Byron Lodge Care Home Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 22 February 2018 and 05 March 2018. The first day of the inspection was unannounced.

Byron Lodge Care Home Ltd is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. People received nursing and personal care.

Byron Lodge Care Home Ltd accommodates up to 28 people in one three storey building. There were 25 people living at the service when we inspected. A number of people received their care in bed. Some people lived with dementia.

There was a registered manager in place. 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.

Not all risks had been managed safely. Risk assessments within the service had not been reviewed and updated following accidents and incidents to ensure that that accident did not happen again. Other risks to people such as risks of a person falling, sustaining injuries when taking medicines which thin the blood, moving and handling, diet and nutrition and developing pressure areas had been well managed.

The provider had not followed effective recruitment procedures to check that potential staff employed were suitable for their roles and had the skills and experience needed to carry out their roles. Appropriate numbers of staff had been deployed to meet people's needs. However, it was not clear how staffing levels had been determined as people's dependency information was not used to calculate the staffing required. We made a recommendation about this.

Medicines had not been managed in a consistently safe way. Medicines were stored safely and securely within a temperature controlled environment. We observed a medicines round and observed the trained nurse explaining to people what medicines they were being administered and why. There was inconsistent practice in relation to records relating to medicines that were classed as controlled drugs (CDs) under the Misuse of Drugs Act 1971. We checked the stock of CDs and found that the number in stock did not match the expected number recorded in the CD book. We made a recommendation about this.

There was inconsistent monitoring and oversight of people's nutrition and hydration needs. Records did not show that all people had been supported to eat and drink enough to maintain a balanced diet. People told us that they liked the food and we observed staff supporting people to drink regularly.

We observed that people made decisions about their care and treatment. Where people lacked capacity to

make particular decisions, mental capacity assessments had taken place.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager had a system in place to track and monitor applications and authorisations, which was not always effective. We made a recommendation about this.

Care plans were person centred and provided details about how people preferred to receive their personal care. People had access to a small range of activities. The registered manager planned to improve activities and enable more people to utilise the communal areas.

People had been asked for their feedback about the service, it was not always evident that they had been listened to. We made a recommendation about this.

A programme of quality audits were in place but had not been effective in highlighting the issues we found at this inspection.

Registered person's had not always informed CQC about serious injuries that had occurred. We made a recommendation about this.

The service had a friendly and homely culture and people told us they liked living at Byron Lodge Care Home Ltd.

People and relatives were engaged in the running of the service. The registered manager was a visible presence in the service and ensured that feedback led to learning and improvement.

Staff had received training in a range of courses relevant to their role. Staff received effective support from the management team.

People were protected from the risk of abuse by staff that understood their role in reporting any concerns.

People had effective assessments prior to admission. This meant that care outcomes were planned for, and staff understood what support each person required.

People received medical assistance from healthcare professionals when they needed it. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. However, It was not always clear that advice supplied by healthcare professionals had been followed.

There was no easy to read menu available to help people living with dementia and people who found it difficult to choose their meals make an informed choice. We made a recommendation about this.

The service was clean and tidy and it smelled fresh. The premises and environment met peoples' needs.

Staff treated people with kindness and compassion. Staff communicated with people in the way in which they preferred.

People and their relatives were consulted around their care and support. People's views and feedback had not always been acted on. We made a recommendation about this.

People's dignity and privacy was not always respected. Staff encouraged people to be as independent as

safely possible. Staff knew people's needs well and people told us they liked and valued their staff.

People and their relatives knew how to complain and were satisfied that complaints had been managed effectively.

People on end of life care had a pain free, comfortable and dignified death.

During this inspection we found five breaches of regulations. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

The provider had not always followed safe recruitment practices. There were enough staff available to meet people's needs. However, the provider had no system in place to ensure people's assessed dependency levels were collated to review the numbers of staff deployed.

Staff knew how to recognise any potential abuse and so help keep people safe.

Some risks had not been managed safely.

Medicines had not been managed in a consistently safe way. There was inconsistent practice in relation to records relating to medicines that were classed as controlled drugs (CDs) under the Misuse of Drugs Act 1971.

Lessons were learned when things went wrong and learning fed back to staff.

The service was clean, tidy and equipment had been properly maintained.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Records relating to food and fluid intake were not always clear, consistent and accurate.

People living with dementia and people who found it difficult to choose their meals were not enabled to make informed choices of their meals.

The principles of the Mental Capacity Act (2005) were being adhered to. However systems to monitor and track DoLS applications were not robust.

People were supported to remain as healthy as possible and had access to healthcare professionals. However, It was not always

clear that advice supplied by healthcare professionals had been followed.

Staff received effective training, support and supervision to meet people's needs.

The environment was suited to people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by staff who were kind and caring.

Staff had not always treated people with dignity and respect and maintained their privacy.

People were involved in the development of their care plans and were involved in making decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

People's care plans were personalised. They contained details that would allow staff to know their preferences, such as around personal care.

Activities were being provided and were in the process of being reviewed.

A complaints policy and procedure was in place and available to people.

People had a pain free, comfortable and dignified death.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Audits had not always been totally effective in identifying shortfalls in the service. Additional improvements to policies, procedures and practice were identified.

The registered manager had not always reported notifiable incidents to CQC.

Staff were aware of the whistleblowing procedures and were confident that poor practice would be reported appropriately.

People and staff felt the registered manager was approachable and would listen to any concerns. Staff felt well supported by the management team.

Byron Lodge Care Home Ltd

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 February 2018 and 05 March 2018 and the first day was unannounced. The inspection was carried out by one 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service including previous inspection reports. These inspection reports related to the same service but the provider's previous legal entity. We looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also reviewed information which had been shared with us by the fire service.

We spent time speaking with nine people who lived at Byron Lodge Care Home Ltd. Some people were unable to tell us about their experiences, so we observed care and support in communal areas. We also spoke with three relatives to gain their feedback about the service. We spoke with a visiting GP and a visiting community nurse to the service.

We contacted health and social care professionals to obtain feedback about their experience of the service. These professionals included local authority care managers and commissioners. We also contacted Healthwatch to obtain feedback about their experience of the service. There is a local Healthwatch in every area of England. They are independent organisations who listen to people's views and share them with those with the power to make local services better.

We spoke with seven staff; including care staff, registered nurses, kitchen staff, activities staff, the registered manager and the provider.

We looked at eight people's personal records, care plans and medicines charts, risk assessments, staff rotas, staff schedules, three staff recruitment records, meeting minutes, policies and procedures.

We asked the registered manager to send us additional information after the inspection. We asked for copies of policies and procedures and staff training records.

The service had been registered with us since 23 December 2016. This was the first inspection carried out on the service to check that it was safe, effective, caring, responsive and well led.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. Comments included, "Yes, I feel perfectly safe. If I need help I have this buzzer to alert the staff"; "There is door security people are only allowed in if they ring and are allowed in"; "Feel safe, have a buzzer beside me to call staff"; "No-one can walk in. Staff all very friendly and caring" and "I preferred to be in my own home. This is my home now, I have kind staff here to help me".

Relatives told us their family members received safe care and treatment. Comments included, "Definitely safe. Front door entrance needs to be opened by a staff member before anyone can get in and out. As dad is on the ground floor staff check the windows are closed and secure at night in the summer time"; "She [family member] is getting full time care she couldn't cope at home any more, there are 24 hour staff here to help her" and "Dad is quite well looked after by staff. Property is well looked after, quite quick to repair dad's mattress when it failed".

The provider had not always followed safe recruitment procedures to ensure that staff employed to work with people were suitable for their roles. The provider had not carried out sufficient checks to explore staff members' employment history to ensure they were suitable to work around people who needed safeguarding from harm. One staff member's employment records showed they left school in 2001; however their employment history did not list what they were doing between 2001 and 2005. Interview records did not evidence that this had been identified or discussed. The interview records detailed 'No gaps in employment'. Another staff member's employment history only recorded what they had done since 2009. They had left school in 1972, which meant 32 years were not accounted for. The interview records detailed, 'No gaps, either with agency or in employment'. A third staff file showed that four years of employment history had not been explored. Records showed that staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Employer references were also checked. Nurses were registered with the Nursing and Midwifery Council and the registered manager had made checks on their PIN numbers to confirm their registration status.

The provider had failed to operate effective recruitment procedures. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were suitable numbers of staff on shift to meet people's needs. Staffing rotas showed that two nurses were allocated to work early shifts and at least one nurse was allocated on an afternoon and night shift. The registered manager worked four days a week, three of these on shift as a nurse. Allowing one day working in the office carrying out their management duties. People's nursing and care needs were met in a timely manner. However, it was not clear how the staffing levels were determined in the home. Each person was assessed to record what level of dependency they had. For example, those people cared for in bed who required assistance with all of their personal care needs, eating and drinking needs were assessed as very high dependency. Each person's dependency level had been reviewed on a monthly basis. However, the information was not then collated by the provider and registered manager to review whether there were

sufficient staff deployed to meet people's needs.

People's call bells had not always sounded elsewhere in the service to alert staff that they needed help. We visited the top floor of the service with a nurse during the lunchtime medicines round. The nurse knocked and entered a person's bedroom to take their medicines to them. The person said, "Too late for the commode, I called for the commode but it is too late, I have done it now". We checked the person's call bell and found this had not sounded elsewhere in the service. No staff were present on the top floor to hear the person call out. The nurse reassured the person and arranged immediate help. This incident was also reported to the registered manager who arranged for contractors to visit and test and repair the call bell. Another person who lived on the top floor told us, "I am on my own for hours. Some staff will chat. Staff are good at charging up my phone for me so I can speak with my family".

We recommend that registered persons review systems and processes to evidence that staffing levels meet people's assessed needs.

Each person's care plan contained information about their support needs and the associated risks to their safety. This included the risk of a person falling, sustaining injuries when taking medicines which thin the blood, moving and handling, diet and nutrition and developing pressure areas. Guidance was in place about any action staff needed to take to make sure people were protected from harm. For people who were at risk of falling, guidance was in place about any specialist moving and handling equipment they required when moving around the service, transferring, when moving in bed and bed rails to prevent them falling out of bed. However, action had not been taken to address risks associated with the environment to learn lessons from incidents. We reviewed an incident form which detailed that a person who lived with dementia had picked up a pest control bait box within the service. The person was found with it in their hand, staff did not know if they had ingested any poison so had called for emergency healthcare and the person was assessed by paramedics. Risk assessments within the service had not been reviewed and updated to ensure that this did not happen again. Although the person no longer lived at the service, there were other people living with dementia who lived at the service who may be at risk of picking up such items. We reported this to the registered manager and the provider. On the second day of the inspection the provider informed us that a risk assessment was now in place in relation this. We observed a staff member assist a person to have their meal in an inappropriate position, which increased the risk of the person choking. We reported this to the registered manager who advised us that the person should be assisted with their meals whilst sitting in an upright position. People around the service were also at risk because they had access to aerosol spray air fresheners which were left around the building. On the first floor on the first day of the inspection, we found multiple cans of air fresheners around the service within reach of people.

The failure to manage risks effectively is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were protected from abuse or harm. All 30 staff had completed training in safeguarding adults. This helped staff to stay alert to signs of abuse or harm and the appropriate action that should be taken to safeguard people. Staff were aware of the company's policies and procedures and felt that they would be supported to follow them. Staff had access to the updated local authority safeguarding policy, protocol and procedure dated September 2017. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any concerns about people's care.

People told us they received effective support with their medicines. Comments included, "I always get my tablets at breakfast time and 14:00. I have a sleeping tablet at night to help me sleep. If my leg is hurting I am

asked if I want a painkiller"; "I always have my medicine at set time. One tablet I take in my mouth and one medication through my PEG [percutaneous endoscopic gastrostomy]. Eye drops in my eyes the morning" and "I came from hospital on a high medication routine. I have to have insulin injections, sugar test three or four times daily and have tablets 15 minutes before my meals. Nurse always makes sure that happens." Relatives also told us their family members received good support with their medicines to keep them healthy. One relative said, "Dad always gets his medication, when the doctor stopped the prescription for his respiratory issues he was struggling to breath, [registered manager] got the respiratory team to visit to access what he needed." Another relative told us, "[Family member] always get his medication. Has his inhaler pump on his table if he needs to use it."

Medicines had not been managed in a consistently safe way. Medicines were stored safely and securely within a temperature controlled environment. The temperatures had been monitored consistently. Medicines were clearly labelled and in date. Healthcare equipment such as dressings were in stock for those people who required support to manage pressure areas and wounds. Medicines administration records (MAR charts) had been accurately completed. Medicines records for medicines such as topical creams had clear body maps which showed staff where the medicine should be applied. People had received their prescribed creams and lotions as directed from their GP. During the inspection, we observed a medicines round and observed the trained nurse explaining to people what medicines they were being administered and why. People were given time to take their medicines. They were observed by the nurse while they took their medicines to ensure they had taken the medicines. During the dispensing of medicines the nurse asked people who were prescribed as and when (PRN) required medicines to manage pain relief whether they required any pain relief or not.

The medicines store had lots of good practice guidance and advice for staff about managing different health conditions such as diabetes and pressure areas. A file was in place for patient information alerts and medical device alerts. The file did not contain any newer alerts or information than 2009; despite the service utilising equipment and medicines (including prescribed thickening powder) which have been the subject of alerts in recent years.

There was inconsistent practice in relation to records relating to medicines that were classed as controlled drugs (CDs) under the Misuse of Drugs Act 1971. There was a controlled drug book in place to record each CD in stock. We checked the stock of CDs and found that the number in stock did not match the expected number recorded in the CD book. For example, the CD book detailed that there were 10 ampules of one CD in stock; however the ampules were not present in the CD cabinet or anywhere in the medicines store. There had been no record that these had been disposed of. Medicines stock checks had taken place and nursing staff had not identified that the medicines were missing. We spoke with the registered manager about this who immediately commenced and investigation. Another person's high strength pain killer had been recorded incorrectly when being transferred from the end balance of the old CD book to the starting balance of the new book. We identified from looking at the MAR that the person had received a dose of the medicine which had not been accurately recorded in the CD book. On the second day of the inspection the registered manager had identified that the 10 ampules had been disposed of on 28 January 2018. The investigation found that when a new CD book had been started a fortnight after the disposal the medicines had been incorrectly carried forward. As a result of this, lessons had been learned when things went wrong in the service. The registered manager had met with all nursing staff responsible for administering medicines to discuss and review practice. They had identified that the error had occurred due to stock checks of medicines and disposals of medicines had been completed on the same day. In future, stock checks and disposals will not be carried out on the same day to reduce the risk of recording errors.

The registered manager had also learnt lessons from other inspection feedback given to registered

managers as part of CQC inspections. The provider was the owner of three local care homes and these were all registered under different legal entities. The registered managers worked closely together which created joint learning. This enabled the registered manager to learn from the two other inspections and take on board feedback they had received to make changes to practice.

The service was clean and tidy and it smelled fresh. People told us that they were happy with the cleanliness of the service and they were happy with the laundry service. People said, "I always have a clean nightdress every day. Laundry comes back ironed and pressed and hanging on a coat hanger"; "Yesterday I had a chocolate biscuit and dropped some on my sheet. When the staff noticed it they changed it straight away"; "Clean nightie every day. Cleaner comes in everyday"; "[The service is] always cleaned every day the cleaner tidies up my room. Hoovers once a week". People were being kept safe against the risk of infection by the prevention and control of infection hazards. Infection control training had been evidenced for all staff. There was an appropriate supply of personal protective equipment (PPE) throughout the service and we observed staff using this as and when they needed to. Each floor had a dedicated sluice room. The sluice contained wash facilities for bedpans as well as cleaning equipment.

Accidents and incidents that had taken place were appropriately reviewed by the registered manager. Actions had been taken such as contacting healthcare professionals, relatives and notifications had been made to CQC. The registered manager monitored accident and incident records to review trends and themes and these were discussed with the provider when they happened. The provider monitored these and checked that action had taken place.

All staff had received training in fire safety. Each person had a personal emergency evacuation plan (PEEP). PEEPs set out the specific requirements that each person had, such as staff support or specialist equipment, to ensure they could be evacuated safely in the event of a fire. PEEPs were stored within people's care records and within the fire file.

Visual checks and servicing were regularly undertaken of fire-fighting equipment to ensure it was fit for purpose. Fire drills had been carried out to ensure people and staff knew what to do in the event of a fire. The last drill had taken place on 08 January 2018. It was noted that fire drill records showed that four staff had not been involved in any fire drills at all. Regular fire alarm testing had also taken place. Maintenance records evidenced that repairs and tasks were completed quickly. We observed maintenance staff carrying out repairs around the service. Checks had been completed by qualified professionals in relation to legionella testing, the passenger lift, electrical appliances and supply and gas appliances to ensure equipment and fittings were working as they should be. Moving and handling equipment such as hoists, slings and a bath had been serviced and checked in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). We found that during the LOLER checks and servicing that the engineer had missed off two baths from their checks. We reported this to the provider who took immediate action to find out what had happened. The contractor reported back that they had three adapted baths to check on their schedule but had only checked one of them as the other two were in use at the time. The provider arranged for the company to come back and carry out the checks that they had been contracted to do.

Requires Improvement

Is the service effective?

Our findings

Some people received their meals through percutaneous endoscopic gastrostomy (PEG). This is where specialised food is passed into a person's stomach through a tube. This procedure is used when people are unable to have food orally because of difficulty or inability to swallow. Records showed that staff had followed guidance in relation to PEG feeds and the rate in which the food is administered, however the feeding regime provided by health care professionals had detailed that one person was able to have small amounts of syrup thick fluids. Fluids records did not detail that the person had been receiving the 1300mls of fluid that they had been assessed as requiring in a 24 hour period. Records evidenced that the person had received 1600mls of fluid on the 16 February 2018 and 675mls of fluid on 17 February 2018. On the 18 February 2018 they had received 1175mls of fluids. This meant that the person's feeding regime had not been followed which put this person at risk of harm.
Records relating to food and fluid intake were not always clear, consistent and accurate. Daily totals were not always added up and entries were missing. Therefore it was not possible to identify if people that used PEG to receive their nutrition and hydration had received suitable and sufficient food and fluid to maintain good health. On the second day of our inspection we sat with the person talking with them. The person had drinks in their room which had not been recorded on their fluid charts which had been stored in their room. We checked with the registered manager and they told us that the drinks that care staff assisted the person with were recorded on a different fluid record which is stored with their daily notes. We checked these at the end of the second day of our inspection. The drinks the person had been given in the morning of this day had not been recorded. This highlighted further that there was inconsistent monitoring and oversight of the person's nutrition and hydration needs.

The failure to adequately meet people's nutrition and hydration needs is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with food and drink that enabled them to maintain a healthy diet and stay hydrated. People had choices of food at each meal time and chose to have their meal in the lounge or their bedroom. We noticed that the dining area was not used at all by people at meal times in the service. During the inspection we spent time in the dining area and lounge area and did not hear people being asked where they wished to eat. We spoke with the registered manager about the lack of use of the dining room. They told us it was people's preferences to eat in their rooms or the lounge and explained the dining room was used when there were parties, events and at Christmas. During meal times people were offered more food if they wanted it and people who did not want to eat what had been cooked were offered alternatives. Hot and cold drinks were offered to people throughout the day to ensure they drank well to maintain their hydration. Staff sat with people to assist them at meal times to encourage people to eat well. People had their nutritional needs assessed and were provided with a diet which met their needs and preferences. The cook met with people individually to discuss their food preferences. We overheard one person talking to the cook to request Welsh cakes as this reminded them of living and growing up in Wales. The cook agreed to research some recipes and make some for the person. A menu board was on display in the dining area. On the first day of the inspection the board did not detail what options were available to people. On the second day of inspection the menu board listed what food had been on offer the day before. It had not been

updated to let people know what meals were on offer. There was no easy to read menu available to help people living with dementia and people who found it difficult to choose their meals make an informed choice. We spoke with the cook about this.

We recommend that registered persons research good practice guidance in relation to menu planning and assisting people to make informed choices.

People were mainly complimentary about the food and told us there were always choices of meals. Comments included, "Very nice cook. Always have low sugar pudding, cannot stand rice pudding but cook does a lovely sponge pudding"; "I used to be PEG fed. When I came here I was very underweight but now able to eat food. I was 30 kilograms now over 40 kilograms, I am weighed each month. The cook chopped the meat fine and the potato is pureed"; "Food is not bad, limited diet"; "Staff prop me up using pillows so I am able to feed myself. Food varies, sometimes I don't like the main dish, there is always a choice"; "If I don't like a pudding, I'll have fruit and a low sugar ice cream"; "Food is pretty good; since I came here I have put on some weight. Trying to cut down. I am a diabetic and staff makes sure I have a low sugar pudding" and "Staff usually ask what you want. Having sausages and chips today. Always like chips with anything." Relatives told us they had made requests for particular food to meet their family member's needs.

The cook explained that the service had provided food to meet people's religious and cultural needs in the past. There was currently nobody that required different foods to meet these needs and no one that required gluten free products to meet their health needs. The cook catered for one person who was vegetarian and another person who was lactose intolerant. The cook detailed how they provided fortified food for people who required additional calories to maintain or gain weight.

A selection of snacks and fresh fruit was available in the lounge area for people. Tea trolley rounds took place during the day. Staff told us that people could access drinks and snacks at night. Care plans detailed people's food preferences, this had been communicated to the cook and kitchen staff. People's dietary requirements were understood by the staff preparing and serving the food and the staff assisting people in the dining rooms or in their bedrooms.

People received medical assistance from healthcare professionals when they needed it. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. Staff had sought medical advice from the GP when required. Records demonstrated that staff had contacted the GP, local authority care managers, occupational therapist, chiropody, palliative care nurses, diabetes nurses, tissue viability services, mental health team, community nurses, ambulance service, hospital and relatives when necessary. However, It was not always clear that advice supplied by healthcare professionals had been followed. On the second day of the inspection one person's healthcare records evidenced that they had been seen by the tissue viability nurse (TVN) on the 23 February 2018. The advice given by the TVN was to reposition the person every hour. Records showed that this had not been followed. Records evidenced that the person had been repositioned two hourly on 27 and 28 February 2018 and 04 and 05 March 2018. Another person's care plan detailed that they had been assessed by a speech and language therapist (SaLT) and they required thickened fluids to help them swallow small amounts of fluid. We were sitting with the person when a staff member offered the person a cup of tea and left a cup of tea in front of the person in reach. We checked with the staff member whether the drink had been thickened, it had not been. The staff member went off to check with the registered manager whether the person had thickened fluids and quickly returned explaining that they had made a mistake.

The failure to provide care and treatment to meet people's assessed needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had lost weight, this had been quickly addressed with support, food supplements and referrals to GP's and dieticians as required. People had seen an optician on a regular basis to check the health of their eyes.

People told us that staff were good at getting medical care. People told us that a member of staff would escort them to the doctors or hospital to help them. On the second day of the inspection a staff member supported a person to go off to hospital for a routine appointment with their consultant. Comments included, "Got a bit of constipation, the nurse monitored me and after a couple of days suggested it was best to get the doctor to visit. Now have a laxative through my PEG daily"; "The chiropodist visited to look at my feet they removed the bone chip now leaving it uncovered has meant it has healed quickly"; "I have my leg ulcer redressed every two days"; "My bottom is regularly creamed. I don't like sitting out to long as my bottom becomes sore". One person told us they had been wheezing and the doctor has visited. When there was no improvement the nurse was concerned. The person said that the "Nurse spoke to the doctor and they advised sending me straight to the hospital. My medication has been adjusted and I feel a lot better". Relatives told us their family members received effective healthcare. One relative said, "[Registered manager] is good at getting the right person to check. Dad had an issue with his skin, matron arranged for the dermatology nurse to visit. Dad used to be prone to urinary infection now has his catheter changed every 12 weeks has not had UTI [urinary tract infection] for a long time." Another relative told us, "He has been to Medway Hospital to sort out his hearing now he is getting a new hearing aid which should help. A member of staff went with him. Dentist has visited him recently".

People's needs were assessed and their care was planned to ensure their needs were met. There were holistic assessments of people's needs prior to a service being provided. Before people moved to the service the registered manager carried out an assessment of their needs. The registered manager had just updated the assessment documentation taking in to place feedback that the provider had received following inspections at their other services. The assessment covered the person's history of falls, all of their diagnoses, mobility personal care and eating. The assessment had identified what support was needed and this was pulled through to the care plan. There were processes are in place to ensure there was no discrimination under the Equality Act when making care and support decisions.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. All staff had undertaken MCA and DoLS training. We observed that people made decisions about their care and treatment. We heard people declining and accepting offers of food, drink, personal care, people chose whether to participate in activities. People who had capacity to consent to care and treatment such as receiving influenza vaccinations had signed consent forms to evidence their consent. Some consent forms evidenced that staff had discussed consent with the person and they had verbally agreed. Where people lacked capacity to make particular decisions, mental capacity assessments had taken place. One person's care records evidenced they did not have the capacity to manage their own finances, property and affairs. An application had been made to the Court of Protection. A court appointed deputy had been appointed to support the person. Where people had lacked capacity, best interests meetings had been held with relatives and health

and social care professionals to evidence decision making around what would be in the person's best interests.

The registered manager had a system to monitor and track DoLS applications and authorisations. There was evidence to show that the registered manager and provider had identified people who may be lacking capacity to consent to reside at the service. They had completed application forms to apply to the local authority to lawfully deprive these people. They had regularly chased the local authority for an update to applications which had been submitted for some time. We found that the tracking system used by the registered manager had failed to capture when a DoLS had been authorised by the local authority with conditions in place. One person's DoLS had been authorised in July 2017. There were five conditions in place in the DoLS which the local authority had asked the service to meet. The registered manager was unaware of these conditions. We checked through documentation and carried out observations to check that the conditions and found these had not been met. The registered manager took immediate action to remedy this.

We recommend that registered person's review systems to monitor and track DoLS applications and authorisations to ensure that people are lawfully deprived of their liberty.

Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. The nurses had received training to carry out their roles. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people. Nurses had received further training to validate their NMC nursing qualification such as diabetes, catheterisation, influenza vaccination and pain management. Training records confirmed that staff had attended training courses or were booked onto training after these had been identified as part of their training and development needs. The training records confirmed that staff had received the training needed to give them the skills and knowledge to care for people including dementia awareness training, stroke and Parkinson's disease. Staff told us they had supervision sessions regularly, where they were able to discuss their role and any issues of concerns with their abilities and skills, with their line manager.

New staff received an induction which included shadowing experienced staff, training, reading policies and procedures and getting to know the layout of the building and the routines. Staff with no background or qualification in care undertook the Care Certificate. The Care Certificate is a course that gives staff just starting in care the basic knowledge of how to care for people. The course includes assessments of course work and observations to check staff met the necessary standards to work safely unsupervised and provide care appropriate and safe. Staff were supported to achieve additional work based qualifications such as diplomas.

Most people's needs were met by the adaptation, design and decoration of premises. People told us it was easy to find their way around. We observed some people on the ground floor moving around independently. Other people relied on staff to help them mobilise or they received their care and support in bed. Toilets and bathrooms were clearly signposted. People had assistance to the toilet or commode and a number of people told us that they wore continence pads and they were supported to change regularly by staff. People told us, "When it is cold I have asked for a bedpan at night otherwise staff take me along to the bathroom"; "I like to be independent and able to go to the toilet on my own. I use my walker and walk round to the toilet next to the lounge." The bedrooms were large and clean and some people had brought personal items from their own homes, which gave the bedrooms a more homely feel. The bedrooms, corridors and shared bathroom and toilet facilities were all clean. However, some bathrooms were cluttered with items not in use such as commodes, wheelchairs, recliner chairs and other equipment. All areas of the service were accessible for wheelchairs and there was a lift to each floor. There were mobile hoists for people who

required them and adapted baths for people with limited mobility. One person had been supported by staff to sit in the lounge. We spoke with them and asked them if they were enjoying the television programme. They explained that they were unable to watch the television in the lounge area as it gave them neck ache. They were unable to reposition themselves to a better viewing angle. The person explained that the layout of the chairs in the lounge had been altered recently which meant they were no longer able to see the television from where they sat.

We recommend that registered persons review the layout of the furniture to ensure it meets people's needs.

Requires Improvement

Is the service caring?

Our findings

People told us they found most of the staff kind and caring. Comments included, "Most of the staff are kind, some of them chat and I can have a laugh with them"; "Some you can have a laugh with, some just want to do their job. On the whole they are jolly natured. If I am feeling down they will say 'are you all right lovely' stroke my hand, very comforting"; "Staff are quite nice, caring and jolly and I can have a laugh and joke with them. One person is always singing, a bit of a tease"; "Staff fine, very patient with people" and "I had lovely ones [staff] today. I gelled with them, had a lovely chat while they were helping me. They are always busy. I would like more contact with the carers. They [staff] have not got time to sit together and talk, always rushing off."

One relative told us, "Staff are very caring, kind, understanding and diplomatic. Always appear very jolly they can read his moods. Staff know him well. I have heard some lovely banter between them; staff are more like an extended family." Another relative said, "Staff are genuine caring people. Another relative told us "Staff seem caring, he is well looked after."

People and their relatives told us that the staff preserved their privacy and dignity. Staff knocked on doors before entering people's rooms. However, on one occasion we observed a staff member entering another person's room to locate a continence pad for a person who was in the room door. The staff member was focused on the task, and did not knock or say what they were doing in the room or acknowledge the person laying their bed. A person told us, "Staff always knock when they come in and close the door if they are giving me a wash". Another person told us, "Always knock and close the door when they are helping me with my bed bath". Relatives told us, "Door always closed when doing his personal care. Staff always knock before they come in" and "When they change his pad they ask us to wait outside to give dad his privacy."

Some people shared bedrooms with other people. We observed that curtains were pulled across to ensure people's dignity whilst they received personal care in bed. A person who had a shared room told us, "Curtains between us and the window curtains are always pulled across when they get me up and washed. When I am taken up to the bathroom I am wrapped up in blanket and towels. When I am sitting out in the chair I am always wrapped up in a blanket." Whilst we sat talking with one person in a shared room, three staff members entered the room to provide care and support to the other person in the room. Only one staff member acknowledged the person who we were sat with.

We observed staff communicating with people in the way in which they preferred. Some people liked to have lots of laughs and banter, other people liked a gentle approach. People were positive about the support they got from staff. One person told us they loved staff. The service had a relaxed and calm atmosphere. People told us their relatives were able to visit at any time. We observed relatives and friends visiting throughout the day including the busy lunch period. People said, "Family always made welcome, my son and daughter in law come to see me every weekend. They are always get offered a cup of tea"; "Staff make my family feel welcome, always get an offer of tea have been offered to join me for dinner"; "Have had three visitors today, staff always make them welcome" and "I attend Jehovah Witness meeting every week, someone comes and takes me. Some people from the church visited me today, staff make them very

welcome". A relative told us, "Staff always make us feel welcome. They all know us now and always tell us what dad has been doing".

People and relatives told us that they felt that any information about them or their family member was kept private and not shared with other people. One person said, "Never heard staff discussing other people living here". A relative told us "We only ever discuss dad's care in his room, I feel staff wouldn't discuss his personal details with other residents."

Meeting minutes evidenced that the registered manager and provider had met with people and their relatives on 10 October 2017 to discuss the service and gain feedback. A focus group meeting had taken place with people to focus on improving communication. The focus group records evidenced that people had asked for a large activities timetable in the lounge areas so they did not have to keep asking what was going on. Another person had told the focus group they would like to have more resident's meetings as they enjoyed discussion and debate. There had been no further 'residents' meetings and there was no large activities timetable in place. this evidenced that people's views had not always been acted on.

We recommend that the provider reviews and acts on feedback from people to ensure their needs are met.

Staff were aware of the people's rights with regard to personal choice. Staff encouraged people to make their own choices where possible, such as decisions relating to meal options or which clothes to wear. Staff members said they always gave people a choice where possible, and spoke with the person and their family where appropriate to determine their history, likes, dislikes, and preferences and to involve them in care planning. Each care plan had a life history section, which had been completed with the involvement of the person or their family. This section provided key information about the person's life, hobbies, preferences and cultural or social needs. Care records included details of the person's preferred routine, for example when they wanted to get up or go to bed, and where they preferred to have their meals. People and their relatives were involved in care planning and review.

Good

Is the service responsive?

Our findings

People told us they had opportunities to join in with activities. Comments included, "I have been doing this word search today. [Activity co-ordinator] is doing a sponsored knit and I am going to join in this. I like doing the bingo. It is so quiet downstairs, most people are asleep and if the TV is on its so quiet I cannot hear it so prefer to stay in my room. I haven't got out of bed today as my leg is painful"; "If there is an external entertainer I'll go down to see them. I like the quizzes. The activities person escorted me to my hospital appointment in London. For the last few months I have stayed upstairs rather than go down unless there is something on. There is not much conversation so would rather watch the TV up here. I like the Geographical magazine when I was in the hospital someone used to sit and read it to me, I am sure if I ask someone would come and read it to me in here"; "I enjoy the bingo and sometimes do some craft work. It's boring doing nothing so I'll sleep"; "I like games and bingo" and "I join in everything, joining in the motivation group today. I am knitting squares for [activities co-ordinator who is going to join them together for charity". Relatives told us, "Dad could but won't sit out in the lounge and join in. He has hearing problems but likes to sit in his room watching the TV programmes he enjoys. He can see the staff walking past and people do stop and chat" and "Dad goes downstairs every now and then. He went downstairs and watched the pantomime and joined in the Christmas activities. He doesn't hear very well so finds it difficult".

People had access to a small range of activities. There was a small activities calendar on the lounge wall which detailed a schedule of activities between Tuesday to Friday each week. Activities listed on the schedule included; bingo, board games, knitting, quizzes, bowling and someone to one time with people in their bedrooms. The schedule also showed that external activities were supplied on a regular basis such as motivation activities. On the first day of the inspection people were given a word search to complete. During the afternoon motivation activities took place. However, only two people participated in this. People were not encouraged to leave their rooms and join the activity and for those that were unable to leave their rooms because they received their care in bed, activities were not taken to them to enable them to join in. The provider employed two part time activities co-ordinators. On the second day of inspection activities included knitting, visiting some people in their bedrooms and a bingo session. The bingo session was attended by 10 people and prizes were given out to the winners. People who lived with dementia were given support to take part in the bingo session, which they enjoyed as they were smiling and laughing and were very happy when they had won a prize. Visiting friends and relatives also joined in with the bingo session.

We spoke to an activities staff member about people who were cared for in their beds. The staff member detailed how one person had received one to one time with staff in their room and as a result they had "Massively improved". The staff member detailed that the person was "Talking to staff now, saying our names, they wouldn't talk previously. [Person] is now getting out of their bed, being in the chair. I am aiming to take her out in the summer to take a walk to the local park and have an ice cream on the way back". The activities staff member said that the service provided regularly shopping trips and trips to the seaside in the summer. They also explained the local park was well used in the summer months. The service carried out fund raising activities to raise money for the hire of a mini bus on a monthly basis to enable people to go out on the shopping trip. Some people went out with their relatives and friends into the local community. The registered manager planned to improve activities and enable more people to utilise the communal areas.

They planned to order suitable reclining chairs to enable people who currently receive their care in bed to spend time out of bed socialising with others.

People had care plans in place, which reflected their current needs. Care plans were person centred and contained information about how each person should be supported in all areas of their care and support. Each person's likes and dislikes and preferences were recorded. People had been asked if they preferred male or female staff to provide them with their personal care. People's daily records showed whether people required support to maintain their oral hygiene. Some people were able to clean their own teeth without support. Other people required assistance to clean their teeth twice a day. Daily records evidenced when care and support had been provided in in relation to this and showed where people managed this independently or when they had refused. People told us they were supported to be as independent as possible. Comments included, "Staff always give me a good wash, they have to hoist me in and out of bed. I would like to go downstairs more often but if there is nothing going on I would rather stay in my room"; "I choose what help I need. As I have got stronger I am now helped out of bed using a stand easy. When I have a wash, I do what I can for myself. I ask staff to help me wash under my arm for me. Staff then help me to dress my top. I sit in this chair and do my exercises to strengthen my legs and feet every day"; "Staff help me to sit up to have my lunch. I am still able to feed myself"; "Staff let me do as much as I can. I come out here for my lunch every day" and "Balance is an issue for me, I need to hold onto something to stop me from falling over; the carers help me to wash. I wash my face and hands and clean my teeth and ask them to help wash the rest of me." A relative told us, "Dad is an independent stubborn person and decided on what care he wanted. He likes to try everything himself, staff very good at helping him to keep his independence."

People's care plans had been updated in relation to their current health needs. One person had undergone an operation on their leg before we carried out the inspection. The care plan clearly detailed how nursing staff should manage the wounds and what signs they should look out for. People's catheter care had been well managed by the nursing staff.

Staff were responsive to people's needs. One person called out from the communal lounge to let staff know that their glasses were in their bedroom. A staff member responded immediately and asked permission to go to the person's room to collect their glasses. When they returned, the staff member identified that the glasses required cleaning and took their time to clean these off. They checked with the person that they were able to see through them okay.

People were supported to have a dignified, comfortable and pain free death at the end of their lives. People who were being cared for at the end of their life had regular visits from their GP and from a community hospice team. People in the last days of life had rapid access to specialist medicines, support and equipment. Hospice staff and palliative nurses had arranged with the service to have anticipatory end of life medicines, and equipment such as syringe drivers, in place for people, so they could be given appropriate care at the final stage of their life. People had completed advance care plans and had made their choices for end of life care. Including whether to be hospitalised or not; whether to be resuscitated and their final resting place. We reviewed one person's documents and saw that they had received good care such as frequent repositioning and regular input from the hospice and GP. They had also made a decision with their GP that they wanted to refuse lifesaving treatment and this had been documented in a do not attempt resuscitation (DNAR) document. A notice board in the lounge and one in the reception area promoted a Will making event that was scheduled to take place later in the month.

People and their relatives told us they would complain to the staff or registered manager if they were unhappy about their care. People had the information they needed to make a complaint should they need to. People told us that they had a booklet given to them when they moved in which explained the

complaints procedure. People commented, "No complaints. I have got a booklet to read on who to speak to"; "If there is a problem and I couldn't resolve it myself I would speak to one of the nurses"; "My daughter deals with everything. She had a moan to one of the staff about waiting for a staff member. Seems to have improved since then"; "No complaints so far" and "I had an issue with another resident. I spoke to [activity co-ordinator], it was soon resolved by matron [registered manager]". A relative said, "No complaints from me about dad's care. We were given details of how to complain if we were not satisfied. It advices to contact Medway Council and CQC. I find it easy to speak to [registered manager] or any of the staff. They all listen and answer any of our queries". Another relative said "Any issues we have are resolved straight away." People and relatives gave us examples of complaints they had made. They were satisfied with the response and improvements that had been made. We spoke with the registered manager about checking with all people living in the service about whether they understood the complaints information as there was not any alternative versions of the information in accessible formats.

Requires Improvement

Is the service well-led?

Our findings

Quality monitoring systems were not effective in monitoring the level of service provided to people. A full programme of quality audits was in place; however, shortfalls identified at this inspection had not been identified by the registered manager. For example, the issue of staff recruitment checks, risk management, nutrition and hydration and person centred care.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had not always been updated by the management team in a timely manner. The safeguarding policy was dated 2009, it had last been reviewed in April 2012. It listed incorrect contact details for the local authority, out of hours help and CQC. The provider's whistle blowing policy gave staff incorrect contact details for the local authority and CQC.

Staff told us that meetings took place where they were able to share information and gain feedback. Meeting records showed that staff meetings (both general staff meetings and trained nursing staff meetings) had taken place frequently. Eighteen staff had attended a staff meeting on 24 January 2018. The previous meeting had taken place on 23 October 2017. The meeting records showed comprehensive discussions and any actions required were recorded. The registered manager had updated the action plan as and when they had completed actions to evidence that required action had been taken in a timely manner. We checked the October 2017 meeting records to check that call bell response times had been discussed. This is because the surveys people had completed reported some long waiting times when call bells had gone off. The survey responses showed that the provider planned to address this at the next staff meeting. The meeting records showed that this had not been discussed which evidenced that the provider and registered manager had failed to respond effectively to feedback from people to improve the service.

The failure to ensure there were systems in place to assess, monitor and improve the quality of service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Audits and checks were carried out by the registered manager. These included audits of infection control, comfort checks, mattresses, catheters, malnutrition, room checks, monthly accidents and incidents audit, monthly observations of care provided by staff, checks of uniforms, shoes, medicines, wounds, charts, weights and filing.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The registered manager and the provider had notified CQC about important events such as deaths and DoLS authorisations that had occurred. Registered person's had not always informed CQC about serious injuries that had occurred. We spoke with the registered manager about this, they were aware of the requirement to inform CQC of serious injuries and what may constitute a serious injury. CQC had not been informed of one person's pressure area. CQC should have been informed because the pressure area was significant.

We recommend that the provider and registered manager reviews wound records and accident forms to

ensure appropriate agencies are informed of notifiable events.

We observed that people and their relatives knew the registered manager well. They referred to the registered manager as matron. Most people and relatives told us that they knew the registered manager and found them easy to talk to. People also told us that the registered manager helped out around the home. Comments included, "I don't know who the manager is. The home appears well managed and not over managed"; "Matron is very accommodating always cheerful"; "I like the matron always smiling. It is a very good home" and "[registered manager] is good and also the three nurses under her. All easy to talk to."

Relatives told us the service was well run and they had confidence in the provider and the management team. One relative said, "Home is very well run. [Registered manager] makes us very welcome, she is very helpful. The staff gel together. Very clean, always feel very welcome. [It is a] Excellent home". Another relative told us, "The home seems to be run very well. Property well looked after, quite quick to repair his mattress."

Staff told us they received good support from the management team. One staff member told us, "Management are approachable, you can go to them at any time especially [registered manager] she is very supportive." Another staff member said, "Management is good. [Provider] is very nice." Another staff member told us, "We get good support because we are small we support each other. We share information and expectations."

Staff attended a handover meeting each day, we observed that nursing staff led these handovers and gave staff an overview of people's health and wellbeing and any concerns or medicines changes. Information was also shared in relation to continence. This meant staff had up to date and relevant information to enable them to meet people's needs.

The registered manager met regularly with the registered managers from the provider's other local services. As registered nurses the registered managers provided each other with clinical support and supervision. The registered manager had also developed links with another local service (outside of the organisation) in order to network, share information and develop and embed clinical support. The registered manager kept themselves up to date with regulations, local and national good practice and developments from attending training courses, research, subscription to nursing publications as well as receiving newsletters and information from CQC and the local authority. The registered manager had signed up to attend the local authorities registered manager forum. The registered manager shared how the service had been involved with a research project which had been carried out by a local university in 2016 called 'measuring outcomes of care homes' and nicknamed the 'MOOCH project'. The project had only just ended and the registered manager had been invited to the launch event which was planned for 08 March 2018. The MOOCH project report relating to findings in the service identified some unmet needs of people in relation to occupation, social interaction and control. The registered manager explained that since receiving the report they had made changes which included more personalised care, recruitment of an additional activities staff member and some changes to people's care records.

The registered manager told us that the provider was accessible to them through regular contact. The provider visited the service regularly and was also available by telephone when required. It was clear the provider knew staff and people well.

The provider's statement of purpose detailed that the philosophy of the service is 'First and foremost, it is the aim of Byron Lodge Nursing Home to provide an environment that all residents can regard as their home. We believe that Byron Lodge should remain: A place wherein each person can feel valued and have their individual requirements met without prejudice. A place with no unnecessary restrictions or regulations.

A place where dignity and comfort take priority. A place where choices are respected. A place where privacy is an individual's right. A place that prides itself on providing up to date, best practice at all times. A place where joint care planning with residents, families, friends and outside professionals is both encouraged and valued. Above all, we will always strive to be a home where residents feel comfortable, safe and secure. We want our residents to feel they can be the individual that they have always been.' We observed that people were supported to live in a clean, comfortable and safe environment which was free from restrictions. Staff treated people with dignity and respect and did their upmost to ensure that people had the best quality of life. There was a relaxed and homely atmosphere at the service. Each staff member we spoke with told us how much they enjoyed working at the service and providing care and support to the people living there. One staff member said, "There is a relaxed atmosphere, everyone gets on really, really well. I want to look after people, I like the people that are here and staff are nice."

Staff were aware of the whistleblowing procedures and voiced confidence that poor practice would be reported. Staff told us that they had confidence in the registered manager taking appropriate action such as informing the local authority and CQC. Effective procedures were in place to keep people safe from abuse and mistreatment.
People and relatives told us that staff listened to their views on how they like to be cared and said that staff treated them respectfully. People had opportunities to feedback about the service they received through completion of surveys and through meetings. Surveys had been sent to people in June 2017 to request their feedback. Thirteen people had responded. People had given positive feedback about food, some had made suggestions for improvements about the menu and variety of food available the meeting records evidenced that this had been actioned. The cook had met with people to discuss their suggestions and to review the menu. Eleven people had detailed in their surveys that they knew about activities in the service. Some comments seen showed not everyone was satisfied; 'Boring at weekends and not much going on in the mornings anymore' and people had requested more outings and church services. Although people had been asked for their feedback it was not always evident that they had been listened to. The activities calendar displayed on the wall of the lounge evidenced that there were no morning or weekend activities. People and staff told us that there were no church services taking place. We heard one person repeatedly ask staff during the inspection why there was no church service taking place. This meant that people's voices had not always been listened to. People's religious needs were not met because they were not supported to attend services to meet their religious needs.

Relatives were able to feedback about the service their family members received. There was a comments book in the reception area which had been well used by relatives. Comments included, 'Excellent service from [staff member]. Needs to be awarded employee of the month' and 'The Christmas lunch was lovely, nicely cooked better than some restaurants. Thank you to [staff member] our little waitress. Well done you made us feel welcome. A big thank you and happy new year to you all'. It was evident that the comments book was regularly checked and reviewed by the management team, replies had been recorded in the book, thanking relatives for their comments and confirming action that had been taken.

The registered manager and provider had received a number compliments about the service. One thank you card read, 'I am writing to thank you all at Byron Lodge for caring so considerately in the summer for our late mother. I think all the staff should be congratulated upon their standard of service and professionalism'.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Registered persons had failed to provide care and treatment to meet people's assessed needs. Regulation 9 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Registered persons had failed to effectively manage risks. Regulation 12 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Registered persons had failed to adequately meet people's nutrition and hydration needs. Regulation 14 (1)(2)(3)(4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Registered persons had failed to operate effective quality monitoring systems and failed to act on feedback to evaluate and improve the service. Regulation 17 (1)(2)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider had failed to operate effective recruitment procedures.
Regulation 19(1)(2)(3)