Laudcare Limited

Osborne Court Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 26 October 2015 and was unannounced. The last full inspection took place in March 2015 and, at that time, three breaches of the Health and Social Care (Regulated Activities) Regulations 2014 were found in relation to safe care and treatment, staffing and the need for consent. These breaches were followed up as part of our inspection.

Osborne Court is registered to provide personal care and nursing care for up to 60 people. On the first floor of the home, care is provided to people with living with dementia and is split into two areas. One providing nursing care and the other providing for personal care needs only. The ground floor accommodated people with both personal care and nursing needs. At the time of our inspection there were 36 people living in the home.

The overall rating for this service is 'Requires Improvement'. However, we are placing the service in 'Special Measures'. We do this when services have been rated as 'Inadequate' in any key question over two

Summary of findings

consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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.

There was no registered manager in place on the day 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. The registered manager left the service in May 2014. Since their departure four people have held the peripatetic manager post. The current peripatetic manager had been in post for approximately three weeks and will remain in post until a new permanent manager is appointed.

In March 2015 we found there was an increased risk of the spread of infections; people were not fully protected because appropriate guidance was not being followed. At this inspection the provider had not made sufficient improvements.

In March 2015 we found that people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for storing creams and ointments. Accurate records were not kept of the application of these medicines. At this inspection we found that insufficient improvements had been made.

In March 2015 we found that people were not always safe as there were not always sufficient numbers of suitably qualified and skilled staff to support their needs. At this inspection we found improvements had been made regarding staffing levels. However, staff were not consistently supported through an effective training and supervision programme.

In March 2015 people's rights were not fully protected when decisions were made on their behalf. This was because some people did not have mental capacity assessments completed where they were required. At this inspection insufficient improvements had been made.

People's rights were not being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In some people's support plans we did not see information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty.

Systems were not being operated effectively to assess and monitor the quality and safety of the service provided. We received a number of negative comments from staff, people and their relatives about the management of the service. The main concern was a lack of continuity in leadership at the service.

Summary of findings

The service was not well-led. Despite sending the Commission an action plan advising how they were going to meet the regulations, the provider had not implemented their stated actions. Insufficient progress had been made regarding infection control, management of medicines and the need for consent. We also found an increased number of breaches regarding governance.

The majority of staff demonstrated kind and compassionate behaviour towards the people they were caring for. Staff were knowledgeable about people's needs and told us they always aimed to provide personal, individual care to people. Feedback from people who used the service and relatives advised that the care was good most of the time and the care staff wanted to provide the best care they could.

People had their physical and mental health needs monitored. Care records that we viewed showed people had access to healthcare professionals according to their specific needs.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 always safe.

People were not fully protected from the risks associated with medicines. The procedure for reporting refusal of medicines in the care home medication policy was not followed.

People were not protected from the risk of cross infection. Best practice had not been followed in relation to infection control.

Safe recruitment processes were in place that safeguarded people living in the home.

Requires improvement

Is the service effective?
The service was not always effective.

Staff were not consistently supported through an effective training and supervision programme.

People's rights were not being upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

The provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained.

There was a risk of people not receiving sufficient to eat or drink. There were inadequate checks in place to ensure food and fluid charts were kept up to date.

Requires improvement

Is the service caring?
The service was not always caring.

We observed staff treating people with kindness. However, we did observe that inappropriate language was used and choices about activities were not always provided.

Staff were knowledgeable about people's needs and told us they always aimed to provide personal, individual care to people.

People and relatives spoke positively about the staff and told us they were caring.

Requires improvement

Is the service responsive?
The service was not always responsive.

Requires improvement

Summary of findings

The care plans did not reflect people's individualised needs. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement.

Although the provider had a system in place to receive and monitor any complaints we received comments that they were not always dealt with satisfactorily.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

Is the service well-led?

Inadequate

The service was not well-led.

Since our previous inspection the service had failed to fully implement the actions in their plan to ensure they were no longer acting in breach of the regulations. This inspection identified that the numbers of breaches of regulations has increased.

The feedback regarding the management of the service received from staff members and people we spoke with was mainly negative.

Systems were not being operated effectively to assess and monitor the quality and safety of the service provided.

Where risks were identified, the provider did not consistently introduce measures to reduce or remove the risks to minimise the impact on people within a reasonable timescale.

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

This inspection took place on 26 October 2015 and was unannounced. The inspection was undertaken by four inspectors and a specialist pharmacist advisor.

We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people who used the service were able to tell us of their experience of living in the home. For those who were unable we made detailed observations of their interactions with staff in communal areas. 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 to us.

We spoke with 11 people that used the service, six relatives and eleven members of staff. We also spoke with the peripatetic manager and the area manager.

We observed four staff administering medicines to people during the morning and lunch time.

We reviewed the care plans and associated records of six people who used the service and the medicines administration records for 36 people. We also reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Requires improvement

Is the service safe?

Our findings

At our last inspection in March 2015 we found that people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for storing creams and ointments. Accurate records were not kept of the application of these medicines. The provider sent us an action plan telling us what they were going meet the regulations.

During this inspection we found that insufficient improvements had been made. Medicines were not consistently administered appropriately to make sure people were safe. There were areas of medicines' management which needed improvement. Gaps were found in three people's topical medicine administration charts (TMAR) charts. A topical medication is a medication that is applied to a particular place on or in the body. For example creams, ointment and lotions are applied topically on the skin. A member of staff failed to record the reason why an ointment was refused by one person. The staff responsible for administering people's medicines did not treat administration of topical formulations with care and attention. Reasons were not recorded when medicines were refused and the procedure for reporting refusal of medicines in the care home medication policy was not followed.

There were gaps in one person's medical administration record (MAR) chart for Lantanoprost eye drops. The person needed the eye drops for treatment of glaucoma. There should be no gaps in all completed MAR charts.

We observed three people who were given levothyroxine tablets with other tablets after breakfast. Levothyroxine is a medicine that needs to be taken on an empty stomach or at least 30 minutes before food and should not be taken concomitantly with some medicines that impair its absorption. This meant staff were not following the correct administration instructions.

A nurse dispensed nine tablets and a capsule into a beaker to give to a person. The person took one tablet from the spoon but refused to take the rest of the tablets/capsules despite several persuasive attempts. The nurse experienced difficulty in identifying which tablets were left in the beaker as some of the tablets were crushed in the spoon during administration. She found it difficult to reconcile what tablets were refused by the person, especially so with the small white tablets. The administration of multiple oral medicines in a single container created difficulties when the medicines were compromised. Owing to the medicines being administered in this way there was no way of knowing what medicine had been taken, or refused.

The staff who administered medications were not up-to-date with their medication administration training and this resulted in poor medicine administration practice. The compliance figures were: Monitored Dosage System training 67%, Care of Medicines Advanced 60% and Care of Medicines Foundation 60%.

The medicines were stored safely and the key holders signed in every shift for the keys. The fridge downstairs was out of order and was not used. The senior care worker had reported this to the pharmacy to take forward.

The provider had not ensured that medicines were managed in a safe way. **There continues to be a breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

In March 2015 we found there was an increased the risk of the spread of infections; people were not fully protected because appropriate guidance was not being followed. The provider sent us an action plan telling us what they were going to do to become compliant. We found insufficient improvements had been made.

The peripatetic manager did have a copy of 'Code of Practice on the prevention and control of infections and related guidance 2010' (code of practice). However they had not assured themselves that the systems and practices in place for infection control within the home, complied with the code of practice and guidance for the protection of people who use the service. They did not have an Infection Prevention and Control (IPC) Lead at the service or a similar role to monitor practice. This would involve identifying the risks to the service and taking responsibility for implementing and monitoring actions to manage those risks.

Best practice had not been followed in relation to infection control. Practices in the laundry had not changed significantly since our previous inspection. There continued to be no clear segregation procedures for clean and dirty laundry. The facilities of the room had not changed. Clean linen was being stored in the same areas where dirty laundry entered the room to be separated and washed.

Requires improvement

Is the service safe?

This flow of dirty linen was insufficient to prevent cross infection between laundry items. We observed one member of staff entering the laundry room without personal protective clothing and putting a dirty cloth in the laundry, this presented a risk of cross infection. Following our previous inspection an internal report had been sent to the property manager on the 3 August 2015 to move the washing machines. This work had yet to be approved.

The provider's policy was to provide all staff with infection control training. It was noted that the compliance figure for infection control training was 79%. This meant that not all staff were up-to-date to ensure their practice was current and following the correct code of practice. However, the domestic and care staff we spoke with had an understanding of their role in controlling any spread of infection. The domestic staff knew the right equipment to use and when to use it. We saw the majority of staff using personal protective equipment such as gloves and aprons.

A cleaning schedule had recently been introduced and maintained within the home. Each room had a scheduled daily clean and a monthly deep clean. However, some areas of the home were not free of odours. The peripatetic manager told us this is an area they have worked hard on recently. One person we spoke with did think the environment could be improved and commented; "My room is nice, a few more air fresheners wouldn't go a miss." A housekeeping review conducted by a member of staff on 7 October 2015 also noted that there was not a pleasant aroma throughout the home.

We found no evidence that regular infection control audits had been undertaken to check that safe standards were maintained. We were advised in the provider's action plan that they would be undertaken every three months.

The provider had not ensured that people were protected from the risk of cross infection. **There continues to be a breach of regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The care plans contained risk assessments including ones for mobility, moving and handling and falls. The assessments had been reviewed monthly, but it was not always clear how plans had been amended in order to reflect people's changing needs in relation to keeping them safe. For example, one person had been assessed as being at high risk of falling. Staff had documented when the person had fallen, and incident reports had been completed when this happened. However, although the risk of falling had been noted, the guidance for staff on how to prevent further falls was not clear and did not provide enough detail. On 26 September 2015, staff had documented the person was high risk and staff should "Continue to monitor and assist with mobility" and "Staff to support". There was no detail in relation to how staff should assist with mobility or how they should be proactive in keeping the person safe.

In another person's care plan, staff had also documented they had assessed the person as being at high risk of falling. The person had fallen five times since June 2015, and staff had suggested a referral to a falls clinic, but it was recorded that the GP had decided this was not necessary. The person's medical diagnosis meant they had an increased risk of falling due to poor mobility. The care plan stated that the person should be started on an observation chart, and that staff should check the person every 30 minutes. On the day of our inspection we looked at the observation chart at 14.40 hours and it had not been completed since 07.40 hours. This meant there was a risk the person could fall and staff might not be aware, and that the risk of them falling was further increased because staff could not confirm they knew the person was safe.

At our last inspection in March 2015 we found that people were not always safe, as there were not always sufficient numbers of suitably qualified and skilled staff to support their needs. The provider sent us an action plan telling us what they were going to do to meet the regulations. We found improvements had been made.

The staffing levels were sufficient to support people safely. Staffing levels were assessed by following the Care Home Equation for Safe Staffing (CHESS) dependency tool. The tool determines the level of staffing required whilst taking into account the dependency needs of the people who lived at the home.

On the day of our inspection 21 people resided on the ground floor. The ground floor accommodated people with personal care and nursing needs. 15 people resided on the first floor. The first floor provided dementia care and was split into two areas. One area provided nursing care and the other area provided for personal care needs only. During the day, one nurse, two senior support workers and four support workers were on duty across the two floors. To ensure that sufficient numbers of staff were maintained the service used agency staff.

Requires improvement

Is the service safe?

The peripatetic manager told us that the current staffing levels were in accordance with the assessed dependency needs of the people who used the service. We received mixed comments from staff and people regarding staffing levels. One person told us, “Staff are around to help when I need it.” One relative commented; “There’s been so many changes, different staff, agency staff, different managers I don’t know if he’s safe. He can’t walk now, but back when he could walk, he could have had falls because he couldn’t see where he was going, his bed side light has been broken for so long”. A member of staff told us; “We manage with the staffing level but it’s so stressful.” Other staff members also told us that they thought the staffing levels were manageable but they would benefit from a floating member of staff at busy times. We observed that people received the appropriate support at the correct times such as meal times and medicine rounds.

The provider had appropriate arrangements for reporting and reviewing incidents and accidents. The peripatetic manager and previous peripatetic manager’s audited all incidents to identify any particular trends or lessons to be learnt. Records showed these were audited and any actions were followed up.

Records showed a range of checks had been carried out on staff to determine their suitability for the work. For example, references had been obtained and information received from the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person’s criminal record and whether they were barred from working with vulnerable adults. Other checks had been made in order to confirm an applicant’s identity and their employment history.

Staff we spoke with demonstrated a good understanding of how to recognise and report abuse. All staff gave good examples of what they needed to report and how they would report concerns. Staff told us they felt confident to speak directly with a senior member of staff and that they would be taken seriously and listened to. They also advised that they would be prepared to take it further if concerns were unresolved and would report their concerns to external authorities, such as the Commission.

Staff understood the term ‘whistleblowing’. This is a process for staff to raise concerns about potential malpractice in the workplace. The provider had a policy in place to support people who wished to raise concerns in this way.

Requires improvement

Is the service effective?

Our findings

At our last inspection in March 2015 we found that people's rights were not fully protected when decisions were made on their behalf. The provider sent us an action plan telling us what they were going to meet the regulations. We found insufficient improvements had been made.

People's rights were not being upheld in line with the Mental Capacity Act (MCA) 2005. This provides a legal framework to protect people who are unable to make certain decisions themselves. In some people's support plans we did not see information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for where needed. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. The peripatetic manager confirmed that DoLS applications had been made to the local authority for seven people and there was a need to make the remaining applications. Applications had not been made to the local authority where people were being deprived of their liberty.

Some plans contained mental capacity assessments, and these were reviewed monthly, but they did not always reflect the outcome of the assessments. For example, in one person's record, they had been assessed as being unable to retain information and make decisions and that a relative should be involved but there was nothing documented to demonstrate this had taken place. In another person's plan, staff had documented the person could make simple decisions, but needed support from staff for more complex decisions. Staff had written "Staff to make sure we are doing everything for [person's name] in their best interests". It was not clear if any decisions had been made on behalf of the person of if any best interest meetings had taken place.

Where a person lacked the mental capacity to make specific decisions about their care and treatment, and no lawful representative had been appointed, their best interests were not established and acted upon in accordance with the Mental Capacity Act 2005. This includes the duty to consult with others such as health professionals, carers, families, and/or advocates where appropriate.

On the dementia unit we viewed three care plans and there was little evidence of people's mental capacity being assessed or meetings held to make decisions in their best interests. The current arrangements showed that the staff had not been involving the necessary people such as relatives, representatives and health professionals in best interest meetings. Of the three care plans viewed one plan held no mental capacity assessments. The second plan held no completed mental capacity assessment. However, there was a statement in the Rights section of the care plan which stated; "The family makes decisions on her behalf as she lacks capacity due to dementia". On the third plan a mental capacity assessment had been conducted on 25 February 2015 which stated; "allow to make simple decisions and ensure the next of kin are involved in complex decisions. No guidance was provided regarding the clarification of simple decisions or what sort of complex decisions should be considered on their behalf. We did not view in any of the three care plans that a GP, relevant professional or named family member was contacted to ensure decisions taken were agreed to be in the person's interests.

Some of the staff we spoke with told us they had not received recent training on the Mental Capacity Act. They demonstrated a basic understanding that informed decision making and ability to consent was dependant on people's mental capacity. One member of staff told us "I always give choices with daily things and respect preferences, particularly surrounding personal care." The provider's training statistics also demonstrated that a number of staff had yet to receive Mental Capacity Act training. It was noted that the provider's compliance figure for Mental Capacity Act training was 79%. The peripatetic manager had conducted a recent mental capacity assessment and DoLS audit. The audit identified that mental capacity assessments need to be completed and DoLS applications were needed for the majority of the people who lived at the service.

There continues to be a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not consistently supported through an effective training and supervision programme. Staff we spoke told us they had not received supervisions regularly. This position was reflected in the staff records. A number of staff had only received one supervision this year. The lack of

supervision meant that staff did not receive effective support on an on-going basis and training needs may not have been acted upon. The provider failed to adhere to its own supervision policy which stated that; "Supervision shall take place every eight weeks or six times per year."

New staff undertook a period of induction and the provider's mandatory training before starting to care for people on their own. Staff told us about the training they had received but some modules of their training were out of date; this covered a variety of subjects such as infection control and dementia care. The training records demonstrated that staff mandatory training was out-of-date and required up-dating. An internal audit conducted by the service in September 2015 also identified that training for mandatory e-learning sessions was 63% against the provider's target of 95%. Their internal audit also identified that staff had not completed practical mandatory training sessions and the compliance rate was 56%.

This was in breach Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained. Not all records were completed accurately to manage and ensure that people's on-going needs were met and risks mitigated.

In one person's plan, they had been assessed as being at high risk of malnutrition and dehydration. Although a food and fluid intake chart was in place it was difficult to see whether the person's total intake for the day was being reviewed by staff. For example, the chart showed that on 24 October 2015 the person's total fluid intake was 1050mls. On 25 October 2015 it was recorded as 500mls. The person's care plan did not contain any evidence that staff had escalated concerns about the poor fluid intake. According to the chart on the day of our inspection, at 15.00 hours the person's total intake that day had been 85mls, which meant they were not meeting their daily recommended amount. It was not clear if this was the total fluid consumed, if documentation was inaccurate or how this would be escalated to the nurse in charge. One member of staff said "We would tell the nurse if someone wasn't drinking" and "Sometimes agency staff don't always fill in the charts". This meant there was a risk of people not receiving sufficient to eat or drink because there were inadequate checks in place to ensure food and fluid charts were kept up to date. There was no clear escalation process to follow if there were concerns regarding a person's food and fluid intake.

When people had been assessed as being at high risk of pressure area breakdown, the plans did not consistently inform staff how to prevent this happening. Alongside this, it was not clear if care plans were always being adhered to because people had developed pressure ulcers. In one person's care plan, staff had documented they had "Vulnerable skin, prone to pressure sores". The plan informed staff to ensure the person's skin was kept clean and dry at all times, because incontinence increased the risk of pressure ulcer development. On 6 October 2015 staff had documented the person had "Two extremely superficial wounds to the bottom". The plan stated the person should have their position changed two hourly and should rest in bed to aid the healing process. However, on 25 October 2015, staff had documented "Handed over by night staff that [name of person] had a vulnerable bottom with broken skin. It was found that [the person's name] had a large wound which required a dressing (this was noted during personal care)". The wound was measured and had been documented as being 1.7 cm width and 1.7 cm long. There was no wound care plan to inform staff of the care required to prevent further damage and promote healing. It was reported to the nurse during morning handover on 25 October 2015. When we asked a senior member of staff how the person had deteriorated from "vulnerable skin prone to pressure sores" to the superficial wounds and then to a grade two pressure ulcer 19 days later, they did not provide an explanation. The position change chart had been completed in full during the previous days and indicated the person had had their position changed accordingly but there was no on-going record of the change of the status of the wound. Staff said the person didn't always want to change position, and sometimes refused, but this had not been documented. Owing to the staff failure to record the refusal of the position change this meant that despite risks being identified, people were not always protected and suitable care to meet their needs was not always adequately managed.

This was in breach Regulation 17(2)(C) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Other plans we looked at showed that guidance was followed and the outcome for people using the service was positive. For example, in another person's plan staff had documented three small broken skin areas on their sacrum. A referral had been made to the district nurse, who had visited weekly to assess the wounds and to give advice. Within a two week period the wounds had fully healed.

People spoke positively about the meals; one person told us "I have a choice of food. If I don't like the option they will get me an omelette. At breakfast I had cereal and toast but I could have had a hot choice". Another person told us, "The food is very good. I choose what I want. This morning I decided to have some bacon with my egg on toast and it was lovely." We observed that people had access to drinks all day in the dining room. The chef prepared food at the correct consistency, in accordance with people's needs.

At meal times, most of the people in the dining room were alert, watching everything that was going on and some were chatting amongst themselves. One person did not want their meal even with staff encouragement so staff brought them an alternative. Another person who was falling asleep at the meal table was encouraged by staff to stay awake and eat their meal.

Requires improvement

Is the service caring?

Our findings

The majority of staff demonstrated kind and compassionate behaviour towards the people they were caring for. Most of the staff on duty knew people well. However, on one occasion we observed a member of staff enter the lounge where some people were sitting. The television was on, but nobody was watching it. The member of staff said "Why are you watching this? You normally watch the gossip show" and they changed the TV channel. They did not ask people if this was what they wanted. On another occasion they asked someone "Have you been good today?" This language did not demonstrate respect for the person they were speaking to.

We also saw some interventions that were not thoughtful or caring. The eight people sitting in the dining room at lunch time had their hands washed with wet wipes, before they were served the meals. One member of staff did not explain what they were about to do. They explained as they washed the person's hands. Another member of staff came along approximately five minutes later and washed the same person's hands again.

However, we also observed staff assisting people around the building in a calm manner. They didn't rush people, and offered them choice such as "Where would you like to sit?" A staff member told us; "I love it here; I'm here for the residents". We heard staff giving people choices and not rushing them. One member of staff asked a person "let's look in here; do you want to watch television or would you like to listen to the radio?" and then showing the person a number of compact discs, asking "here you are, which singer would you like to listen to?"

Within people's care plans there was a section for end of life planning. This planning enables people's preferences and choices to be taken into consideration while they are still able to communicate them and for those that matter to them to be involved. However, the end of life plans we looked at had not been completed. Although resuscitation decisions had been recorded, there was no other detail available. This lack of information meant that staff may not know how to manage, respect and follow people's choices when the time arose. The manager told us that the care plans were in the process of being reviewed and transferred into a new care planning paperwork system. The new paperwork should incorporate the appropriate recording of end of life planning.

If they had any concerns people and relatives we spoke with would feel confident to approach senior staff. One relative commented; "If [person's name] didn't like it here I would move him." Mixed comments were received regarding the communication levels between the service and relatives. One relative commented that they had not been approached when their relative was refusing personal care and thought they should have been told. Another relative complained as they were contacted very early in the morning regarding a relative's fall. They thought they should have been contacted at a reasonable hour in the morning and told us that they had informed the service of their preference of when to be contacted.

People and relatives spoke positively about the staff and told us they were caring. One relative told us; "As care homes go she's very happy here. [person's name] likes the staff and they give her a sense of security. The staff are really good and dedicated." Another person told us; "I have no complaints with the staff. They're marvellous. I mostly have the same staff and they're caring and most know what they're doing."

We saw and heard several caring interactions during the day. Examples such as, "Hello, and good morning to you, I've got your breakfast, its Shreddies and toast, is that ok for you?", "How are you this morning?"- the person nodded and smiled back at the staff member. "I'll just go and get your apron so you keep your clothes nice and clean - is that ok?" We saw one member of staff assisting a person with their meal. The member of staff was encouraging, warm, supporting and used a light reassuring touch on the person's arm.

People's privacy and dignity was respected. We regularly observed staff knocking on the door before entering people's bedrooms. We heard the majority of staff speaking with people in a respectful and friendly way. We saw staff walking along side people and sometimes holding their hands. We also heard people and staff holding two way conversations and being fully engaged.

Staff were knowledgeable about people's needs and told us they always aimed to provide personal, individual care to people. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. Staff gave examples of how they gave people

Requires improvement

Is the service caring?

choice and encouraged independence such as; “I assist people by giving them choices. I like to make sure people look nice and wear clothes they like. I talk to families about what people like.”

Requires improvement

Is the service responsive?

Our findings

We found that the care plans did not reflect people's individualised needs. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement.

Some of the language used within the care plans did not reflect a personalised approach and demonstrated a lack of respect for the person. For example, we saw phrases such as "There are times when [person's name] is moody" and "[person's name] will ask for help, what he is gonna do now, or also to go wee".

We observed one person at different times during the day. We saw the person taken from the lounge, back to their bedroom when their behaviour changed. They tried to hit out at a staff member, who responded by saying, "No (name of person), No". The staff told us the person would calm down in their bedroom. The person was transferred from a wheelchair into a recliner chair. Staff told us they didn't use a hoist on this occasion as the person was agitated and the person could stand and transfer safely. We did not hear reassurance given to the person when they were upset. The care plan stated the person should be transferred with the use of a hoist. The care plan stated the person, "Needed reassurance", and "Sometimes behaviour can escalate without warning". ABC charts had been completed on occasions (six times in October 2015). An ABC chart is an observational tool that allows a service to record information about a particular behaviour. The aim of using an ABC chart is to better understand what the behaviour is communicating and incorporate strategies on how best to deal with challenging behaviour. There was no evidence that consistent management strategies had been implemented, monitored or effectively reviewed.

'My life, my preferences' documents had been completed in some of the plans we looked at, but not all. This meant there was a risk that care plans would not always reflect the ways in which people wanted to receive their care and also inform the activities and stimulation that would benefit individuals. We were advised by the peripatetic manager that the documents were 'work in progress' and they acknowledged this was an area of their work which required improvement.

This is a breach of Regulation 17(2)(C) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of our inspection there was no dedicated activities coordinator working at the service. We were told that one activities coordinator was currently on leave and the other person was on maternity leave. One member of the laundry team joined people living with dementia in the afternoon to play cards. We reviewed the activities programme for the week and it lacked mental and physical stimulus. On the dementia unit the programme often only offered one activity throughout the day such as word search, knitting or a card game. We received mixed responses regarding the activities programme. Comments included; "There's enough to do for me. There's activities between two and three in the afternoon in the lounge. There's quizzes and word games, sometimes bingo" and "They're no activities at the weekend. They're not a lot of activities generally. We have cooking and bingo but it's not held every week." One member of staff described the activities as "dismal." The service did not enable people to carry out activities which encouraged them to maintain hobbies and interests and maintain their social skills.

Although the provider had a system in place to receive and monitor any complaints, we received comments that were not always dealt with satisfactorily. The peripatetic manager told us they were not aware of any outstanding complaints. The records showed that two formal complaints had been received this year. The issues of concern of these two complaints were taken forward and actioned. One relative told us they had experienced continual and repeated issues about missing clothing and other people's clothing in their relative's wardrobe. We found no record of this complaint on the complaints file and it was an on-going unresolved concern. They told us they were, "Probably known as a complainer" and they had almost given up because, "Nothing ever gets done."

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

To ensure that their care was specific to their needs staff we spoke with knew how to refer people to external professionals when required, such as a dietician, dementia well-being team or a district nurse.

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Our findings

Since the first inspection in February 2014 Osborne Court has failed to fully meet all the regulations at each inspection conducted at the location. Since the previous inspection conducted in March 2015 the provider had failed to fully implement the actions in their plan to ensure they were no longer acting in breach of the regulations. As well as not implementing the stated actions in the plan we found that the number of breaches of regulations has increased.

The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. This resulted in poor practice across the service. Medicines were not consistently administered appropriately to make sure people were safe. The provider had not assured themselves that the systems and practices in place for infection control within the home complied with the 'Code of Practice on the prevention and control of infections and related guidance 2010' (code of practice) and guidance for the protection of people who use the service. People's rights were not being upheld in line with the Mental Capacity Act (MCA) 2005 which provides a legal framework to protect people who are unable to make certain decisions themselves. Staff were not consistently supported through an effective training and supervision programme. The provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained. Care plans did not always reflect the ways in which people wanted to receive their care and also inform the activities and stimulation that would benefit individuals. It was evident that systems were not being operated effectively to assess and monitor the quality and safety of the service provided. The service did not have a programme of regular audits. The provider's systems had failed to identify all the shortfalls found at this inspection and to implement their actions plans to mitigate future risks.

Examples of areas where they failed to implement the actions stated in their plan included; "Infection control audits will be completed at three monthly intervals until practice is fully embedded; They will work one to one with individuals to ensure that process is followed to make best interests decisions associated with the Mental Capacity Act; An extra 16 hours of an activity coordinator will be in post to enhance the provision of meaningful stimulation and arrange for events to take place."

Since the departure of the previous registered manager in May 2014, four people have held the peripatetic manager post. The high turnover of peripatetic managers has resulted in poor practice and a lack of leadership. The feedback regarding the management of the service received from staff members and people we spoke with was mainly negative. People and staff we spoke with expressed their frustration regarding the change of managers. One relative was not sure who the current manager was, and told us they had lost count of the manager's there had been during the last couple of years. Another relative commented; "I just wished we had a manager that stayed here." Some people we spoke with didn't know who was currently managing the service.

Where risks were identified, the provider did not consistently introduce measures to reduce or remove the risks to minimise the impact on people who use the service within a reasonable time scale. This included for example, the need to address the inadequate laundry room facilities.

People were not encouraged to provide regular feedback on their experience of the service. The previous peripatetic manager held a residents and relatives meeting on 5 August 2015. The minutes demonstrated that concerns were raised regarding changing personnel, no weekend manager cover, lack of activities and laundry concerns. Despite persistent concerns, the issues had not been adequately actioned by the provider.

Staff did not feel well supported and one staff member told us; "It's becoming a joke. We don't know if the [current peripatetic manager] has been appointed. There is no presence." We found no record of regular staff meetings being held. Staff training and supervisions also required up-dating. Since the arrival of the new peripatetic manager they have communicated with staff about the service and improvements that have to be made; such as the need for person-centred documentation.

The peripatetic manager acknowledged that improvements were required regarding their record-keeping and accuracy of records. To ensure improvement is made they had incorporated a care plan audit system. They made recommendations and then

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reviewed the actions had been completed. We saw records that confirmed these audits and recommendations were being taken forward. However, the majority of the files were still in need of a review.

This was a breach of Regulation 17(2)(a)&(b) of the Health and Social Care Act 2008 (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 legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** The provider had not ensured that people were protected from the risk of cross infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** Staff were not consistently supported through an effective training and supervision programme.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** The provider had not ensured that medicines were managed in a safe way.

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** People's rights were not being upheld in line with the Mental Capacity Act (MCA) 2005.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(a)(b)&(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** The provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained. The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service.

This section is primarily information for the provider

Enforcement actions

Where risks were identified, the provider did not consistently introduce measures to reduce or remove the risks to minimise the impact on people who use the service within a reasonable time scale.

The enforcement action we took:
Warning notice