insulin had not been dated on opening. The date should be written when medication is opened to ensure it is not used past the recommended time.

The home did not have a robust medication audit in place. We were shown the results of monthly medicines audits but these appeared to be random action plans and general reminders for staff rather than the outcomes of routine audit. The audit did not check general drug stock, audit any MARs, or check the recording of fridge and room temperatures. Having a more robust audit would identify issues found at the inspection, as described earlier. There was a file in the medicines storage room entitled 'Medication Incidents Reports' ; it contained blank copies of several documentation sheets but there were no records of any incidents.

One person had dry skin and was prescribed cream for this. Two carers informed us that this was rubbed into the person's skin all over their body every day. There was a chart to record this on but it was not completed daily. The form did not lend itself to identifying what cream had been applied or where; the care staff had to use the code 'CA'. The cream was prescribed and therefore was signed for every day on the MAR sheets. Carers informed us that if this person's sacral area was looking red they applied a different cream. There was nowhere to record this different cream on the daily charts that the carers completed. Whichever cream was applied was recorded using the same code. We found there was also no mention of specific creams in this person's care plan, but the use of a barrier cream was documented. There were body maps on the MAR sheets, which the care staff had no access to and therefore, no record was made of where the cream was applied.

One person required a bladder washout twice a week; the washouts were prescribed and documented on the care plans. The recorded dates on the MAR sheets for the washouts were: 18, 24, 30 November 2015 and 3 December 2015. This administration regime was not in keeping with the written instructions from the hospital; a copy of which we saw in the care notes. The dates were recorded in the daily reports and there was only one occasion out of the four dates recorded that the sticker from the washout was stuck to the documentation which would indicate best practice. The lack of clear recording increases the risk of a nurse identifying when the washout was next due.

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

We looked at four care records and found the care plans had very detailed description of how to move and handle residents and what equipment to use. There were, however, gaps in all the care plan evaluations and we therefore concluded they had not been evaluated on regular basis. The care plans were not easy to read, especially around wound and catheter care so information was not clear. We found that the information was documented in the daily reports making it difficult to find. We spent some time with all of the people concerned. They did not appear undernourished, dehydrated, and none of them had acquired a pressure ulcer. However we found several issues with the care plan recording for all four people. This meant that accurate records were not kept about people's health and this put people at risk of harm.

Risk assessment tools were in people's records including; risk of pressure ulcers, falls, and nutrition but these were not always updated and often did not reflect the risk in the care plans. This meant that the records did not show an accurate picture of people's needs

We looked at a further six care plans. These care plans were more consistent and risk assessments and care plans had been completed for them to help ensure people's needs were met and to protect people from the risk of harm. Three people who had moved into the home in November had care plans and completed risk assessments to inform staff of their health and care needs.

Inadequate

Is the service safe?

These findings are a breach of Regulation 12 (1)(2)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2014.

We looked at how the home was staffed. Staffing rotas were displayed in the foyer. We found no consistency in the numbers of both trained staff and care staff scheduled on duty each day. For example from 7 to 10 December the rota showed six carers and a senior carer on the 9th and seven carers and a senior carer for the other days. For 9 to 14 November the rota showed 3 nurses rostered on one day, with a different number of carers each day, from six to ten. On the first day of our inspection we spent time in different parts of the home. In the dementia unit we observed that there was mainly two care staff on duty to support 10 people. A third member of staff was not on the unit all of the time as they had responsibilities throughout the care home. One staff member on the dementia unit told us that one care staff who should have been working that day had gone on a training course. We asked if they had been replaced and were told they hadn't. We saw that this impacted on staff availability to assist some people with their personal care routine and getting out of bed. This was because some people required two staff to assist them and if they had done so the other people in the unit who were in the lounge area would have been left unsupervised for a period of time, which was not safe. Staff were unable to assist one person out of bed and with their personal care routine at 12 noon, as there were only two staff working on the unit at the time. At the same time one staff had to support a person as they were very distressed. This left one staff to support the remaining people on the unit. Two staff on the unit did not appear to be adequate to ensure people's needs were being met and people were kept safe.

We discussed the staffing issues with the manager on the second day of our inspection. They told us that the staffing numbers were not 'short' the first day of our inspection. They said the usual staffing compliment was from 8am to 8pm, two nurses and eight care staff: two care staff per floor and two for the dementia care unit. No formal assessment tool was used to determine whether staffing numbers were planned on people's assessed care needs.

We spoke with staff about the numbers of staff available. We were told by three different care staff that there was not enough staff on the middle floor. They told us there were only two carers and four people were currently being nursed in bed. This meant that usually two staff were required to assist people in bed to be hoisted or 'turned' or they needed more support with eating and drinking. Some other comments from the staff included: "I am not happy regarding staffing; there is not enough on this floor, sometimes three on but mostly two, and when we have three staff it is usually when someone needs an escort to hospital", "Good staff who work hard but not enough (staff)", "Girls (staff) are very caring but not enough care staff, this floor should have three; they are missing, filling out forms, often not enough time" and " There are different numbers of staff; no consistency."

These findings are a breach of Regulation 18 (1) HSCA 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they were safe living at Byron Court.

We looked at how staff were recruited. We saw the files for three new employees. We found application forms had been completed and applicants had been required to provide confirmation of their identity. We found that staff had not commenced their employment at Byron Court until a DBS check had been completed and returned. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff.

A team of domestic staff were responsible for the cleanliness of the building. We observed that the home was cleaned to a high standard. We spoke with staff who told us they were responsible for certain areas within the home. Written cleaning schedules were not kept but conversations we had with two of the staff assured us they all knew their responsibilities and routines for cleaning the home.

Two staff worked each day from 8am to at least 2pm. The staff team ensured by covering the shifts between themselves that there were always staff available to clean the home and do the laundry.

Staff were observed to use personal protective equipment (PPE). They wore appropriate gloves and aprons when carrying out personal care and when handling food.

Staff understood how to recognise abuse and how to report concerns or allegations. Staff we spoke with informed us that they would report it initially to the nurse

Inadequate

Is the service safe?

in charge and then the manager if nothing was done about it. There were processes and policies in place to help make sure people were protected from the risk of abuse. Staff confirmed they had attended safeguarding training. Information provided by the registered manager confirmed this had taken place in May 2015. Some care staff we spoke with had a limited understanding of the different types of abuse. However they all told us how they would keep people safe.

We saw how the incidents/ accidents were monitored each month and action taken where appropriate. Staff were aware of their responsibilities in reporting such events.

Systems were in place to maintain the safety of the home. This included health and safety checks and audits of the environment. A fire risk assessment had been completed and people who lived at the home had a personal emergency evacuation plan (PEEP). This helped ensure their needs for evacuating the building had been assessed and the information was readily available to be shared when required. We spoke with the member of staff responsible for the maintenance of the home. They told us that emergency evacuation drills were completed within the home. Records we saw confirmed that a drill had taken place every month, the last one being in November 2015.

Safety checks of equipment and services such as, fire prevention, hot water, legionella, gas and electric were undertaken; maintenance work was completed in a timely way to ensure the home was kept in a good state of repair.

The home had received a 5 star [very good] food hygiene rating in February 2014.

Requires improvement

Is the service effective?

Our findings

At the previous inspection in September 2015 we found that nursing staff had not received the appropriate training in relation to catheter care and tissue viability. There were also concerns that people were not being weighed when they should have been as records were often incomplete. The registered manager informed us following that inspection that people were now being weighed. Food and fluid intake had also not been consistently recorded for some people. The effective domain had been rated as requires improvement at the last inspection.

On this inspection we found that little improvement had been made. There was a continued poor monitoring and management of people's eating and drinking which puts people who use the service at risk.

We found that information such as people's weights, was passed to the registered nurse by the carers but this was not always reflected in the care plans/daily report.

There was no consistency in what information was recorded to show how to meet each person's individual needs. The quality of the care plans and the completing of the various charts for food, fluid intake and weights appeared to be dependent on which staff member had completed them and reviewed them. The fluid and food charts were kept in a file in the lounge so were not accessible for staff to complete at the time any positional change or eating or drinking had taken place

A person who had lost weight and had been referred to the dietician had put weight back on. However we found gaps in the recording of their weight which meant the risk had not been well monitored. Records showed a weight documented on the 19 September 2015 but then not again until 21 November 2015. The nutritional screening document was not signed and had not been updated since the person's admission.

One person was being nursed in bed and was not being weighed monthly. This was because the home did not use alternative methods to weight people who could not use the scales. This had also been raised at the last inspection.

We saw that one person had been reviewed by the community dietician in May 2015; there was a letter in the person's care plan advising that they be weighed monthly. We could not find weights recorded for this person. The last recorded weight was 59.6kg and this was documented on the dietician's letter. We discussed the recording of weights with the registered manager. There could be two recording systems in use. In addition some staff did not appear to be recording the weights at all. We asked the registered manager to inform staff of the one place to record people's weights so they can be found easily and evidenced. This had been raised on the previous inspection in September 2015 and progress had not been made.

These findings are a breach of Regulation 9 (1) (a)(b) (3) (i) HSCA 2008 (Regulated Activities) Regulations 2014.

Following this inspection, we received documentation from the provider that training in tissue viability and catheter care had been completed for all nursing staff.

People at the home expressed their needs and wishes in different ways and our observations showed staff understood and responded accordingly. People appeared comfortable and relaxed with the staff.

A relative told us, "My family member has settled here. It helped because this is where they wanted to be. They cannot look after themselves at home, they were not eating properly; here they have put weight on."

Staff appeared to enjoy their work. Staff we spoke with told us, "Byron Court is one of the better homes I work at", "I love working here, happy to come to work, better than a previous home I worked in" and "You get a decent handover when coming on duty."

Throughout the inspection we found that staff were very knowledgeable about the needs of the people in the home.

Staff told us they felt well supported and trained to meet people's needs and carry out their roles and responsibilities effectively. One staff member we spoke with told us they had recently completed a three day induction when she started work at the home Other staff we spoke with told us they received regular training. Training records we looked at showed us that 81% of all care and ancillary staff had completed a National Vocational Qualification (NVQ) in health and social care at level two or three. Only five staff had not completed a health and social care qualification.

On the day of the inspection we spoke with an agency nurse on duty. They informed us they had worked a lot of shifts at the home and knew the residents well.

Requires improvement

Is the service effective?

We spoke with one member of staff about a person recently admitted to Byron Court. They told us how they had contacted the hospital and the GP to request medical attention in relation to a long standing health condition the person had which had not previously been resolved. We were informed on the second day of our inspection that the person had received a hospital appointment to address their health concern. Staff had acted quickly and effectively when aware of the person's health issues.

We spoke with the chef. The main chef was absent from work because of sickness. The role was being covered by a senior carer. We saw that when a dietician had seen a person, a laminated sheet with details of any restrictions or supplements was created for each person. Any letters from the dietician about people's diets were copied and the chef kept copies in the kitchen. 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 was 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.

The store cupboards and fridge/freezers were well stocked. We were informed that the ordering of meat had recently changed to fresh from using frozen meat. Fresh fruit was available.

We saw that people were regularly offered a hot drink and snack throughout the day. One person told us, "The food is lovely here, I get enough to eat"

People ate lunch in two dining rooms. We observed a small group of people having lunch on the first floor. We observed that people received support with their meal and drinks from staff in a safe and timely manner. Staff did not rush them to eat their meal. We did observe staff on a different floor giving drinks to people and they were offered choices of tea or coffee. The staff appeared to know the likes and dislikes of the people who lived in the home.

The home had a separate dementia unit. We saw improvements to the environment from our last inspection We found the environment of the unit did not always promote a positive dementia- friendly environment although we observed improvements and changes had been made since our last inspection. The lounge/dining area was light and brightly decorated in a modern style. Photographs of the era were on the corridor walls that people who lived in the home would recall. Furniture was simply placed around the outside of the room. We found the bedrooms were personalised with people's belongings and photographs. Bedroom doors were individually determined by its number. However we found each

door was the same, with no additional personalised information, such as memory boxes, containing

photographs. The manager told us that this issue was being discussed with people's relatives We found the signage on the bathrooms was now large and at an appropriate level for people to identify.

We did not find any information clearly displayed to identify the day, date and year, which would help people orientate themselves. There was a white board in use for this purpose but on the day of our inspection the board was blank. The television was switched on throughout the day.

We observed how lunch was served on the dementia unit. The menu for the day was not displayed anywhere to remind people what meal they were to expect. We noticed that a choice of meal was not offered, although everyone accepted the meal and appeared to enjoy it. Meals were served on plain white crockery; The use of bright coloured crockery, as a contrast to the table, tray and food is known to assist people with dementia to distinguish the food on the plate or dish.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Requires improvement

Is the service effective?

We checked whether the service was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met.

The provider had met the requirements in the DoLS. Applications had been appropriately submitted to the local authority who are the 'Supervisory Body' for authority to do so. Applications under the DoLS had been authorised and the provider was complying with the conditions applied to the authorisation.

The provider has properly trained and prepared some of their staff in understanding the requirements of the Mental Capacity Act.

Good

Is the service caring?

Our findings

We asked people who lived in the home their views on the staff. Their comments included: “They are a nice bunch of girls and look after me; they are kind and caring”, “I love it here. I was in another home; It’s a lot nicer here. The carers are very nice.” A relative told us, “They are a nice bunch of girls that work here, always make us feel welcome.”

Our observations throughout the inspection showed that people who lived in the home appeared to be treated with kindness, respect and compassion. We observed staff speaking to the people in an appropriate kindly manner; often initiating conversation. We saw that staff’s approach to people was caring and thoughtful. We saw one staff sat with a person who had lived in the home for some time and was clearly distressed. The staff member displayed good skills and was caring when providing support. We observed staff were compassionate and empathetic towards a person who had recently come to live in the home and their family.

We observed staff supported people in the home in a discreet manner when attending to their personal care. We saw staff knocking on people’s bedroom doors before entering and explaining to people what they were doing when supporting them. People who lived in the home and relatives we spoke with all told us that people were treated with respect and their dignity and privacy was maintained.

People in the home were involved in the day to day decisions affecting them. The home had a resident’s committee who made decisions about activities and trips as well as suggestions for meals. They had also discussed with the staff representative the amount of laundry that goes missing. The meetings had been held several times during 2015. In 2015 people who lived in the home had enjoyed trips to a local park and stately home, a garden centre, the circus, the museum and some people went on a barge trip.

On the first day of the inspection we observed staff helping people to make Christmas cards. Staff interacted well with people. We observed good interactions between staff and people who lived in the home. Staff used humour to engage in conversation with some people. There was lots of laughter.

Some people who lived in the home had made decisions regarding their end of life care and these were recorded. We found in the care records we looked at evidenced that end of life care had been discussed. A DNACPR [do not attempt cardio pulmonary resuscitation] decision had been made for one person and was recorded in their care plan. The person was nursed with bed rails in place to ensure their safety and an air mattress had been provided to help ensure comfort and maintain skin integrity. Family had been involved in making the decision with the GP and the staff in the home regarding the DNACPR. This was evidenced in the person’s care plan.

Contact details for a local advocacy service were available were displayed in the hallway.

Inadequate

Is the service responsive?

Our findings

At the last inspection in September 2015, we found that care plans had not been evaluated on a regular basis and care was not specifically individualised for people who lived at the home. We were told that all care plans were being re-written. The responsive domain had been rated as requires improvement at the last inspection.

On this inspection we found that concerns remained and little progress had been made to ensure people received care and at the time they needed it.

We looked at records appertaining to the persons indwelling catheter. It was difficult to identify when the person last had their catheter changed, by whom, and the size used. If there was a serious untoward occurrence with this person's catheter the home would be unable/or have difficulty in tracing back to show what batch number of the product they had used.

One person had a very detailed care plan describing how they transferred, what equipment was used and how many people were required to assist with each manoeuvre, but there was no evaluation recording sheet to accompany it. It was last reviewed on 14 September 2015 This meant we could not be certain this information about the person's needs was up to date.

Similarly, a behavioural risk assessment was completed and it was identified the person was low risk but was last reviewed on 26 July 2015. Care staff on duty were knowledgeable about the person and informed us that they were still a low risk but this was not clear from the care records as no formal evaluation had been recorded.

The second person whose care plans and file we reviewed was nursed in bed due to their frailty. They were physically unable sit up straight in a chair. We found that this information was passed on verbally and not documented in her care plan. There was no turn chart in this person's room to record positional changes; important to monitor skin integrity. One member of staff told us, "Sometimes we miss filling charts out as they (the charts) are not with the residents and then they get forgotten about as there is always someone else wanting us." Our observations during the inspection identified that this person appeared to be in the same position since approx. 9.30hrs that morning. We spoke with the nurse in charge who then arranged for this lady's position to be changed.

The third person we pathway tracked was also on fluid charts, pad changes/ turn chart. We were informed that these were kept in a file 'downstairs', despite the person not having a bedroom on the ground floor. However on the day of the inspection these charts could not be found so we could not check if they had been completed. Staff told us, "Their charts are kept downstairs in a cupboard as normally this is where the person likes to spend their time. We (the carers) have to go downstairs to complete them today." The nurse in charge told us that staff "Need to observe regularly as the person slides out of their chair." We could not find any reference to the person being at risk from sliding out of the chair in their care plan.

Another person had dressings to both lower legs. There was a care plan in their records dated 21October 2015 and had been evaluated on 22 November 2015.Information and advice from tissue viability team was documented. In a hand written care plan which was difficult to read it was documented what dressings to use and the frequency dressings were to be changed. . There was no supporting wound chart with the care plan to indicate clear monitoring including what dressings were applied or any improvement or deterioration in the wounds. We had to read through all the daily reports to find out when the dressings were done and in the majority of cases it was recorded "dressings to legs renewed". This was not an effective way to identify the important information, when required.

We did not find a record of any monthly weights in this person's care plan. There was no MUST (Malnutrition Universal Screening Tool) in this person's care plan. They required a nutritious diet to help with the healing of their leg wounds.

These findings are a breach of Regulation 12(1) (2)(a)(b)HSCA 2008 (Regulated Activities) Regulations 2014.

The registered manager was still in the process of writing care plans in a new format for people. We had been told all of the people in the home were to have new care plans at our last inspection in September 2015. However from the care records we looked at we found few had a record of people's likes/dislikes and very little detail of life stories in the records. We found there were gaps in all the care plans with respect to their evaluations/updates. The care plan files were not easier to read, especially around wound/ catheter care – information was documented in the daily reports making it difficult to find. By comparison, we looked

Inadequate

Is the service responsive?

at the care records for people staying in at Byron Court for 'residential care'. We found their care plans and risk assessments had been completed and reviewed regularly. We saw more personal information recorded about them.

In the 10 records we looked at there was very little information written about people living with dementia and their care needs around impaired cognition. The new care plans that had been written were of an inconsistent standard and lacked the necessary detail. Gaps in recording evaluations were evident meaning people were at risk of not being effectivity monitored.

These findings are a breach of Regulation 9 (1) (a)(b) (3) (b) HSCA 2008 (Regulated Activities) Regulations 2014.

We spoke with a relative about the care their family member received at Byron Court. They told us, "I have no concerns but would approach the staff if I had. The home does involve me in decisions regarding money and if (family member) needs anything."

During the inspection we observed staff responding to people's daily needs as they arose such as the application of creams and provision and support with food and drink.

The home employed an activity coordinator. They told us about the different activities that were provided for people who lived in the home. A weekly timetable for the activities was displayed on the notice board in the hall way and included both one to one and group activities. Activities included art and craft, flower pressing, reminiscence, armchair exercises, reading group, quizzes, 'knit and natter', pamper sessions and the pensioners' club. They also supported people to go out on a 'one to one' basis to a local café or for personal shopping. People also told us about other activities such as, tai-chi, entertainers who came in the home and about religious services that were held. People were encouraged to continue with their hobbies and interests. The home had use of a vehicle every fortnight. Trips out to various destinations were arranged. The staff in the home were busy with preparations for the Christmas activities. We were told of a raffle that was taking place for people in the home and their families. The staff had prepared many large food hampers as prizes.

The provider had a complaints procedure which was displayed in the hallway for everyone to see. We saw that action had been taken to investigate complaints and resolve them to people's satisfaction. The registered manager told us there were no complaints currently being investigated. People we spoke with who lived in the home told us they did not have any complaints.

Inadequate

Is the service well-led?

Our findings

We checked to see if the ratings from either the June 2015 or the September 2015 inspection were displayed in the home as it is a legal requirement to do this within 20 days of publication of a CQC rating. We were unable to find the poster required to be used to display the ratings to the public.

This is a breach of Regulation 20A of the HSCA 2008 (Regulated Activities) Regulations 2014.

We looked at the quality assurance systems in place to monitor performance and to drive continuous improvement. Although quality assurance systems were in place, they were not robust to ensure the health, safety and welfare of people was effectively assessed and monitored.

The registered manager informed us that she and the newly appointed deputy were auditing care plans. However given the evidence of poor recording and gaps in the care records we found that the managers were not auditing the current care records effectively, but were replacing people's care records with care plans and risk assessments in the new format and this process had not been completed. A robust care plan audit would regularly identify the lack of reviewing of personal information and poor recording of charts by staff, as found by the inspection team.

We were shown the results of a monthly medicines audit completed in September 2015 but this appeared to be random action plans and general reminders for staff rather than the outcomes of routine audit. Nursing staff were not aware of the outcomes of any audits and had not been informed about any medication incidents or issues.

We saw that the audit tool used produced several findings relating to individual people in the home and their medication. Apart from the count of controlled drugs the audit did not appear to have checked MAR sheets, the stock in the trolleys or staff competency. This meant that the audit was not robust and did not identify or follow through any improvements that were required for the safe management of medicines.

An audit completed by the infection control team was carried out in March 2015. The home was awarded a score of 88%. We saw that the points raised in the action plan had been resolved.

These findings are a breach of Regulation 17 (1) (2) (a) & (b) HSCA 2008 (Regulated Activities) Regulations 2014.

We observed quality audits had been completed during 2014/2015 related to gas and electrical appliance testing, fire prevention equipment, passenger lift and the heating and water system. In addition audits were completed regularly by the cleaning and the kitchen staff. We saw action plans from the audits which had been completed in a timely manner. This assured us that people who lived in the home were supported to live in a safe environment.

A process was in place to seek the views of families and people living at the home about their care. In March 2015 questionnaires were given to people who lived in the home, relatives and staff. We received a mixed response to the completion of the questionnaires from people who lived in the home. Some said they had not completed any, whilst another person said they had not been able to complete it. The provider sent us the questionnaire results after our inspection. Responses from people who lived in the home were positive in relation to the cleanliness, décor and facilities provided in the home. Everyone who completed a questionnaire said they would recommend the home to others. The attitude of staff and the care provided was rated highly.

Staff completed an annual questionnaire in March 2015. The results showed they were 'generally satisfied' and enjoyed working at Byron Court. The results for job satisfaction and staff morale were less positive.