Bymead House Limited

Bymead House

Inspection report

Axminster Road
Charmouth
Dorset
DT6 6BS

Tel: 01297560620
Website: www.bymeadhouse.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Bymead House is a residential care home providing personal and nursing care to up to 30 people. The service provides support to older people and people who have a physical disability. At the time of our inspection there were 28 people using the service.

Bymead House is an extended premises occupying a large plot with accessible grounds. There is a passenger lift and accessible bathrooms to enable access throughout the service.

People's experience of using this service and what we found
We have made recommendations about medicines, staff supervision, and storage of confidential information. Throughout the inspection we mentioned any areas of concern found and all were immediately improved, if not completely addressed, a detailed action plan was devised.

There was mixed feedback about meal provision, people and their relatives were involved in giving regular feedback about meals.

We made a recommendation about data storage as we were not assured information in an office had been properly secured. We looked into numerous concerns that had been raised about the service and while able to corroborate some, for others we were not able to find evidence to prove or disprove them.

Not all staff had participated in 1-to-1 staff supervision, and supervisions were not seen as effective. We have made a recommendation to review best practice guidance and update procedures accordingly.

Medicines were safely administered, and audits ensured oversight of the process. There were some improvements required around risk assessments and storage, we have made a recommendation about this.

Accidents and incidents were recorded, and actions taken both to minimise future occurrences and to ascertain any patterns that could inform risk management.

Staff completed training in safeguarding and both people and their relatives felt the service was safe. Staff were safely recruited and, before commencing in post, induction and mandatory training was completed. The premises were very clean and use of PPE and visiting was in line with current guidance.

Peoples' needs were assessed before being admitted to the service and a procedure of clinical review of assessments prior to admission was in place to ensure only those who's needs could be met were admitted.

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

We received mostly positive feedback about the service and the management team, and the provider was developing new quality assurance questionnaires to issue to people, staff, and relatives so they could benchmark people's opinions of the service.

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

Rating at last inspection
The last rating for this service under a previous legal entity was good (published 8 June 2018). The service remains rated good.

Why we inspected
The inspection was prompted in part due to concerns received. A decision was made for us to inspect and examine those risks. We were not able to corroborate most of the concerns raised with us.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

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

Recommendations
We have made recommendations in 3 areas following our inspection. We have asked the provider to review data storage, staff supervision and medicines administration, and make improvements as needed.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Bymead House

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by 4 inspectors over 2 days. There were only 2 inspectors on site at any time. An Expert by Experience contacted relatives to obtain feedback by phone following the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

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

During the inspection
We spoke with 7 people and 2 relatives during our inspection and contacted 23 more relatives by telephone following the inspection, 9 of whom gave us detailed feedback. We spoke with 11 staff members in person including the nominated individual, registered manager, clinical leads, housekeepers, registered nurses, chef, care practitioners, senior care assistants and care assistants. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We received emailed feedback from 24 staff members following the inspection. We requested feedback from 7 health and social care professionals and received feedback from 5 of them. We reviewed 8 care records and multiple medicines records. Records relating to the day-to-day management of the service were also reviewed.

Good

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant people were safe and protected from avoidable harm.

Using medicines safely
• Medicines were safely administered, and people received their medicines as prescribed however we found some improvements were needed that have already been implemented by the service.
• We saw medicines delivered by the supplying pharmacy were not in their original packaging and did not have a use by date on them. We mentioned this to a clinical lead who obtained the use by date the same day and added a check when deliveries were received to ensure all medicines were either in original packaging or had use by dates on.
• We also noted medicines that had been delivered were opened and counted by staff. This meant the date opened that was written on the medicine when it was administered was not accurate as the bottle had already been opened. Again, this was immediately acted on and medicines were disposed of to alleviate any possible risks.
• The medicines room was quite warm when we inspected, and staff assured us a fan was provided for the room should the temperature become too high. We saw temperature records were not always completed as these were added to the electronic care system. When we returned to inspect on a second day, a paper record had also been added and improvements had been made.
• Some care plans and risk assessments needed to be completed, these included protocols for PRN or 'as and when' medicines, this had been identified in a previous audit, and cross-referencing risks to people taking blood thinners with other risk assessments such as falls. Clinical leads and registered nurses were aware these documents were outstanding but had been unable to allocate time to complete the tasks. They had communicated this to the team using the electronic care system.
• Audits of medicines and other clinical areas were completed every month by the clinical leads. These gave a clear overview of the clinical aspects of service delivery. When we inspected, the registered manager did not view these audits as they were not clinical. We suggested it would be good practice for a clinical lead and the manager to review these together monthly to ensure the registered manager was fully briefed.

We recommend the provider reviews best practice guidance on medicines storage and administration and their current procedures to ensure they align.

• There was an electronic medicines system and medicines administration records (eMAR) were accessed through a tablet or laptop. eMAR's had been completed to indicate medicines had been given and if not given, reasons for this were recorded.

Systems and processes to safeguard people from the risk of abuse
• People thought the service was safe, a person told us, "I feel safe, they're (staff) at the end of a button when pushed."

• Relatives also believed the service was safe, they told us, "The best thing is that my relative is looked after. The worry is taken out of my hands" and "Yes, 100% confident (relative) is safe. It's because (relative) is happy and staff are going in and out all the time."
• Staff completed training in safeguarding at induction then annually to ensure their knowledge was current.
• A monthly audit completed by the registered manager ensured staff training, safeguarding alerts and actions had been completed and people were safeguarded.
• Safeguarding concerns were recorded, reported and investigated and learning from them shared with the staff team.
• There was mixed feedback from staff about whistleblowing. Staff were aware they should raise concerns should they have them about poor practice however not all were confident their concerns would be acted upon. However, we found no evidence to indicate safeguarding and practice concerns had not been addressed in a timely way.
• A staff member told us, "Personally, I think Bymead is a safe place to work. I believe that the management deal with things correctly and are always there to listen. An example of why I believe the home is safe is that the home had to go on lockdown due to an emergency in the village, and the management ensured all residents and staff were safe throughout."
Assessing risk, safety monitoring and management
• Risks associated with people's health and wellbeing had been assessed and actions taken to minimise risks while accommodating people's wishes. For example, a person did not want to be repositioned by staff however had a very high risk of pressure wounds. The provider sourced a lateral turning system, an air mattress that gently repositioned the person without a need for staff support. This reduced the risks significantly in a way that was acceptable to the person.
• Other risks assessed included falls, moving, and assisting and completing a malnutrition universal screening tool (MUST).
• Risks associated with the environment, chemicals in use and activities had also been assessed and all assessments were reviewed as needed.

Staffing and recruitment
• Staff were safely recruited. We saw very well organised staff records which contained documentation of all required checks detailed in schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included references from previous employers, full employment histories and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• Sufficient staff had been deployed to meet people's needs in a timely way. When we arrived, during a night shift, there were 2 senior care assistants and 1 registered nurse on duty. All responded immediately to call bells and there were no long waits for care to be delivered.
• There were no significant delays in answering care calls during the day and there were sufficient staff available to provide support, activities and maintain supervision of people. However, some staff voiced concerns about having to cover in the absence of kitchen, housekeeping, and activities staff. There were vacancies in these areas that at times meant care staff could be called on to support. Recruitment was ongoing to fill these vacancies.
• We asked people what they thought of the staff team at Bymead House. One person told us, "Absolutely delightful, you couldn't ask for more. Everyone is so nice." Another person told us, "The staff are very nice and helpful. I am well looked after."
• Relatives were also positive in their feedback about staff telling us, "The staff are outstanding. A lovely cheerful atmosphere." The same relative mentioned 2 care staff by name and told us, "They've [staff members] been there a long time. My relative's face lights up when she sees them. I'm particularly grateful to them."

• There was no dependency tool used when we inspected to determine how many staff are needed to support the needs of people using the service however, the registered manager was working to source one that could be used by Bymead House and the provider's other services.

Preventing and controlling infection
• The premises were very clean and there were no malodours at any time during our inspection.
• Staff had been concerned about changes to previous practice of having trolleys with personal protective equipment (PPE), clean and soiled bedding and incontinence products. The registered manager believed these to be a fire risk due to limiting access in corridors and an audit completed by an external consultant had identified these as an infection prevention and control (IPC) risk. This was due to potential contamination between clean and soiled items.
• As a result of the external audit, new PPE stations had been added to bathrooms and laundry trolleys were now stored in trolleys in the bathroom and in a cupboard in the hairdressing room. Though this meant PPE and bedding were not immediately to hand, the premises were not large and staff, when prepared managed the change without difficulty.

• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was supporting people living at the service to minimise the spread of infection.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was responding effectively to risks and signs of infection.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
• There were no current restrictions to visiting at Bymead House however, visitors were asked if they had any symptoms of COVID 19 or other communicable infections before entering.
• During outbreaks of infection, people had remained in contact with relevant others using phone and video calling.

Learning lessons when things go wrong
• Accidents and incidents were recorded and reviewed by senior staff. Each month, clinical leads audited the reports to ascertain what type of incidents had occurred, types of injuries, when they occurred and to whom. This enabled them to identify patterns and new areas of risk that could be reduced.
• Information from these reviews was shared with the staff team through the electronic care system, handover meetings and general staff meetings.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. The rating for this key question has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• Since commencing in post, the registered manager had not completed 1-to-1 supervision sessions with all staff members. We saw supervision records that included team and clinical meetings as group supervisions.
• The registered manager told us 1:1 supervisions with staff had been inconsistent and staff told us they did not always find supervisions effective. We discussed this with the registered manager who told us they had plans to improve 1:1 sessions with staff and we encouraged this.

We recommend the provider refers to best practice guidance and improves 1-to-1 support for staff.

• Staff completed an in-depth induction when they commenced in post at Bymead House and shadowed more experienced colleagues to learn the more practical aspects of their role and to get to know people.
• Training courses were regularly refreshed. Unfortunately, a systems failure with a training provider meant staff could not access their training for the months of June and July so courses that expired during those months could not be completed. Once this was remedied, courses were arranged and training for 2023 would be fully completed by the end of August 2023.
• Clinical training had been booked for all registered nurses and care practitioners and would take place over the next few months. As the records were not available to indicate which sessions were due, all clinical staff were completing all clinical training to ensure they were competent in all areas.
• Staff could complete qualification training in order to progress in their careers. Diplomas in levels 2, 3 and 5 were available and other more specific training including training in syringing ears was being arranged to enhance the skills held by the staff team.

Supporting people to eat and drink enough to maintain a balanced diet
• We had mixed feedback about meals at Bymead House, some people loved the food, others were less positive, and one person favoured one chef's cooking over another's.
• Other feedback from people included, "You could say it's pretty good, sometimes not so good. You can choose what you want to eat. They ask quite often for feedback about the food", "The food is wonderful. The other morning, the chef sent me up 2 pancakes. I happened to mention to them all that I enjoyed pancakes, and he sent some up. I really enjoyed them", "I enjoy breakfast and tea, but lunch is not always nice. They ask for feedback and once a month we have meeting and I complain about the food. I'm not the only one but it's not improved."
• Relatives told us, "Food is the biggest issue. Relative was always a good cook. Finds it a bit of a drop in standards. Staff monitor their weight. They have lost weight. No worries as they don't eat a lot. Slightly

better food would be nice." And "Relative has a pureed only diet. Somebody is needed to feed them and encourage fluids. There is always somebody experienced to help relative. They were a choking risk in the past."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Before admission to Bymead House, people were assessed by senior staff from the service, or a trusted assessor at the hospital. This helped ensure safe admissions to the service. Recently an unsafe admission had been made, however this was due to a person's needs not being fully disclosed before admission, rather than an assessment being insufficiently completed.
• The registered manager or clinical leads completed assessments, however, before admission was agreed, assessments completed by the registered manager were reviewed by clinical staff to ensure the service was prepared to meet all their needs. On occasion, this had not happened, which could potentially lead to inappropriate admissions.

• Assessments were thorough and addressed people's health and social needs. This information was used to guide which risk assessments and care plans were needed. These were regularly reviewed, and a resident of the day programme ensured that all plans were reviewed.
• People had also made plans to not have additional treatment, for example, only being admitted to hospital for injuries and not for treatment of other conditions. These are sometimes known as advance treatment plans.

Adapting service, design, decoration to meet people's needs
• The premises had been significantly extended and adapted to provide accommodation for older people and people living with physical disabilities. Rooms had ensuite toilet facilities and there were adapted, accessible bathrooms.
• The premises were in good decorative order and were homely and comfortable. A hairdressing and nail salon had been created so people could have a more authentic experience.
• Maintenance was carried out when needed, the provider had arranged cover from the previous maintenance post holder to ensure urgent works were carried out until their replacement was found. The provider was responsive to concerns we raised about a door, where it was noted in March 2023 repairs were needed. Unfortunately, we could not find a record of this being reported to maintenance, however when we identified the concern, they immediately fixed the door.
• The provider had plans to further extend the premises and to refurbish the current building. This would be done with input from people and staff in terms of new décor and facilities.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• The provider had positive working relationships with local health and social care providers working with, for example, the frailty team, local GP's, and specialist nurses such as tissue viability (TVN) and Parkinson's nurses.
• People were supported to access hospital appointments however were not always accompanied by staff members. One relative had been concerned their family member spent a day in hospital for an appointment without food or drink. The registered manager told us if a person did not have dementia or complex needs a staff member would not routinely accompany them. In this instance, the hospital transport system failed, and the transport booked for the person was not supplied and they were not driven home in time for lunch as planned. People attending hospital appointments that run for a longer period are supplied with a drink and a packed lunch.
• Healthcare professionals had frequent contact with the provider, for example, the TVN worked closely with a person who had long standing pressure wounds and the Parkinson's nurse had regular visits with people

living with the condition to monitor them and ensure they were on the correct medicines.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• The provider was working within the principles of the MCA, however this needed to continue to be improved. The current registered manager was updating the documentation used for MCA assessments and best interest decisions as the previous records did not provide sufficient detail.
• The newer records were clearer and detailed the assessments and decisions better, however we saw those consulted with when considering options was completed with generic terms and needed to be more specific. We spoke with the registered manager about this, and they were updating the records.
• Staff had a good understanding of the MCA, telling us, "As we are working with elderly residents, it is vital to obtain and understand the Act as some individuals don't have the capacity to make their own decisions, for their own safety and well-being. This needs to be considered, crucially as it is important to enable residents to make their own decisions and have independence, however, also make sure they are safe, and their well-being is protected." And "Yes, you should always assume a resident has capacity until stated otherwise by an adequately trained professional. Or if a resident has fluctuating capacity always ensure to ask them at the best time for them." And "It helps me understand people who lack the ability to provide their own decisions and helps me to support our residents to achieve what's best for them."
• There had been 2 DoLS applications sent for people however neither had been authorised at the time of our inspection. These were regularly audited, and new applications or reminders were sent to the local authority at intervals.

Good

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• The registered manager had been in post for almost a year and had a clear understanding of their role at the service. Two clinical leads were in post, one had stepped down from their deputy manager role to work in a more clinical role again. The registered manager was supported by the nominated individual who attended the service most weeks and had contacts with other managers within the providers other services.

• The clinical leads were responsible for all clinical aspects of the service however at the time of our inspection had not received clinical supervision for several months. Registered nurses work to the 'Code'. These detail the fundamental standards that must be upheld when registered with the Nursing and Midwifery Council (NMC). The lack of clinical supervision means registered nurses at Bymead House are currently not receiving the support or having the opportunities to debate clinical matters as they should, or to, "share your skills, knowledge and experience for the benefit of people receiving care and your colleagues."

• Audits of clinical areas including medicines, infections, and accident and incidents were completed each month by the clinical leads. These were thorough however the medicines audit often identified discrepancies in medicines counts and the recorded amount in the medicines system. These were manually corrected and reasons for the discrepancies investigated by registered nurses. The investigations were not recorded which meant there was no evidence to show why the discrepancy happened. We spoke with the clinical leads who will in future include their findings.

• The registered manager audited the non-clinical aspects of the service. Again, these audits were thorough and covered all relevant aspects of service provision. These included the environment, safeguarding, the premises, catering, and laundry. Some of the audits were completed by staff such as the chef and maintenance person and the registered manager had final oversight of these.

• A concern raised with CQC was that an agency support staff member had used an office to sleep in when working some shifts as they were not able to easily travel to Bymead House. We saw the room in which they stayed, a bed had been added to the room, but there were several filing cabinets, all unlocked in the room and files containing documents on the shelves. Some files in both the cabinet and on the shelves contained confidential information.

• The registered manager assured us the room had been cleared of all such records before the staff member used the room however, we were not able to corroborate this as some of the information was in cabinets behind the bed and the information on the shelves appeared to not have been moved for some time.

• On arrival at Bymead House, there were no office-based staff on duty. We were able to access all document storage in the reception office as the staff record cabinet was unlocked and the keys for the other cabinets

were not securely stored.

We recommend the provider reviews all record storage and ensured it meets with current data protection standards.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people
• We were in no doubt that people receiving a service at Bymead House were receiving a good standard of person-centred care. They were given choices, could get up when they wished, eat where they wanted and attend activities or opt out. Care was delivered when people wanted it as they preferred it. The service was inclusive and embraced people of different cultures.
• The experience of some staff members and the registered manager since the service was purchased by the current provider had been less positive. We received more positive than negative feedback from staff about the current situation in the service, however the ongoing lack of cohesion between the staff team and the management team was noted by some people when we spoke with them. The registered manager and nominated individual were considering how best to address these issues and took seriously any concerns raised with them by staff.
• Concerns had been raised anonymously with CQC prior to our inspection and while some could be substantiated, such as the need for improved storage of confidential records and an inappropriate admission, many were outside of the CQC remit. We did however discuss all concerns raised and with most, there was an aspect of fact that had either been misinterpreted or exaggerated and as a result appeared more significant that it was. For example, we found no evidence to support a concern raised about modern slavery, in discussion about this allegation we found the provider had been supportive to staff members in sourcing accommodation on their behalf. We suggested suitable agencies for staff to approach with other concerns.
• The culture in the service was mostly very positive, there was significant support for the registered manager and some of the changes made since they began in the role. We discussed possible ways this could be improved with the registered manager and nominated individual during the inspection and once regular 1-to-1 sessions are taking place it is hoped relationships across the team will improve.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The nominated individual and registered manager understood their responsibilities under the duty of candour and a policy supported this.
• People and their gave mixed feedback about the management of the service. A person said, "You can't like and take to everybody, I have no affinity with the manager. I wanted to talk about my experience with the transport to hospital at the last residents meeting and she told me not to talk about it and said she would come to my room, but she never did." Another person said, "I think she is more interested in getting ticks against things she needs to, she tried to get things done quickly forgetting that we are human."
• Other feedback from people was more positive including, "I know the manager she has said I can move to a better room. Registered manager is delightful and kind, she is lovely and very smart.", "New manager seems nice." and, "The manager, can't remember their name, well I like her. She would tell you if she doesn't like something and I like that."
• Relatives were all positive in their feedback about management. Their comments included, "I know the manager. They are accessible and approachable. They discuss listen and resolve any concerns." And "Yes, the home is well managed. I speak to the manager, and she listens." And "I think it's a well-managed home. It functions as it should. I only know the manager. I'm more remote from the owner."

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics; Continuous learning and improving care; Working in partnership with others
• There had been full team meetings, clinical meetings and residents' meetings since the new provider took over the service. The nominated individual who was also the owner had visited the service however some people would like to see more of them and spend more time getting to know them.
• Instead of a meeting, a questionnaire had been issued to people for 1 month. This was to give them all an opportunity to have their views heard, including those either unable to, or lacking the confidence to speak up in meetings. We saw the results of the surveys and almost all were very positive.
• Other quality assurance questionnaires were under development using an online platform. This meant staff, people and their relatives would be able to provide candid feedback anonymously which could be used to provide a clear picture of people's views of the service.
• Learning from feedback, meetings and from mock inspections that had taken place on 2 occasions fed into a service improvement plan and was cascaded to staff as required.
• The provider worked effectively with stakeholders such as health and social care professionals which promoted the well-being of people living at Bymead House. We received positive feedback from healthcare professionals about Bymead House.