Four Seasons Homes No 4 Limited

Osbourne Court Care Home

Inspection report

Park Drive
Baldock
Hertfordshire
SG7 6EN
Tel: 01462 896966
Website: www.fshc.co.uk

Date of inspection visit: 07 October 2014
Date of publication: 19/01/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 07 October 2014 and was unannounced. The last inspections of this service took place on 02 May 2014 and 01 September 2014 during which we found the provider was not meeting the requirements of the law in relation to how the quality of the service was monitored. At this inspection we found that shortfalls remained in this area.

Osbourne Court Care Home provided nursing and personal care for up to 69 older people, some of whom may be living with dementia. There were 68 people living at the home when we inspected.

At this inspection we found the service to be in breach of Regulations 9, 10, 11 and 14 of the Health and Social care Act 2008 (Regulated activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The home did not have a registered manager and has not had one since December 2012. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection applications had been made to the local authority in relation to people who lived at Osbourne Court Care Home and may be considered to have their freedom restricted. The provider had acted in accordance with the Mental Capacity Act, 2005 DoLS.

The manager made appropriate referrals to the local authority safeguarding team when needed. However, staff members did not demonstrate that they could recognise the signs of abuse or how to respond to incidents if the manager was not in the home. This meant people were not always safeguarded from the risk of abuse.

Referrals were not always made to health care professionals for additional support when needed in a timely manner. This meant that people did not always receive support from the appropriate people when their needs changed.

We found that people's health care needs were assessed however; people's care was not always planned or delivered consistently. In some cases, this either put people at risk or meant they were not having their individual care needs met. For example, people were not always repositioned effectively in line with their pressure care management plans and people were not always supported to eat and drink enough to meet their nutrition and hydration needs.

The service was not operating an effective recruitment procedure to ensure the right people were employed to provide care and support for people by not checking applicants' work history or validating references.

People who used the service and their relatives told us they felt their privacy and dignity was respected and they made positive comments about the staff team.

The manager investigated and responded to people's complaints, according to their complaints procedure. However, some relatives had told us immediately prior to this inspection, that they were not satisfied with how their complaints had been dealt with.

The manager carried out regular audits and developed action plans. These were reviewed by the regional manager and relayed to the provider. However, we found that where matters of concern had been identified by these audits there had not always been actions taken in a timely manner to reduce the risk of harm for people.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Staff members were not aware what constituted abuse and how they would report any suspicions of abuse.

People's care was not always planned or delivered consistently, specifically with regards to pressure area care and hydration.

Medicines were managed appropriately and people told us they felt safe in the home.

Requires Improvement

Is the service effective?
The service was not effective.

People who needed support and encouragement to eat and drink were not protected from the risks of inadequate nutrition and hydration.

People had access to health and social care professionals.

Requires Improvement

Is the service caring?
The service was caring.

People were treated with dignity, respect and kindness.

The staff team knew the people who lived in the home well and were aware of their individual preferences.

Good

Is the service responsive?
The service was responsive.

People we spoke with and their relatives told us that they had been involved in developing and reviewing care plans.

People and their relatives had regular meetings with the home management so they could express their views about the services provided at the home.

Requires Improvement

Is the service well-led?
The service was not well-led.

The service did not have a registered manager in post.

Systems in place to monitor the quality of the service provision did not ensure that people's health, safety and welfare were promoted.

Inadequate

Osbourne Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012 and to look at the overall quality of the service.

We inspected Osbourne Court Care Home on 07 October 2014, the inspection was unannounced. The inspection team consisted of three inspectors.

Prior to the inspection we requested the provider's information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR had been completed but had not been returned, a copy was provided during this inspection. Before our inspection, we reviewed the information we held about the home, which included incident notifications they had sent us. We contacted the commissioners of the service and healthcare professionals from the district nursing team to obtain their views about the care provided in the home.

Some people who used the service were unable to tell us about their care. Therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who cannot tell us about their care.

During our inspection we spoke with nine people who used the service, three relatives, two members of nursing staff, five members of care staff, two external health professionals, the manager and the regional manager. We reviewed a range of records about people's care and how the home was managed. These included the care plans for six people, the training and induction records for all staff employed at the home, a sample of people's medication records and the quality assurance audits that the manager completed.

Is the service safe?

Our findings

People told us that they felt safe living in Osbourne Court Care Home. Comments included, "I feel safe here, it's a lovely place." Relatives also confirmed that they felt that people were safe living at Osbourne Court Care Home.

However, people were at risk of developing pressure ulcers because the tool used to evaluate the risk had been calculated incorrectly and control measures in place to minimise the risks of people developing pressure ulcers had not been followed. For example, staff told us that additional risks such as people living with diabetes, peripheral vascular disease or anaemia had not been taken into account. We saw that risk assessments advised staff that one person identified as being at high risk of developing pressure ulcers needed to have their position changed hourly. However, we found that the person was often left for four hours in the same position and on one occasion had been left for six hours in the same position.

For a person who had a catheter we saw that the catheter bag was laid on the bed next to them which meant that it could not drain properly as it relied on gravity. This meant that there was a risk of urine not draining properly and potentially causing a urinary infection. We asked staff about this catheter bag and they told us that they thought it should be resting on the bed.

We looked at the care provided to a person assessed as having 'paper thin' skin. We saw that an incident occurred in September 2014 where the person had sustained skin tears to their arm. As a result of this incident staff should have been undertaking daily skin checks. Staff were not carrying out skin checks. The member of staff told us that the district nurse had attended to dress the person's wounds however, there was no record in the person's care notes as to how the wound healing was progressing. This meant that this person was at risk of unsafe care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that staff were unclear about what would constitute abuse and may not be able to identify a person who was at risk of abuse. Staff were not clear how to report suspicions of abuse and how to report concerns externally. For example, a staff member told us when asked about reporting concerns, "I don't have any other choice. I don't know where else to go so I would just forget about it or put an anonymous letter in the suggestion box [located in the main foyer]." Another staff member said, "I am not aware of how to report safeguarding concerns. To go beyond the company [provider] I feel would be a betrayal." This showed that staff did not have the skills and knowledge necessary to promote the safety of people who used the service. However, at this inspection we did not identify any examples where this had resulted in a negative impact for the people who used the service.

Guidance about the whistleblowing policy and procedure was worded in such a way that it could discourage staff from reporting concerns externally. This is a concern in light of the fact that staff did not know how to report concerns externally. The guidance did not include any details of the external agency that dealt with safeguarding matters or how to contact them.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff recruitment process included completion of an application form, evidence of a formal interview, references, identity checks, professional qualification checks and a criminal records check. However, we saw that in most cases where references had been provided they had not included proof or verification as to who had provided them. There were unexplained gaps in people's employment histories, in one case the gap was two years and in another it was 12 years. The manager was not able to confirm that these gaps had been explored with the applicants. This shows that improvements are required to ensure that the provider's recruitment processes are robust and effective.

People who used the service and their relatives shared mixed views with us about the staffing levels in the home. For example, one relative told us, "Staffing levels are frequently not what they should be, that's what we see and staff tell us". They told us there had been occasions when their relative wanted to be repositioned in bed but there were not enough staff available to do this. They told us that this was worse at weekends.

We conducted a period of observation in a lounge area. There were seven people seated in the lounge, five of whom were immobile. There was a period of 25 minutes where staff did not check the lounge to ensure that people were safe.

Is the service safe?

Staff told us that there were usually enough staff on duty to meet people's needs during the week however this was not always the case at weekends. We were told that, "Weekdays staffing is good but weekends are a joke. Sundays are very bad. We rarely start with the right number [of staff". We observed the breakfast service in the home. The staff seemed unhurried and calm; this was reflected throughout the inspection. During the course of the day we heard call bells sounding from time to time throughout the home however, these were answered in a timely manner.

We discussed staffing levels with the management of the home and we reviewed staff rotas. We found that staff absences and staff deployment were not always managed well at weekends and peak times. This is an area that requires improvement.

Medicines, including controlled medicines, were stored safely and kept at the correct temperature. We saw that medicines were administered at people's own pace. There was clear communication between the home and GP surgery when care staff encountered difficulties in administering a person's liquid medications. For example, we saw that advice had been requested about how to administer a person's medication safely. Medicine Administration Charts (MAR) charts were completed correctly and had been coded appropriately to show the reason why any medicines had not been given. This meant that people were cared for by staff that were supported to administer medicines safely and to an appropriate standard.

Is the service effective?

Our findings

People made positive comments about the food provided and mealtime experience. One person said, “The meals are lovely. There are menus and you can choose what you want.” Another person told us, “There is choice of food, menus. If you don’t like meal choices you can have jackets [potatoes], soup, sandwiches or omelettes.”

We saw that sufficient quantities of water and a choice of juice were available in people’s bedrooms and in communal areas on the residential unit of the home. However, this was not the case on the nursing floor, where most people were immobile and were unable to help themselves. For example, we noted instances where people had not had a drink from 5.30pm until 9.30am the next day. We saw three people that had very dry mouths. Records indicated that in some instances people received less than 500mls of fluid a day and no action plans had been developed to ensure improvements in people’s fluid intake. Nursing staff told us, “We just get the care assistants to push fluids and check fluid intake when we do the medicine round.” There was no robust system in place to ensure that those people who were most dependent were given enough to drink to make sure they were hydrated and did not feel thirsty.

Staff on the residential unit of the home told us that where concerns with people's weight or fluid intake had been identified weekly checks were undertaken and a monthly report was sent to the GP for review. We saw that the GP responded with appropriate instruction for staff to follow to provide the appropriate support for people. However, we found that a person accommodated on the nursing unit had lost nine kilograms (kgs) in weight between November 2013 and February 2014 and a further 9kgs by March 2014. We saw another example where a person’s weight had reduced by 14.6kg between November 2013 and July 2014. Records acknowledged the significant weight loss and that people were at risk however there had been no referrals made to a dietician until 29 September 2014. Actions had not been taken to address the reasons for weight loss in a timely manner and no robust plan had been put in place to ensure people had access to a professional opinion and a proper nutrition plan.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives told us that they were aware of people’s care plans and had been involved in developing them.

A recently recruited nurse confirmed that they had received a good induction when they started to work at the home. Other staff confirmed to us that they received training to keep their skills up to date. Staff told us they received supervision however; said that they were not sure that it was frequent enough to be effective. Comments included, “I have had four in two years and never had an appraisal.” Another staff member said they had regular supervision but could not recall ever having had an appraisal.

Where people had capacity to consent we saw that they had signed to indicate their agreement to, for example the use of bedrails to keep them safe in bed and the use of photographs for identification purposes. Where people did not have capacity we found that their next of kin had signed on their behalf.

We saw three Do Not Attempt Resuscitation (DNAR) forms; two had been completed whilst the people involved had been inpatients in hospital. One was competed thoroughly including a record of the discussion with the person; however, a second form had been completed for someone who did not have capacity. This had been signed by the hospital doctor, with the reason for the DNAR. There was no record of any discussion with the person or their next of kin and nothing in the care plan to indicate that this omission had been followed up by the home. This is an area that requires improvement.

We observed the mealtime experience in the residential unit of the home and saw that staff chatted easily with people whilst supporting them to eat their food at their own pace. There were tablecloths, condiments and flowers on the tables with menus that were in clear bold font and detailed the choices available for all the meals throughout the day. People had a choice of cereal, porridge and toast and there was a choice of fruit juices.

We spoke with health professionals visiting people on the residential unit of the home, they told us that people received good care and attention and that staff followed their advice and support plans. They also said staff contacted them in a timely manner when people’s needs changed.

Is the service caring?

Our findings

We received positive comments about the staff and about the care that people received, people told us; “They [staff] are very kind and very nice….they are good to me. All of the staff are very obliging, helpful and nice. I get lots of visits from relatives.” Another person who used the service told us, “It’s a lovely place, like home from home. The staff are very courteous, kind and respectful.”

Relatives were complimentary about the staff team and told us that people were treated with courtesy and respect. One person told us, “Overall the carers are all very good. They know [relative] as a person and treat them as such. By and large [relative] is well looked after, they [staff] meet their needs most of the time, they are good to them.” and another person said, “Staff are quite friendly and very helpful. They treat [relative] with respect, dignity and kindness; I have no concerns.” Relatives told us that they were able to visit with their relatives at any time and that there were no restrictions to visiting hours.

We saw that staff interacted with people in a warm and respectful manner. For example we saw a member of the care staff greet a person in the morning by giving her a cup of tea and a warm friendly acknowledgement. The person responded with a big smile and clearly appreciated the affectionate greeting. We observed care staff speaking kindly with people and being patient if people had difficulty communicating clearly. It was clear that the care staff knew the people who lived in the home well and were aware of their individual preferences.

We heard staff speak kindly and respectfully to people. We heard one care assistant explaining gently to a person who lived with dementia the choices for breakfast and suggesting what they may like based on their usual preferences. We heard staff in a person’s room chatting to them about their photographs and their family. We saw a staff member interacting with a person with limited verbal communication. The staff member bent down to the person's level and spoke very slowly and clearly. The person responded with gestures that the staff member clearly understood. People were communicated with in a way that was meaningful to them.

We saw that staff spoke with people about what was happening in the news and one staff member was telling a person about her kitten, which they were interested in. We observed one person being asked which newspaper they would like to read and whether they wanted to go to their room or sit in the communal lounge. We saw that people were supported to sit where they chose in the dining room. Staff members supported people's choices by moving chairs to where people said they wanted to sit.

We heard care staff informing people that they were going to help them have a wash. Even though the person could not respond, the staff member asked if that was alright. We heard staff involve people who used the service in choices about where they wanted to sit, how they wished to have their medications and what they wanted to eat.

People’s care needs were recorded in a way that expressed their individual wishes and demonstrated their involvement. People told us that they were involved in planning their care and relatives said that they were able to contribute to this process.

The manager told us that there were advocacy services available should anyone require this support. However, there was no information available in the home and staff we spoke with did not have knowledge about how this support could be accessed for people.

During our inspection we saw that a social worker visited to discuss one of their clients who was resident in the home. There was a private room where the social worker spoke with the person’s relative about their continuing care.

Is the service responsive?

Our findings

People told us that they had choices and were involved in decisions about their daily life. A person told us, “I get up earlyish but if I wanted to sleep in I’m sure that would be OK.” And another person said, “The food is excellent. If I said I don’t like it they [staff] would change [it] but I never object. I have heard people say they don’t like the food and they say sorry and change it.”

People we spoke with and relatives told us that they had been involved in developing and reviewing care plans to meet people’s individual needs such as mobility, communication, medication and continence.

There were regular meetings held for people who used the service and their relatives to express their views about the services provided at the home. We noted that these meetings started with the manager’s feedback about actions they had taken in response to previous meetings. These included such areas as lampshade replacement, linen replacement and flooring.

People expressed mixed opinions about the activity provision in the home, some said it was inconsistent. For example, a person told us, “Some days there are enough [activities] to do, sometimes not. We play games, quizzes and watch films. There is an activities board on the wall which lets you know what’s occurring each day.” We saw an entry in the activity diary of a person with limited communication that stated they had been read to. We heard a person ask the staff member responsible for activities to paint their nails, an arrangement for the next day was made to do this.

The activities schedule was primarily arranged around group events such as morning coffee with papers and a chat, arts and crafts, puzzle time and reminiscence and reflection. There was nothing to indicate that people’s hobbies and pastimes prior to living in the home were represented within the schedule.

During a period of observation in a lounge area we noted that there were no care staff in the lounge to ensure that people were content or to interact with people. The television was on but nobody was engaged in watching it and there was no other stimulation provided. During the course of the inspection we did not observe any stimulation being provided for people either in a group or on an individual basis.

People and the relatives we spoke with told us they knew how to raise concerns and issues. They said the manager and staff listened to their views and helped them to sort out any problems. A relative of a person who had lived in the home for some years told us, “I have had a few little grumbles, nothing major, but I always bring it to their attention and things improve.” However, some relatives had told us immediately prior to this inspection, that they were not satisfied with how their complaints had been dealt with.

There was a complaints procedure which was displayed in the home for all to see. We saw that complaints had been managed in line with the policy and mostly resolved to people’s satisfaction. There were three complaints that were under investigation at the time of this inspection. We saw that the organisation's regional management and the local safeguarding team had been involved in the processes.

Is the service well-led?

Our findings

People who used the service told us that they felt they had a voice and that their opinions were taken into account. A person said, "[The home] does have regular residents' meetings. I have never had the need to make any complaints; on the whole I am very happy." Another person said, "[Name] is the manager. They are busy but walk around and he says hello. We have residents' meetings every few weeks. We do have a voice and they [manager] listen. We do get listened to here."

Relatives of people who used the service said, "They do try and involve us. There are relative's meetings and [the provider] send out surveys and questionnaires." Another relative told us, "I emailed a problem to [the provider] regarding some concerns. They responded very quickly and resolved the issues promptly."

When we inspected the service in May and September 2014 we were concerned about the systems used to assess and monitor the quality of the service. At this inspection, we found that there had been some improvements made, but that the systems were still not effective. Where shortfalls had been identified as part of the management team's quality monitoring audits we found that the action plans in place had not proved to be effective. For example, the regional manager's audit of 18 September 2014 had identified that some people on the nursing unit were at risk of poor hydration and that the regional manager considered this to be a 'grave concern'. At this inspection on 07 October 2014 we found that the risk still remained. There had not been any on-going monitoring of the concern by the manager of the home to ensure that appropriate actions were being taken to protect the health, safety and welfare of people.

We found that there were shortfalls in the recruitment procedures which meant that recruitment processes were not robust and effective. This had not been identified as part of the management quality audits which showed these to be ineffective.

Staff did not have the learning outcomes from incidents to support them to provide safe and effective care. Incidents and accidents occurring in the home were reported via an electronic system. Once the nursing staff had reported incidents via this system they had no further involvement. The deputy manager told us that incidents and learning arising from them were discussed at staff meetings however, senior staff we spoke with were unclear about any actions taken and learning outcomes implemented as a result of incidents.

This demonstrated a continual breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home did not have a registered manager and has not had one since December 2012. During the course of the inspection we were told that the manager's registration application had been submitted to the Care Quality Commission and that they had received their fit person interview. However, we were also told that the current manager would be moving to another location imminently and that an experienced interim manager will be taking over the management of Osborne Court Care Home until a permanent person was recruited for the post.

The organisational culture did not support staff to question practice. For example, guidance about the whistleblowing policy and procedure was worded in such a way that it could discourage staff from reporting concerns externally. This is a concern in light of the fact that staff did not know how to report concerns to external bodies. The guidance did not include any details of the external agency that dealt with safeguarding matters or how to contact them.

Staff members told us that the manager was approachable and that they were involved with the running of the home. One person said, "We get the minutes from family and residents meetings so we know what the issues are. We have regular staff meetings where we discuss issues, new ideas, what we are doing well and not so well. I feel we have a voice and are listened to." Another staff member told us, "The managers are very approachable. They will attend 'handovers' to discuss priority issues or will put them on a notice board. We have regular staff meetings." The managers were in the process of sending out surveys to gather staff views. The responses to these surveys would help the managers develop the service.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken the proper steps to ensure that each service user is protected against the risks of receiving treatment of care that is inappropriate or unsafe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person does not have suitable arrangements to ensure that service users are safeguarded against the risk of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person does not ensure that service users are protected from the risks of inadequate nutrition and dehydration.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person does not operate effective systems to protect service users against the risks of inappropriate or unsafe care.**

The enforcement action we took:
A warning notice was issued.