Byron Lodge (West Melton) Limited

Byron Lodge Care Home

Inspection report

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Rotherham
South Yorkshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 6 and 9 March, 2017 and was unannounced on the first day. The home was previously inspected in June 2016, when we identified a breach in Regulation 17, good governance. At the time the service was rated overall requires improvement. Previously the service had been rated inadequate. We brought this inspection forward due to concerns we had received about the service.

Byron Lodge is a care home providing accommodation for up to 61 people. The home has four units, Browning and Wordsworth which provide residential care and Ruskin and Shakespeare which provide nursing care. The home is situated in the West Melton area and is approximately six miles from Rotherham town centre.

The service did not have a registered manager in post at the time of our inspection. 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. However, the deputy manager had been promoted to this position and was in the early stages of registering with the Care Quality Commission.

We found risks had been identified and measures put in pace to manage the risk. However, we found the risks were not always managed so people were at risk of harm. This showed the provider was not doing all that was reasonably practicable to mitigate risks associated with people's care and treatment.

The provider did not have safe arrangements in place for managing medicines. We found that people did not always receive their medicines as prescribed. We found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. However, there was a lack of protocols in place to guide staff in how these should be administered. The temperatures of the rooms used to store medicines was not always monitored or recorded to determine that they maintained the required temperatures. We also saw the fridge temperatures were not always recorded. It was therefore not evident if the required temperatures were maintained.

The premises and equipment used by people were not always clean and/or properly maintained. During our inspection we looked around the service. We found many areas were not kept clean and infection prevention and control policies were not adhered to. For example, store rooms were cluttered and not well organised. Many items were stored on the floor, which meant they were difficult to clean. We saw several dining chairs throughout the service which had ripped seats which could not be cleaned effectively. Other chairs were stained and marked.

We saw moving and handling slings were not labelled or stored appropriately. This meant the staff could not easily access them or know which size sling to use to ensure the correct sling was used for each person requiring moving with the mechanical hoist. Staff we spoke with were unsure of which sling was to be used

for each person.

Overall, people we spoke with said there were enough staff on duty to meet people's needs. However, some people felt that additional staff were needed. From our observations we found that there was enough staff around on the days we completed our inspection. However, we found staff lacked leadership, direction and were not deployed in an effective manner. This meant that people's needs were not always met in a timely manner.

Some staff had not received appropriate support, supervision and appraisal necessary for them to carry out their duties. Staff were not always knowledgeable about people's needs and there were some gaps in the training record.

Decisions made where people lacked capacity did not follow best practice and did not evidence decisions were made in a person's best interest. We identified people's conditions in relation to the authorised Deprivation of Liberty Safeguards (DoLS), were not being followed so some people were being deprived of their liberty.

The mealtime experience did not ensure people received adequate nutrition. Some people were not adequately supported which led to people leaving their meal.

People were not always treated with dignity and respect. We saw personal information belonging to people on display or not appropriately stored. We observed staff interacting with people who used the service and found that some staff interacted well. However, staff were task focused and we observed staff only interacted with some people to complete specific tasks. For example, we saw that people who spent time in their rooms were only spoken with when staff had to enter their rooms to complete a task, such as assisting with meals. There was a lack of social stimulation, especially for people who spent most of their day in their bedrooms.

We found people did not always receive care that was responsive to their needs. We saw many care plans had been rewritten in June 2016, yet we identified in most that we looked at had only been reviewed once since that date.

All the people we spoke with knew how to raise a complaint and said they felt comfortable speaking with the acting manager or any of the staff.

We found that there had been a lack of consistent managers at all levels and a lack of provider oversight and governance which had contributed to the decline of the service. Audits in place to monitor the quality of service provision were not effective and did not identify the concerns we had raised as part of this inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider was not doing all that was reasonably practicable to mitigate risks associated with people's care and treatment.

The provider did not have safe arrangements in place for managing medicines.

The premises and equipment used by people were not always clean and/or properly maintained.

Infection prevention and control policies were not adhered to.

Overall, people we spoke with said there were enough staff on duty to meet people's needs. However, some people felt that additional staff were needed and we saw staff were not deployed effectively.

Is the service effective?

Inadequate

The service was not effective.

Some staff had not received appropriate support, supervision and appraisal necessary for them to carry out their duties. Staff were not always knowledgeable about people's needs and there were some gaps in the training record.

Decisions made did not follow best practice and did not evidence decisions were made in a person's best interest. We identified people's conditions in relation to the authorised DoLS were not being followed so they were being deprived of their liberty.

There was a lack of support for some people at mealtimes to ensure people received adequate nutrition.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect. We saw

personal information belonging to people on display or not stored appropriately.

We observed staff interacting with people who used the service and found that some staff interacted well. However, staff were task focused and interacted with some people only to complete specific tasks, putting them at risk of social isolation.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive person-centred care which was appropriate and met their needs.

There was a lack of social stimulation especially for people who spent most of their day in their bedrooms.

All the people we spoke with knew how to raise a complaint and said they felt comfortable speaking to the acting manager or any of the staff, with some saying they would speak with their relatives too.

Is the service well-led?

Inadequate

The service was not well led.

We found that there had been a lack of consistent managers at all levels and a lack of provider oversight and governance which had contributed to the decline of the service. Current managers in post were new to their positions.

Audits in place to monitor the quality of service provision were not effective and did not identify the concerns we had raised as part of this inspection.

Byron Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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.

The inspection took place on 6 and 9 March, 2017 and was unannounced on the first day. The inspection was completed by three adult social care inspectors. At the time of our inspection there were 45 people using the service.

Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the manager. We were also accompanied by a contracts compliance officer from the local authority who was undertaking their monitoring of the service.

We spoke with ten people who used the service and seven relatives/visitors. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 11 staff members including nurses, care workers, a senior care worker, ancillary staff and the acting manager. We also spoke with the regional support manager and the regional manager. We looked at ten people's care and support records, including the plans of their care. We looked at the systems used to manage people's medication. We also looked at the quality assurance systems to check if they were robust and to see if they identified areas for improvement.

Inadequate

Is the service safe?

Our findings

We found risks had been identified and measures put in pace to manage the risk. However, we found the risks were not always managed so people were at risk of harm. For example, one person was at risk of poor nutritional intake. The management of this risk was to monitor the persons food and fluid intake and weight on a monthly basis to determine any weight loss and if significant contact health care professionals for advice. We saw this person had been weighed on 19 January 2017 and the weight recorded was 56.5kgs and then was weighed again on 28 January 2016 and the weight was 54.2kgs. This was a loss of 2.3kgs in only 7 days. The review did not identify this and no other weights were recorded so this person had not been weighed in six weeks. We asked staff why they had not been weighed and staff said the person did not like to be hoisted. However, there are other alternative means of monitoring weight loss following malnutrition universal screening tool. These had not been considered. We looked at the person's food and fluid charts these were not completed properly, were not evaluated or reviewed. It was therefore not possible to determine the risk had been managed and the person's needs met.

Another person had an assessment in place for dehydration which indicated that a care plan should be in place to minimise the risk from occurring. The care plan in place for eating and drinking only gave information regarding the person's food and drink preferences. The risk assessment actions were to offer drinks on a regular basis and to document this on a fluid chart. This was last reviewed in December 2016. This showed the person was at risk of dehydration, but no one had oversight of this.

We saw that another person had a moving and handling risk assessment in place which had no date and was not fully completed. The risk assessment stated that the person did not mobilise independently and that transfers should be completed by the use of a stand aid and in to a wheelchair. This required two staff. However, there was no instruction as to what size or type of handling belt should be used or where the straps should be positioned.
We saw moving and handling slings were not named or stored appropriately. This meant the staff could not easily access them. It was not clear which sling belonged to which person and on many occasions we asked staff which sling belonged to which person and they were unsure.

This was a breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not doing all that was reasonably practicable to mitigate risks associated with people's care and treatment.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MAR's).

There was a medication storage room on each floor. The downstairs room was air conditioned and this was set to 17 degrees centigrade. The upstairs room was not air conditioned, but had an air conditioning unit available if the temperature rose. However, we found the room temperature was not monitored or recorded to determine that it maintained the required temperatures. We also saw the fridge temperatures were not always recorded. It was therefore not evident if the required temperatures to ensure the correct storage of

medicines was maintained.

We found medicine pots were single use, however, these were being rinsed in the wash hand basin and reused. We discussed this with the nurse and on the second day of our inspection new disposable medicine pots had been purchased and were used. This had not been recognised by staff or identified through their own monitoring system.

We found staff who administered medicines did not always record the amount of medicines received or the amount carried forward from the previous month. This made it difficult to account for medicines. For example we found one person's medication had recorded that only two tablets were left in stock yet we found there was an additional box of 28 tablets that had been dispensed on 13 December 2016 and had not been recorded on the MAR as carried over.

When we asked the staff member why carried over amounts were not recorded they told us they were aware carried over amounts should be recorded on the MAR and staff were aware to do this, but told us there were none recorded on the MAR's this month. This meant staff could not always be assured that medication was given as prescribed as a clear audit trail had not been maintained.

We found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. For example, medication for pain relief and to alleviate agitation. We found people did not always have PRN protocols in place which provide guidance to staff when to give PRN medication and explain how people presented, for example when they were in pain and agitated. Staff told us people who were prescribed these medications were not always able to tell staff when they were in pain or distressed due to their medical conditions. This meant that people who used the service could be in pain or distressed and not have medication administered as staff did not know what signs to determine when it was required.

We identified people's PRN medication was not always being given as prescribed. For example, one person was prescribed medication to help alleviate agitation and aggression caused by Alzheimer's disease. This was prescribed to be given as and when required, yet we saw this was given regularly three times a day. We found no records detailing why this person had been given the medication. There was nothing in the care plan or daily notes to indicate they had been continually agitated or aggressive and the staff member when asked did not know why it had been given regularly. It was therefore not possible to determine if this person required this medication or not.

We also found on the MAR's we checked that when people were administered PRN medication the reason why it was administered was not recorded. It was therefore not possible to determine if the medication was given as prescribed.

The medication was administered by staff who had received training to administer medication. The deputy manager told us all staff had received competency assessments, yet we found errors and some areas of poor practice were still occurring so these were not effective. Medication audits we saw were not carried out in line with the provider's policy. The last daily check was carried out on 22 February 2017 and during February 2017 there was only one weekly audit completed which was on 27 February 2017. This audit showed compliance, for example it had ticked that PRN protocols were in place, however, we identified that they were not always in place.

This was a breach of Regulation 12 (1)(2)(g)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have safe arrangements in place for managing medicines.

During our inspection we looked around the service. We found many areas were not kept clean and infection prevention and control policies were not adhered to. For example, store rooms were cluttered and not well organised; many items were stored on the floor, which meant it was difficult to clean. The acting manager told us staff were aware that items should not be stored on the floor so this was not following the homes policies.

We also found floors in store cupboards were black with engrained dirt, the underside of shower chairs were encrusted in dirt and not clean and the dining room floor was sticky and we could see smear marks of dirt from the mop yet a sign was in situ saying 'wet floor' as cleaning had just been carried out.

We saw several dining chairs throughout the service which had ripped seats which could not be cleaned effectively. Other chairs were stained and marked. One microwave, which was in use, was dirty and rusty on the inside of the door. We also saw a fridge freezer that was rusting.

One bathroom had been decommissioned and the bath and sink had been removed. This room was being used as a store room. The walls and floor had not been repaired since the removal of the bath and sink. This meant the staff were not able to effectively clean the room as it was not well maintained.

Overall, people we spoke with said there were enough staff on duty to meet people's needs. However, some people felt that additional staff were needed. On Browning unit, one relative said, "Sometimes, for example holiday periods, there are only two staff on the night shift." [which they felt this was not enough]. They also told us they felt weekends were not as efficiently run as there was no management on duty. They added, "Someone should be in charge, in control at weekends. There is usually enough care staff, it's the management."

Another person said they felt more staff was needed on nights on the ground floor. They added that sometimes there was only one care worker on their unit so staff had to come from other units to help out.

One person using the service said, "The staff are good, but we could do with more. They are never here much [in the lounge]. I would like to have a chat to them." However, four other people in this lounge did not raise this point.

One relative visiting someone on the Shakespeare unit felt that staff were sometimes stretched. They said at least two relatives visited the home at teatime to assist their family member to eat, they wondered how staff would cope if they didn't help. They said, "Staff are busy helping people in their rooms, which just left one care worker in the dining room to dish out the food."

Staff we spoke with told us that there was usually enough staff around but this depended on leave such as sickness and holidays. We spoke with the manager who stated that there should be a senior care worker between the two residential units and two care workers on each side during the day, with an occasional carer floating between the two. The manager told us that there should be two care workers on each of the residential units at night. The manager said, "Ideally there should be nine staff for 45 people [this included the nursing units], but this could drop to between seven and eight." There was no mention of having assessed people's dependency levels to ascertain the correct number of staff needed.

From our observations we found that there was enough staff around on the days we completed our inspection. However, we found staff lacked leadership, direction and required deploying in an effective manner. We found that this meant that people's needs were not always met in a timely manner.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were not always deployed effectively to meet people's needs.

The service had a policy and procedure in place to safeguard people from abuse. Staff told us that they had completed safeguarding training and were aware of what to look for and how to report incidents of abuse. However, staff were not sure who they could report concerns to outside the company and were not aware of the role of the local authorities safeguarding team.

We observed two people being moved with a mechanical hoist prior to lunch on Wordsworth unit. Staff took time to explain what was happening and why. A relative on Shakespeare unit told us their family member had been prone to falls before being admitted to the home but since admission had only fallen twice, in the early days. They said staff had ensured a profile bed with sides had been put in place along with a crash mat and alarm pad for if they got out of bed, which made the relative feel, they were safe. One person living on Browning unit described how staff assisted them to move from their bed to the chair, using stand and turn equipment. They said they did this in a safe way.

We looked at staff recruitment files and found the provider had a safe and effective system in place for employing new staff. Staff confirmed they had gone through a robust recruitment process that included completing applications, providing references and undertaking a Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable people. Staff we spoke with confirmed that they had to wait for the checks to be returned and satisfactory prior to commencing their post. One staff member told us that they completed essential training as part of their induction. They also told us that they were able to shadow experienced staff for a period of time in order to learn aspects of the job.

Inadequate

Is the service effective?

Our findings

We spoke with people who used the service and their relatives and they told us the staff appeared competent to do their role. Staff we spoke with told us they felt they received adequate training and support to carry out their roles.

Staff we spoke with confirmed that they had received additional moving and handling training recently. They also told us that they had received training in mandatory subjects such as health and safety, dementia, hand washing and mental capacity. A care worker said they had completed the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training, but they could not remember when and had no knowledge of MCA when asked to tell us basically what it was about.

We looked at the training matrix, which was a record of training completed and training due to take place. We saw that there were several gaps in this record which indicated that training was required. The acting manager told us that they were accessing training to ensure the training needs of the staff team were addressed.

Some staff told us that they felt supported and that they received supervision regularly. Supervision sessions were one to one meetings with their line manager. However, other staff told us they had not received supervision or an appraisal of their work. We spoke with the manager who informed us that supervisions and appraisals were being addressed and showed us a schedule that was in place for when staff should expect to receive this.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some staff had not received appropriate support, supervision and appraisal necessary for them to carry out their duties. Staff were not always knowledgeable about people's needs and there were some gaps in the training record.

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.

We found the service was not always meeting the requirements of the Mental Capacity Act 2005 and

Deprivation of Liberty Safeguards (DoLS). Most staff we spoke with had a satisfactory understanding and knowledge of this, and people who used the service had been assessed to determine if a DoLS application was required. We saw for some people where a DoLS had been authorised where there were specific conditions associated with the authorisation we found they were not being met. For example, one person's condition was to monitor behaviour and record medication to determine any triggers to be able to manage their behaviour that may challenge. We found medication was not properly recorded to be able to meet this condition. It could not be determined that medication was given in response to their behaviour and if given unnecessarily this could impact on their liberty.

We found people's best interest decisions were not always clearly documented or followed. We found the documented evidence of decisions made in people best interests varied depending on who was the named nurse for the person. We identified some documentation was in place and showed involvement of health care professionals, family and key workers to ensure where a person lacked capacity to make a decision it was made in their best interest. However, in many care files we looked at decisions made did not follow best practice and did not evidence decisions were made in a person's best interest.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Decisions made did not follow best practice and did not evidence decisions were made in a person's best interest. We identified people's conditions in relation to the authorised DoLS were not being followed putting them at risk that they may be deprived of their liberty.

When we asked people about meals one person living on Browning told us, "I can't complain." Another person told us, "Very good food." A relative told us how staff supported their family member to eat a soft diet and drink enough. They went on to describe the meals as, "Good" saying they offered good choice and their family member was eating well.

We observed breakfast, lunch and evening meals during our inspection. One of these observations was done using our Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We found the meal time experience could be improved. We found staff were task orientated and did not offer personalised support to people who required assistance with eating. This meant people did not always eat their meal. We saw times when staff were not present in the dining area and on one occasion two people became very vocal during the meal shouting at each, other staff did not intervene to alleviate the situation.

Some people were served their meal in their bedrooms. We saw that people were not assisted to sit up properly so they could eat their meal safely and comfortably. We saw some of these people did not eat their meals.

During the lunch time meal the domestic was cleaning the carpet outside the dining room on the corridor. The carpet cleaner was very loud and was not conducive to a calm environment for people to eat and enjoy their meal.

There were no picture menus so people living with dementia were struggling to make choices. The menu on the table detailed in writing the food for breakfast, lunch and evening meal. One person thought they could choose anything to eat from the menu for their evening meal and asked for bacon and eggs only to be told that was at breakfast and not available at tea. The person was very confused and did not understand that there were only two choices for the meal and did not want either choice. Picture menus would have made the choice easy and cause the person less anxiety.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The mealtime experience and lack of support did not ensure people received adequate nutrition.

Requires Improvement

Is the service caring?

Our findings

One relative told us they visited their family member daily, they said, "I have always found they [staff] treat my wife well." When we asked if staff respected peoples dignity and offered choice one relative commented, "Definitely, the staff think the world of her and everyone." One person using the service said, "I can get up and go to bed when I like. They close my curtains and the door."

A relative on Shakespeare unit told us staff were, "Generally as good as gold." They said, "They show her respect and offer choice, but they know her well now. Initially they didn't help her with drinks, but now they know they can't just put it in front of her and leave her."

The people we spoke with were happy with their or their family members, rooms. Care workers told us the information in care plans helped them find out about people needs and preferences, however we found care records were not always fully completed or updated. One care worker told us, "I care for people how I would like to be looked after."

We observed staff interacting with people who used the service and found that some staff interacted well. However, staff were task focused and interacted with people to complete specific tasks. For example, we saw that people who spent time in their rooms were only spoken with when staff had to enter their rooms to complete a task, such as assisting with meals.

We also observed that dignity and respect for people was not always maintained. For example, during the meal service the maintenance person entered the dining room, made no apologies and commenced checking and changing light bulbs above and behind people. This caused some disturbance to people eating their meals. We also observed one person coughing at the table. We saw a care worker approach the person and attempted to pat the person on the back as they spat the food out. At this point the care worker told the person they were 'naughty.' This did not show any respect for the person.

We also observed personal information on display throughout the service. For example, each bathroom in use had a bath/shower list on the wall which indicated who had used this facility and the date it was used. We also saw dietary information on bedroom walls and we observed that daily charts containing people's personal information were kept in an unlocked draw in the lounge on the Shakespeare unit.

We walked round the home and found that one bedroom had an offensive odour. We saw that the person who used this bedroom was eating their main meal in there. Another person had dirty underwear on their bedside table which remained there, despite the staff entering the room to assist the person.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always treated with dignity and respect.

Inadequate

Is the service responsive?

Our findings

We found people did not always receive care that was responsive to their needs. We saw many care plans had been rewritten in June 2016, yet we identified in most that they had only been reviewed once since. We also found many assessments not completed including; continence and choking. Therefore if people had needs in these areas they had not been identified so staff could not be responsive to people's needs. It was not always clear if people had been involved in their care planning as preferences, choices and interests had not always been documented.

Some care plans we looked at were not fully complete and did not always reflect the current needs of the person. For example, one care plan had professional visitor notes regarding a specialist chair which was required for posture. On the 18 January 2017 the chair battery was flat and was left in a laying back position. The person had recently fallen out of this chair whilst in this position. The care plan for mobility and falls did not reflect the person's needs in relation to the chair. We also saw that there was no update and the battery was still flat. This meant the person did not have an appropriate chair for their comfort which met their needs. We spoke with staff who told us the chair required the battery to be charged. We saw on the second day of our inspection the person was visited by an occupational therapist who completed an assessment using a different chair. This was a temporary measure until the battery was charged. This person also had a crash mat in their room which was in use but not documented in their care plan.

Another person had been assessed as being a high risk of developing pressure areas and had a care plan in place which stated that they required the use of a specialist chair. The person's care plan also stated that they required two to three hourly pressure area care which involved the person being moved using a hoist. This was to relief pressure and to promote comfort. During our inspection we saw that this did not happen. We spoke with staff who told us the person sat in the specialist chair all day apart from a period of bed rest in the afternoon. The positioning chart in place did not record any pressure relief on the first day of our inspection.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive person-centred care which was appropriate and met their needs.

The relatives we spoke with knew their family members had a care plan and their involvement varied. One person said other family members had not been involved, while another person stated that they had been fully involved in the initial planning and in making changes when needed. The relatives of one person recently admitted to the home [that day] confirmed the unit manager and a care worker had visited them prior to admission and carried out a needs assessment.

Another relative commented, "She [family member] has come on leaps and bounds since she came here." However they added that when there were only three staff on the unit people could be left up to 30 minutes without there being a member of staff in the lounge, which they felt was too long. The same relative went on to discuss how their family member had initially been cared for in bed but had recently started to walk again.

We found for some people they enjoyed activities and were happy, however for others and particularly those who were cared for in their rooms there was very little social stimulation. For example one person's activity log recorded, 'I have tried time and time again to engage in activities they are very hostile'. We found this person wanted to talk and visibly liked our company when we visited them in their bedroom on a number of occasions during our inspection. The person did not want to come out of their room but this did not mean they did not want social stimulation. We found many activities organised were for a small number of people and did not involve people who were cared for in bed so these people could become socially isolated.

People who used the service told us they were happy with the activities provided at the home. One relative told us representatives from religious groups visited people. This relative also said, "They also do bingo and have entertainers in the home." One relative described the activities co-ordinator as "Wonderful" adding that they went above what they expected her to do. For instance, parties for people's birthdays.

Five people [in Browning unit] said they would like more to do. One commented, "There's not much to do." Another person we visited in their room said they did not take part in activities, this was their choice.

Care workers told us people went to church services. The activities co-ordinator facilitated hand massages, arts and crafts and did one to one sessions with some people. The activities co-ordinator described the stimulation she provided included bingo and crafts. She told us she had visited a new person that day and told her about the hairdresser and would accompany them to the hairdresser the next day and stay with them to provide support and encourage her to join in any activities taking place.

The activity co-ordinator told us there was a monthly newsletter published. They said she did not have any activity sheets highlighting what people liked to do, but she would write it in her diary. She did not have a way of ensuring all service users had input from her and had not had any training in providing appropriate activities for people living with dementia. She said she was hoping to join a group run by the local authority to help her develop her skills.

All the people we spoke with knew how to raise a complaint and said they felt comfortable speaking to the acting manager or any of the staff, with some saying they would speak with their relatives too.

One relative told us there had been one or two 'mishaps' when their family member had first come to live at the home, such as laundry being lost, but these had been resolved. They added, "I have no complaints." They went on to show us their family member's wardrobe, which had clothes on the floor. The relative said they had raised this with staff in the past as they were unsure if the clothes were clean or dirty. They said they hung them back up as they looked clean, but added "It's not very nice is it." The complaints record did not evidence that this had been raised in the past or how this was dealt with.

Inadequate

Is the service well-led?

Our findings

The management team consisted of the acting manager, who was previously the deputy manager and had been employed at the home for approximately eight years in different roles. The previous registered manager had left the service in December 2016. The acting manager was supported by a new unit manager of the residential unit, who had recently commenced in post. A clinical lead was due to commence employment at the home in March 2017. This person would be the unit manager for the nursing unit. The acting manager was also supported by a regional manager who had been in post since October 2016 and an assistant regional manager who was also new to post. A new operations director had also been appointed recently and was intending to register with the Care Quality Commission as the nominated individual for the service.

We found that there had been a lack of consistent managers at all levels and a lack of provider oversight and governance which had contributed to the decline of the service.

At our last inspection in June 2016, we identified a breach in good governance. This was because the provider's systems were not effective in the monitoring of the quality of service provision. The provider had started to develop systems but they required embedding in to practice.

At this inspection we saw some systems were in place to monitor the quality of service provision by the use of audits. However, issues we had identified during our inspection had not always been picked up as part of the quality monitoring systems at the service. The audits did not cover certain aspects of the home. For example, there was no audit completed around the dining experience, infection control or equipment and therefore issues we identified had not been highlighted and therefore not addressed. We saw some audits were used for monitoring things such as, care files and medication, but again these had not identified the concerns we raised. For example, the medication audits had not identified that the room temperatures were not always being monitored and was not maintaining the required temperatures. Another example was care plans which did not always reflect people's current needs due to changes that had occurred.

The acting manager explained that the regional manager had completed an audit on 22 February 2017. This included areas such as finance, health and safety, training, medication, and care plans. We saw an action plan had been produced as a result of the audit and had identified some areas we had raised but not all. It was also not clear what actions had been achieved and which were being addressed. There was no timeframe as to when the actions would be completed and the acting manager had been identified to ensure actions were met.

Prior to the inspection we had received concerns regarding people's moving and handling. Due to these concerns we had carried out this inspection. During the inspection we looked at moving and handling equipment. We found the slings used with hoists and stand aid were stored in various places. We found them in bathrooms, store cupboards, bedrooms, toilets and linen stores. The majority were not labelled and did not have people's names on to determine which sling was to be used for which individual. Some were named and when we asked staff who the person was they told us they were no longer living at the home.

People were assessed for slings by occupational therapists to determine size and type required to be able to move a person safely. The correct sling should be used for each person as an incorrect size sling could be unsafe. Staff we spoke with did not know who the slings belonged to and were not clear which sling to use for people who required using a hoist to be moved safely.

The acting manager told us they had recently had all slings checked by an external contractor to ensure they were fit for use. We were given the completed check list. However, the serial numbers on the list did not correspond with the slings that we found in use and it was impossible to determine if the slings in use were maintained, fit for purpose. Some slings we found in use had a date 01/17 on the label which appeared to mean that they should be checked again in January 2017. We spoke with the acting manager about this and were told that some slings required checking, as when the external contractor visited, some slings were in use. The acting manager told us they had arranged for these slings to be checked.

We found no oversight by the acting manager or provider to ensure moving and handling equipment was maintained and correctly labelled and used correctly for each individual.

We have asked the provider to action this to ensure moving and handling equipment is safe.

We looked at accident and incident reports and found that they were not analysed and there were no conclusions or outcomes noted. This meant that it was not clear what the trends and patterns were or any way of assessing if any action could be taken to minimise incidents in the future.

This was a breach of Regulation 17 of the Health and Social Care Act 2008, Regulated Activities 2014. The system in place for monitoring the quality and safety of the service was poor and did not always identify areas of improvement.

The majority of staff commented positively about working at the home. One care worker told us, "I love it [working at Bryon Lodge]. Staff are good team players, there's a good manager, team, nurses etc." They added, "Morale is fantastic since [manager's name] took over. She is approachable and supportive. I feel I can go and talk to her about anything." Another staff member told us they would recommend working at the home to other people as they felt it had improved recently. They added, "You can talk to [two named managers] now, before [managers] were not as approachable." The activities co-ordinator/bank care worker told us, "It's a good home but some staff are not as committed as others." However, a member of staff we spoke with said the company was not very supportive. They told us they promised to do things, such as redecoration, but this did not happen.