Byron Court Care Home Limited

Byron Court Care Home

Inspection report

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

Date of inspection visit: 28 May & 4 June 2015
Date of publication: 05/08/2015

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?	**Good**

Overall summary

This unannounced inspection of Byron Court took place on 28 May and 4 June 2015.

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.

The manager for the home was registered with 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.

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

There were enough staff on duty at all times to ensure people were supported safely.

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.

Summary of findings

Staff had not been trained in the new system of medicines supply and recording which had been implemented at the home a month before we visited. We found records had not been completed to support and evidence the safe administration of some medicines.

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. Mental capacity assessments had been completed for people living at the home but these were general in nature and not decision-specific.

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. One person told us, "Lovely food, I have what I want. If you want anything special anytime they try and get it for you."

The building was clean, well-lit and clutter free. Measures were in place to monitor the safety of the environment and equipment. We found the environment of the dementia unit did not always promote a positive dementia- friendly environment.

People's physical and mental health needs were monitored and recorded. Staff recognised when additional support was required and people were supported to access a range of health care services.

People told us they 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 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.

We saw that people's care plans and risk assessments were regularly reviewed. People had their needs assessed and staff understood what people's care needs were. 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 ensured issues were addressed within the timescales given in the policy.

We found person-centred culture within the home. This was evidenced throughout all of the interviews we conducted and the observations of care.

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

We received positive feedback from health care professionals who told us the home worked well with them and liaised to support people's on-going health and social care.

The service had a quality assurance system in place with various checks completed to demonstrate good practice within the home.

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?

Requires improvement

The service was not always safe.

Staff had not been trained in the new system of medicines supply and recording which had been implemented at the home a month before we visited. We found records had not been completed to support and evidence the safe administration of some medicines.

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

There were enough staff on duty at all times to ensure people were supported safely.

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

Is the service effective?

Requires improvement

The service was effective.

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.

People's physical and mental health needs were monitored and recorded. 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 their received the support and care they required.

We saw that staff demonstrated kind and compassionate support.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People had their needs assessed and staff understood people's care needs. We saw that people's care plans and risk assessments were regularly reviewed.

Referrals to other services such as, the dietician or occupational therapist and GP visits were made in order to ensure people received the most appropriate care. We received positive feedback from health care professionals who told us the home worked well with them and liaised to support people's on-going health and social 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?

Good

The service was well led.

We found an open and person-centred culture within the home. This was evidenced throughout all of the interviews we conducted and the observations of care.

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

The service had a comprehensive quality assurance system in place with various checks completed to demonstrate good practice within the home.

Byron Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 was undertaken on 28 May and 4 June 2015. The inspection team comprised two adult social care inspectors, a pharmacy inspector 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.

We had not asked the provider to submit a Provider Information Return (PIR) prior to the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection we reviewed the information we held about the home. We looked notifications and other information CQC had received about the service. We contacted the commissioners of the service to obtain their views.

During the inspection we spent time with eight people who lived at the home and spoke with three family members or friends (referred to as visitors throughout the report) who were visiting at the time of the inspection. We spoke with the manager of the home, the chef, three nurses and three care staff. We approached one health care professional who was visiting the home at the time of the inspection for their views of the care provided.

We looked at the care records for eleven people who were living at the home, three staff recruitment files and records relevant to the quality monitoring of the service. We looked round the home, including some people's bedrooms, bathrooms, the dining room and lounge areas.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. Their comments included: "I feel perfectly safe with all [staff] of them", I am very happy here; have been here for seven years and never felt unsafe in all that time" and "I feel safe; they are okay with me. I depend on them and trust them."

We looked at a sample of the medication records and observed part of the medicines administration round. We saw that support was offered where people needed help with taking their medicines. Arrangements were in place for medicines labelled "before food" to be given at the right times however, we saw two examples where medicines usually administered before breakfast had not been given. There was no evidence that these medicines had been offered later in the day. Day staff told us there was no formal system for advising them when medicines had not been given, in order that they could be offered later in the morning. We also found examples where insufficient time was left between repeated doses of the same medicine, increasing the risk of side-effects.

We saw that people's medicines needs were recorded on admission to the home and people wishing to self-administer medicines were support to do so. However, a written risk assessment was not in place for one person choosing to self-administer some of their medicines. Similarly, consideration had not been given to how people's medicines needs would be best met whilst they were enjoying a trip away from the home. One person's records indicated that the covert (hidden) administration of medicine was used. GP advice had been sought but contrary to current national guidance about managing medicines in care homes records of an assessment of capacity and the decision making process had not been made to evidence how that person's best interest were protected.

We looked at 13 medicines administration records. Most of these were clearly presented to show the treatment people had received. However, two of the medicine administration records had not been completed to support and evidence the safe administration of anticoagulants. It is important that their safe administration is clearly recorded; the National Patient Safety Agency [NPSA] identified "anticoagulants are one of the classes of medicines most frequently identified as causing preventable harm". Similarly, a third record did not evidence the use of eye drops as prescribed. Contrary to current national guidance about managing medicines in care homes these omissions had not been recorded and investigated as medicines-related safety incidents.

Medicines were administered by trained carers or qualified nurses. However, a new system of medicines supply and recording had been implemented at the home a month before we visited. Contrary to current national guidance about managing medicines in care homes staff had not been trained in the system now used in the care home for administering medicines. The manager told us that this training had been arranged for the week following our visit. The home's medicine policy had not been reviewed to reflect these changes.

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

People who lived at the home and visitors consistently told us there were enough staff on duty at all times. One of the people living there said, "Yes I think there are enough staff. They respond right away if you want anything and will make time to talk to you when they pass." A visitor told us, "Yes I think there are enough staff to look after them (people) properly; perhaps less at weekends but still adequate. You can always find someone pretty quickly and usually one in or near the lounge." Other comments included, "There are always staff around when I come to visit", Staff respond very quickly", When I came to today my relative required assistance. I rang the buzzer and someone was here almost immediately."

Staff all told us there were enough staff, at all times to safely meet people's needs. Staffing levels had been revised so that there were always two nurses on duty each day, from 8am to 8pm. In addition there were usually six carers and one senior carer each day. A nurse said, "There are enough staff and the ratio is right too." A nurse told us the steps they would take if staff were sick or absent or people's needs increased to ensure that a safe staffing level was always maintained.

We looked at the staffing rota and this showed the number of staff available. The staff ratio was consistently in place to provide necessary safe care.

The home had three floors and although there was a nurse call system that sounded on every floor, it was sometimes difficult to locate individual members of staff. There was no

Is the service safe?

intercom or internal phone system. Staff we spoke with said they carried mobile phones to contact other members of staff if necessary. Staff said that colleagues were fast to respond to emergencies on the call system. During the day, we saw that call alarms were responded to quickly. This helped to show us that there were enough staff, across the floors, to meet people's needs.

We looked at how staff were recruited to ensure staff were suitable to work with vulnerable people. We looked at four staff personnel files. We found that appropriate checks had been undertaken before staff began working at the home. We found application forms had been completed and applicants had been required to provide confirmation of their identity. We saw that references about people's previous employment had been obtained and Disclosure and Barring Service (DBS) checks had been carried out prior to new members of staff working at the home. 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.

An adult safeguarding policy and procedure was in place. The policy was in line with local authority safeguarding policies and procedures. Staff we spoke with all understood how to keep people safe from abuse by being alert to different types of potential abuse. They all knew how, and were confident they would report and escalate any suspicions appropriately. Training records confirmed staff had undertaken adult safeguarding training.

We saw that the home was clean and smelt fresh. Staff we spoke with told us they had adequate supplies of personal protection equipment such as aprons and gloves. All of the bathrooms and toilets were clean and stocked with hand wash soap and paper towels. Staff knew when to wash their hands, between caring for different people and before serving food. This showed us that staff were aware of how to protect people from the risk of cross infection and were provided with the facilities to do so.

Staff had received fire safety training and fire alarms were tested each week. Not all staff knew how to use evacuation equipment but the manager had plans to ensure that all staff received this training in the near future. Each individual had an evacuation plan but not all staff knew about it or where it was stored. We discussed this with the manager who agreed this would be rectified. We saw that the last fire drill took place on 27 May 2015.

Arrangements were in place for regularly monitoring the safety of the environment and records were in place to support this. They included regular checks of emergency lighting, fire equipment, water safety and the call bell system. Arrangements were in place for regularly checking equipment, such as hoists and slings.

We saw that windows had been fitted with restrictors to prevent people falling out of them and help to secure the property. These were checked each month to ensure they were in good working order.

The manager showed us how the incidents were monitored each month and action taken where appropriate. We found one incident report had not been sent to the manager. This meant that the incident was not included in the manager's monthly audit and analysis of incidents that month. The manager was not aware the incident had occurred.

The care records we looked at showed that a range of risk assessments had been completed and were reviewed each month. These included a falls risk assessment, moving and handling assessment, nutritional and a skin integrity assessment. A general risk assessment was also in place for each person and this took into account risks associated with the person's bedroom and the use of equipment, such as bedrails. Care plans related to risk were in place to provide guidance for staff on how to minimise the risks for each person.

A kitchen safety record book had been introduced in January 2015. This had been completed each week by kitchen staff who checked fridge temperatures and correct food storage. This helped staff to maintain a safe and hygienic kitchen which meant that any risk of food poisoning was minimised. A kitchen cleaning schedule was available and we saw that regular cleaning had taken place. Improvements had been made since our last inspection such as the installation of a new dishwasher, fridge and dedicated hand washing sink.

We saw that an external infection control audit had been carried out in April 2015. The home had received a mark of 93.72%. A recommendation for staff to have guidance about waste segregation had now been provided.

Requires improvement

Is the service effective?

Our findings

People who lived at the home gave us good feedback about the staff team and the care and support they provided. They felt their health care needs were being met because staff had the right skills and training to help them. One person told us, "When I am not well, staff notice and come and talk to me and ask if I need the doctor. Another told us, "Staff understand about my medication and my illness. They keep an eye on me."

Relatives told us they were kept informed about their family member's health and welfare. One person told us," They [staff] are very good at keeping me informed. If I ask anything about their health or care they tell me." Another relative told us, "They let me know if they're not well or if any changes to their care when I come in or they phone if it's important and I'm not due to visit."

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 regular training, supervision and an annual appraisal.

Training records we looked at showed us that most of the care staff had completed a National Vocational Qualification (NVQ). Ten staff had achieved NVQ level 2 and nine had NVQ level 3. We saw that staff regularly received mandatory (required) training in a range of subjects such as: safeguarding vulnerable adults, health and safety, infection control, moving and handling, health and safety, COSHH and fire safety. Other training courses staff had attended included 'the principles of dementia', first aid, food hygiene, challenging behaviour, care planning and nutrition. Two of the nursing staff and the registered manager had completed 'end of life training'.

New staff had completed a period of induction. We saw that staff had received an appraisal in 2014/2015 and regular supervision in accordance with the provider's policy. The manager checked that all of the nurses working in the home were currently registered with the Nursing and Midwifery Council (NMC). We saw evidence that this was the case. This meant they were eligible to practice nursing.

We observed several examples where staff demonstrated their knowledge of people's needs and were able to meet their needs effectively. For example, people who needed pressure area relief had their position changed regularly or sat out of bed for short periods. One person confirmed they were unable to sit out of bed due to deterioration in their health but said they understood why this was and that staff had explained the reasons. One staff told us, "Some people [who live in the home] often say they are fine, even when they're not: because staff know the residents they are able to recognise when things aren't right and find out what the problem is and sort it out." We saw staff intervene quickly and discreetly to reassure someone who was becoming upset and agitated.

We spoke with a GP who was visiting during our inspection. They said, "We've got a good relationship with staff in terms of coordinating care." They said that when a nurse called them with concerns about the health of a person living at the home, they always provided appropriate information and that they tried to limit transfers to hospital appropriately." They told us they thought this was "Exceptional."

People who lived in the home spoke very highly of the chef and the quality of the food they provided. People told us there was a variety of good quality food on offer and that they were given some choices. Some of their comments included: "Lovely food, I have what I want" and "If you want anything special anytime they try and get it for you."

We observed how lunch was served in two dining rooms. The menu for the day was displayed on a notice board in the main dining room. Tables were set with tablecloths, glasses, cutlery and jugs of cold drinks. Most people sat at the table whilst some people chose to stay in an armchair in the room. A choice of cold drinks was served by staff and hot drinks were served after the meal.

Staff told us that people made their choices for lunch after breakfast. We saw that some people changed their minds, for example asking for a salad or egg and chips and this was provided. Some people asked for bread and butter and this was provided. Food looked and smelt appetising. One person needed thickened drinks and staff knew the correct measure of thickener to use. This was important to ensure people did not choke and were able to eat and drink safely. Several members of staff were on hand to encourage people with their meals and respond to requests.

During the meal, some staff took food to people who were not in the dining room and supported them to eat and drink. After lunch staff completed food and fluid charts for people who were at risk of malnutrition. We saw that these

Is the service effective?

were accurate and up to date. We checked records for one person who had had a risk of malnutrition. We saw the person had a weight gain of 6kgs in the previous six months. This showed us the service had been effective in improving nutrition for the person.

We spoke with the chef. They told us that menus were changed every three months. Comments that people made about the food were recorded in the kitchen safety book and information from this and residents' meetings informed new menus. The chef said, "We look at individual preferences and at what people actually eat and enjoy." One of the carers said, "The food is brilliant here now."

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.

The chef was extremely knowledgeable about special diets and the nutritional quality of the food the service provided.

The home had a separate dementia unit. We found the environment of the unit did not always promote a positive dementia- friendly environment. For example, bedroom doors were individually determined by its number. Each door was the same, with no additional personalised information, such as memory boxes, containing photographs. We found the signage on the bathrooms to be placed above eye level which may have made it too high for some people to read. The signs were small in size. 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 the writing was in red ink and not clearly written to be able to understand it. The television was switched on throughout the day. At times throughout the day the radio was switched on as well, playing modern music and adverts on an independent radio station. After lunch on the second day of our inspection, people were encouraged to watch a film on the TV but the sound was too low to understand the dialogue. On the first day we observed staff played a game of dominoes with one person. No other activities took place with people on the dementia unit during our inspection to provide stimulation and interaction with others.

The lounge/dining area was light and brightly decorated in a modern style. We did not see any photographs of the era that people who lived in the home would recall. This would have helped stimulate conversation with people regarding their family, their lifestyle, employment, hobbies and interests etc.

Furniture was simply placed around the outside of the room. We found the bedrooms were personalised with people's belongings and photographs.

We observed how lunch was served on the dementia unit. Four people were in the communal area for lunch. Three people sat in easy chairs, with one person sat at the table. The table was not set for lunch; no cutlery or condiments were put on the table prior to service. 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. We heard staff reminding people what the meal was when serving them. 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.

Staff who worked on the dementia unit also worked throughout the main house. Staff worked on a rota basis. The manager told us that staff usually worked for two consecutive days on the unit for familiarity. Staff we spoke with had mixed feelings about this new way of working. Some told us they liked the variety of working with all the people who lived in the home; others preferred to work just on the dementia care unit. At the previous inspection in 2014 there was a consistent staff team working on the dementia unit which provide familiarity for the people who lived there. On the second day of our inspection we noted that throughout the day a total of eight different staff, including one agency staff, supported people on the dementia care unit. The manager told us this was to cover staff breaks and was unusual because a day trip was taking place.

We recommend that the provider considers current guidance in relation to the design and adaptation of the environment for people with dementia.

Staff we spoke with understood the principles of capacity to consent, although not everyone understood that the test must be applied to specific decisions. However, our discussions with staff showed us that in practise people who might lack capacity were always given choices about

Requires improvement

Is the service effective?

daily living; for example when offering food and drinks. One nurse we spoke with had a very detailed knowledge of the principles and test for capacity and told us they had attended several training courses about it. Staff understood that if a deprivation of liberty safeguard (DoLS) was in place, the principle of minimum restraint was used.

The manager advised us that one person living at the home was subject to a Deprivation of Liberty Safeguards (DoLS) plan. Other applications had been submitted to the local authority and were awaiting a doctor's and Best Interest Assessor's visit. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

We found care files contained general capacity assessments. However the provider had used mental capacity documentation for these assessments which are used when a specific decision needs to made. We informed the manager of this during the inspection.

Staff said there was enough equipment, such as hoists to meet people's needs.

Good

Is the service caring?

Our findings

We asked people who lived in the home to describe the staff and the care they received. They said, "kind, caring, professional, efficient, happy, friendly, compassionate and respectful." Other comments included, "I think they [staff] are marvellous. They do their job but have a joke with you and make you laugh", "Have always got a smile and a kind word", "Wouldn't change them [staff] for anything" and "They're [staff] all lovely. I've learned to laugh and smile. Found the inner me and feel it is coming from the heart. Both day and night staff and the manager have been great."

Relatives we spoke with told us "Staff are caring; they treat my family member with utmost respect and dignity" and "Staff are always very welcoming when we come to visit. They always have a few words about how things are." Relatives felt that the nursing and care staff communicated effectively with them.

During the day we observed staff interacting with different people in a gentle and pleasant manner. We saw staff engaged well with people in the home and gave them their full attention. A nurse we spoke with said, "There is a friendly atmosphere here, we have some banter with some of the residents."

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. One person told us, "When staff wash me they make sure I am covered and I don't feel embarrassed at all."

A member of staff talked about a person living at the home and described things the person liked to do, including the music they liked. The way they talked showed us the carer genuinely cared about the person.

One person had a 'do not attempt to resuscitate' order (DNAR) in their file. This had been signed by a doctor after discussion with a relative. The person was not able to be involved. The option to review or make an indefinite decision had not been checked. It was therefore unclear if this decision was to be reviewed at a future date. Although there was a document for end of life planning in the person's file, this had not been completed.

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

Good

Is the service responsive?

Our findings

We found that people received the care and support they needed. Before people came to live in the home the registered manager visited them and completed an assessment. This was to ensure that their care needs could be met at Byron Court before they were admitted.

We looked at the care plans for 11 people who lived in the home. We found that care plans and records reflected people's identified needs. They were very detailed and had been completed for many aspects of people's care and health needs. For example, risk assessments had been completed in areas such as falls, skin and pressure ulcer care, bed rails, moving and handling, nutrition, nursing dependence, night care and continence. We found that staff updated these assessments every month to ensure the information was current. We spoke with a number of staff and asked them to describe the risks and needs of four individual people who lived at the home. Staff knew the current care people needed. We found the information they gave us reflected the information recorded in their care files in detail. We did this in order to check that staff were aware of any assessed risks and that the care people actually received was in accordance with the care plans. We found the staff were fully aware of the risks people presented and the support they required to manager the risk. This helped demonstrate that people received with good and effective care and support which met their needs.

Staff had started to complete new personalised support plans with the person and/or their family members. This recorded comprehensive information about the person's daily routines, their likes and dislikes; what they like to do each day and any personal preferences regarding taking medication and how would like to be supported by staff. We saw the support plan recorded how dementia affected the person and the detailed the care they required. The manager told us they were in the process of completing this new support plan with the people who lived on the dementia unit.

A separate /file was kept to record people's wound care treatment. We found people had been referred to the tissue viability nurses or the district nurses when their specialist intervention was required. People had been weighed each month to monitor their health. Increases or decreases in weight were noted and referrals made to the GP or dietician when appropriate.

People who lived in the home told us about their daily routines. They said they were able to get up and go to bed at times that were preferable to them. Some people were unsure if they had been involved in the planning of their care. One person told us." I have never seen a care plan, or as far as I know talked about it. They [staff] just do what I want them to do. They help me get dressed. I get what I want to eat, go out, do my knitting, and have a lovely bubble bath each week. They [staff] are very good to me here. I am very happy here." Another person told us they had been involved in their care planning. They told us," I was involved just last week, in a care plan for my health needs. I am down as nursing care' but when I am well I do what I can for myself." Another person made it very clear to us that they felt the care they received was focussed on their need as an individual.

A relative we spoke with said, "Staff are good and do their best to get to know people in their care. It's not easy as my family member can't tell them. It's the little things that make the difference, including them in conversations and talking to them even if they can't answer."

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. One person told us they enjoyed knitting and went out to buy wool when they needed it.

The home had use of a vehicle every fortnight. Trips out to various destinations were arranged On the second day of our inspection some people went on a barge trip. For people who had not gone on the trip no other activities were arranged that day. We did observe one staff member playing dominoes with a person in the dementia unit. This person confirmed to us that they had chosen to play dominoes. Other card and board games were available on the dementia unit. Another person was reading the newspaper.

Good

Is the service responsive?

A ‘residents’ committee' was recently set up and plans to meet every two months. The meeting was chaired by someone who lives in the home. The chairperson told us a meeting had been held just once so far on 16 April 2015 and amongst the items discussed were food and activities. They told us they had made the activities coordinator aware of people’s comments and suggestions. We saw from the minutes that some suggestions had now been implemented.

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 there did not have any complaints.

Good

Is the service well-led?

Our findings

The service had a registered manager in post. People we spoke with knew who the manager was. They told us they had been working in the home about a year now and had introduced a number of changes. Two people who lived in the home told us that they got on very well with the manager and they [the manager] found time to talk to them.

Staff all said that the manager was visible around the home during the day. One said, "The manager has made improvements since they've been here." They told us these included improving the quality of food and increased staffing levels. Another said, "The manager has a heart of gold."

A visiting health professional we spoke with told us they had a very good relationship with the manager and could easily raise issues with them.

We found a person-centred culture within the home. This was evidenced throughout all of the interviews we conducted and the observations of care.

We enquired about the quality assurance systems in place to monitor performance and to drive continuous improvement. The manager was able to show us a series of quality assurance processes both internally and external to Byron Court to ensure improvements were made and to protect people's welfare and safety. 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.

We saw that medication audits were carried out but the paperwork we were shown was not in any order to gather a clear view of the process. The manager was in the process of completing a medication audit during our inspection. The manager forwarded the audit to us after the inspection. We saw that the audit tool now used produced an audit of all aspects of the medication administration process. This enabled the manager to monitor staff performance and included a monthly check of medication stock and medication administration records. The home had introduced a new system on medicine administration in May 2015. During our inspection we found staff responsible for medication administration were confused with the new paperwork to be used. This was because training had not been arranged by the manager prior to the system being introduced. After the inspection we received confirmation from staff and the home's pharmacist that all nurses and senior care staff had completed the required training on 12 June 2015.

A monthly health and safety audit was completed, which included checks of bedrooms, window restrictors and the nurse call bell. Other audits were completed by the department leaders for the kitchen, laundry, maintenance and infection control. Care plans were audited each month by people's key workers to ensure the information was current and support was given in accordance with people's care needs.

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. This assured us that people who lived in the home were supported to live in a safe environment.

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

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.

Staff meetings were held. A staff member felt staff meetings were not always conducted in a way that encouraged staff to raise issues. They said the atmosphere was not always conducive to discussing things and that, "communication could be improved." Another staff member we spoke with told us that they would have liked recent changes to staffing to be discussed with them before being introduced.

Good

Is the service well-led?

These comments were confirmed by similar ones made in the staff survey results. After our inspection we asked a senior manager to let us know what action had been taken about this.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with safe care and treatment because risk assessments for the use of covert medicine administration were not carried out in accordance with the Mental Capacity Act 2005. Regulation 12(2) (a). People who use services and others were not protected against the risks associated with medicines because effective measures were not in place for the safe management of medicines. Staff responsible for the management and administration of medication were not suitably trained. Regulation 12(2) (g).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with safe care and treatment because risk assessments for the use of covert medicine administration were not carried out in accordance with the Mental Capacity Act 2005 Regulation 12(2) (a). People who use services and others were not protected against the risks associated with medicines because effective measures were not in place for the safe management of medicines. Staff responsible for the management and administration of medication were not suitably trained. Regulation 12(2) (g).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with safe care and treatment because risk assessments for the use of covert medicine administration were not carried out in accordance with the Mental Capacity Act 2005 Regulation 12(2) (a). People who use services and others were not protected against the risks associated with medicines because effective measures were not in place for the safe management of medicines. Staff responsible for the management and administration of medication were not suitably trained. Regulation 12(2) (g).