Byron Lodge (West Melton) Limited

Byron Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Byron Lodge is a residential care home providing personal and nursing care for up to 61 people. At the time of our inspection there were 43 people living at the home. Some people using the service were living with dementia.

People's experience of using this service and what we found
Systems in place to monitor the service were not always effective. Audits identified areas of some improvement but some issues were not actioned in a timely way. For example, the sluice bin had been identified for replacing on 6 March audit, but this was still not replaced when we carried out our inspection. This audit also identified that equipment should not be stored in bathrooms, but this was still evident on inspection and storerooms required attention, especially the decommissioned bathrooms.

People did not always receive person centred care. We observed the meal service on 2 units and found the meal time experience poor.

We found some concerns regarding medicine management. The provider could not always evidence people were given their medicines as prescribed. Following our inspection, the manager took appropriate actions to ensure systems improved.

We carried out a tour of the home with the manager and the home generally, was visibly clean, but deep cleaning was required to ensure equipment, furniture and storerooms were clean. Storerooms required organising and sorting out. The manager confirmed action had been taken following our inspection.

Risks in relation to people's care and support were in place. However, some people had lost weight and there were limited evidence to show how this was being addressed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff were aware of what actions to take to safeguard people from the risk of abuse. The manager kept a record of safeguarding concerns and monitored the outcome.

Accidents and incidents were analysed but there was lack of evidence to show what actions had been taken to mitigate future risks. Following our inspection, the manager introduced a system to improve this analysis.

People, relatives, and staff spoke highly of the new manager and felt she was approachable and taking action to improve the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 25 December 2020).

Why we inspected
The inspection was prompted in part due to concerns received about medicines management, infection control, and leadership. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Byron Lodge on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to medicine management and governance and leadership.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Byron Lodge Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Byron Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Byron Lodge is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been recruited and was in the process of registering with CQC. The manager had been in post about 4 weeks.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people who used the service and 2 relatives about their experience of the care provided. We spoke with 7 members of staff including the registered manager, nurses, senior care workers, care workers and ancillary staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 5 people's care records, multiple medication records, staff files in relation to recruitment and staff supervision and quality monitoring records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- People did not always receive their medicines as prescribed. For example, we found some gaps in the recording of medicines on the medication administration records (MAR's).
- We found an instance where someone's prescribed medication had run out of stock and the person had not received their prescribed medicines for 5 days. There was no evidence to show what action had been taken to obtain these medicines. We raised this with the manager who took immediate action.
- MAR's were not accurate and did not always record the amounts of medicines in stock, therefore audits were ineffective.
- Some people were prescribed medicines on an 'as and when' required basis. Protocols were not always in place to ensure these medicines were administered correctly.

The provider had failed to ensure the proper and safe management of medicines which is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The home was visibly clean; however, some areas required a deep clean. For example, storerooms were untidy, disorganised and in need of cleaning. We have reported on this in the well led section of this report.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- People were supported to maintain relationships with family and friends who were welcome to visit the home without restrictions.

Learning lessons when things go wrong
● The provider had a system in place to record and analyse accidents and incidents. However, the analysis did not always show what actions had been taken to mitigate future incidents. The manager took action to improve this system.

Systems and processes to safeguard people from the risk of abuse
● The provider had a system in place to safeguard people from the risk of abuse.
● The manager kept a record of any safeguarding concerns and could evidence issues were reported to the safeguarding authority.
● Staff we spoke with told us they received training in safeguarding and could explain the providers safeguarding procedure.
● People we spoke with told us they felt safe living at the home. One person said, "I do feel safe, but it's not like being at home. We are cared for, and we get enough to eat." Another person said, "I get looked after, fed and cleaned and showered."

Assessing risk, safety monitoring and management
● Risks associated with people's care had been identified but some care plans required more detail to accurately reflect people's needs.
● One person had a behavioural support plan but gave limited detail on how this was managed. Supporting documentation was also limited and did not give enough detail about what happened before, during or after incidents.
● Staff we spoke with knew people well and were knowledgeable about people's needs and how to mitigate risks.
● We informed the manager who took appropriate actions to address our concerns.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment
● The provider's recruitment policy helped them recruit suitable staff. This included pre-employment checks such as Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.
● People we spoke with gave mixed views about the quantity of staff. One person said, "I just shout for them [staff] and they come. I can be shouting for 30 minutes before they come." However, another person said, "They come if you press [your call bell], you don't wait long."
● Some staff with felt there were times when they didn't have enough staff. One staff member told us they

were the only carer on 1 unit, and this regularly happens. However, since our inspection we have spoken with staff who feel this has since been resolved. Another staff member said, "You [staff] need to be organised with only 2 staff but we manage well, we work as a team."

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

- Systems in place to monitor the service were not always effective and required reviewing and embedding into practice.
- Audits completed identified areas of improvement, but these were not always actioned in a timely way. For example, the infection control audit completed on 6 March 2023, the sluice bin had been identified for replacing, but this was still not replaced when we carried out our inspection. This audit also identified that equipment should not be stored in bathrooms, but this was still evident on inspection.
- Storerooms required attention especially the decommissioned bathrooms. These were full of items and not organised, clean or tidy.
- The medication audit completed in February 2023, identified carried forward quantities not recorded accurately on MAR charts to ensure reflective stock counts are maintained and dates of opening were not written on boxes and bottles. These issues remained when we inspected the home.
- Following our inspection, the manager took appropriate actions to address these issues. However, systems and processed require embedding into practice to ensure their efficacy.

The provider had failed to ensure governance systems were effective. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people

- People did not always receive person centred care. We observed the dining experience on 2 units and both mealtimes could be improved. For example, on 1 unit all people were given drinks in adapted cups when some people preferred to drink from ordinary cups and there was no reason for them to use an adapted cup.
- The manager was in the process of developing systems to improve the service and was promoting a positive culture. These systems required further embedding into practice.

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- At the time of our inspection the provider had employed a new manager who had been in post about 4 weeks. During this time, they had reduced the number of agency staff required by giving their own staff an

incentive to cover hours additional to their contract. This gave people the consistency of receiving support from staff who knew them well and motivated staff.

● The manager was clear about their role and understood their responsibilities. There was a system in place to ensure the manager and provider was open and honest when things went wrong.

● People, relatives, and staff spoke highly of the new manager and felt they were approachable and improving the service. One person said, "The new manager is nice. She's doing stuff different; she's improving things already. I am very happy here, no problem. I wouldn't be here if I wasn't."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider had a system in place to involve people, the public and staff to share their comments and suggestions about the service.

● The management team and staff worked with other professionals to ensure people received appropriate care and support.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure governance systems were effective.