Four Seasons Homes No.4 Limited

Osbourne Court Care Home

Inspection report

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15 June 2022

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Osbourne Court Care Home is a residential care home providing personal and nursing care to up to 69 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 30 people using the service.

Osbourne Court Care Home accommodates up to 69 people across two separate floors, each of which has separate adapted facilities.

People's experience of using this service and what we found
Some people had unexplained skin tears due to how personal care was delivered and during support with moving and handling. In addition, some skin tears were unexplained. In many cases these had failed to be reported internally and had not been reported externally, to the local safeguarding authority or the Care Quality Commission (CQC), as required.

While we found that the provider's management team had been taking action to address these concerns which were raised at previous inspections, they had not resolved the issues.

The home was being managed by the deputy manager with support from the provider's regional management team. There was positive feedback from staff about the approach and changes being made in the service.

People told us they felt safe. Staff were seen to be working in accordance with guidance and supporting people in a positive way.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 11 May 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected
We undertook this targeted inspection to check on specific concerns we had about the care people were receiving, their safety and the safe leadership of the home. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted

inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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

Enforcement
We have identified breaches in relation to safeguarding people from the risk of abuse, notification of incidents and good governance at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Special Measures:
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Osbourne Court Care Home

Detailed findings

Background to this inspection

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

This was a targeted inspection to check on a concern we had about the care people were receiving, their safety and the safe leadership in the home.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Osbourne Court Care Home 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. Osbourne Court Care Home 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 15 June 2022 and ended on 24 June 2022. We visited the location's service on 15 June 2022.

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 all of this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection-
We spoke with eight people who used the service about their experience of the care provided. We spoke with nine members of staff including the regional support manager, quality support manager, deputy manager, nurses, care workers and agency care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and a review of specific records relating to risks and people's safety in the home.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inspected but not rated

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 this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check a concern we had about the safety of people living at the service. We will assess the whole key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse

- People who were able to speak with us told us they felt safe. We observed staff interact with people positively.
- However, we found that there had been a number of occasions when people had sustained skin tears or bruising when being supported with personal care. We found that this had happened on more than one occasion. This meant that the required, or sufficient, action had not been taken to reduce the risk of harm to people.
- We also found that people had sustained skin tears or bruising when supported with moving and handling. We found that this had happened on more than one occasion. This also meant that the required action had not been taken or sufficient to reduce the risk of harm to people.
- We also found that at times people had sustained unexplained skin tears and this had not been reported or investigated. The lack of reporting on more than one occasion meant that there were missed opportunities to safeguard people and help reduce the risk of ongoing harm.

Therefore, this was a breach of regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- The provider had been informed at the last two inspections about the concerns relating to the lack of internal recording, reporting of unexplained injuries, and the required statutory notifications. However, we found that this remained an issue at this inspection.

Assessing risk, safety monitoring and management

- People told us that staff were looking after them well.
- We noted that there had been work ongoing to improve safety standards within the home. This included management checks to ensure people were supported with repositioning, drinking, the use of thickener in foods and drinks to aid swallowing and appropriate personal care.
- We saw that there had been some improvement in relation to repositioning and support with eating and drink. However, care plans in places still had conflicted information or writing that could not be read. We also found that there had been occasions when moving and handling and personal care had not been done so safely. This put people at risk of harm or ongoing risk.

Staffing and recruitment

● We received concerns that the home was frequently supported by a large number of agency staff. We were told that the agency staff, and some of the permanent staff lacked the required knowledge of the people they supported. We spoke with staff about people we reviewed and found that they were able to answer our queries.

● The provider had added in an 'at a glance' sheet for all staff that gave an overview of people's risks and needs.

Inspected but not rated

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 this key question was rated inadequate. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check a concern we had about safe management of the service. We will assess the whole key question at the next comprehensive inspection of the service.

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

- The provider had been made aware of the need to ensure they had oversight of unexplained injuries in the home and reported them at previous inspections. We found that there had been further notifiable events that the provider had not notified us about. This lack of reporting meant missed safeguarding opportunities to involve other organisations, such as the local safeguarding authority or the CQC.
- Unexplained injuries or injuries sustained during support from a staff member were not reported by statutory notification to the CQC as required. We spoke with the management team who acknowledged these should have been sent. The management team sent two statutory notifications retrospectively when they were reminded of the requirement.

The failure to submit statutory notifications as required was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- We found that people had suffered skin tears or bruises during personal care and moving and handling. Not all these injuries had been reported internally so that they could be recorded on the internal monitoring system.
- However, even though there were ongoing concerns with the service, the provider had not ensured they had oversight of people's care notes to review for any events that needed remedial action or reporting. In addition, we saw at least one injury on a person that had not been recorded in their care notes. This had not been identified by the provider's current monitoring systems.
- We also found that not all injuries were recorded as being shared with the person's next of kin where appropriate.
- The incident forms were completed to state if an incident was reportable to outside agencies or under the duty of candour. In many cases these were answered as 'No'. We were told by a member of the management team that there should have been controls in place to ensure these were completed and actioned fully, but this had not been done.
- The home was being managed by the deputy manager with support from the providers regional team. Staff were positive about the recent changes and current support. However, there was no registered manager as required under the conditions of the provider's registration. A senior member of the

management team had told us following the previous inspection that a regional manager would be registering as manager to support the home. However, this had not happened.

The lack of effective oversight and governance systems was a continued breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of harm and or abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems failed to identify and address the safety concerns to people.