Osmaston Grange Care Home Limited

Osmaston Grange

Inspection report

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Date of inspection visit:
03 September 2020

Date of publication:
16 October 2020

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Osmaston Grange is registered to provide personal care, nursing care and accommodation for up to 80 people across two buildings. At the time of the inspection only one of the two buildings were open , providing accommodation and personal care to people either on a permanent basis or for short-term care. Nursing care is no longer provided at Osmaston Grange. On the day of our visit 30 people were using the service.

People's experience of using this service and what we found

We found some concerns in relation to the services practices in keeping people safe and in providing oversight. Risk assessments had not always been updated when people's needs changed, and this had an impact on their care. Some people had inappropriate footwear, and this placed them at risk of falls or damage to their feet. Lessons were not always learnt or shared with staff following safeguards or incidents.

People received their medicine; however, we noted some recording and stock errors which had not been identified by the providers audit. We also identified a delay in the ordering of topical creams. Other audits had not identified the areas within the home relating to infection control or safety in relation to the homes flooring or equipment.

Polices used by the provider had not incorporated national guidance about the national pandemic. The provider shared with us their specific policies around this area, however not all the updated guidance had been included or implemented within the home.

Infection control measures had not always been followed in line with Covid 19. This related to inappropriate face coverings, areas for changing and the guidance in relation to visitors.

Staff felt there was an open culture they were able to speak with the registered manager and felt listened to. However, we received a mixed response from relatives. Some felt the care met their relative's needs, others felt the communication and care needs required some further development or direction from the management.

Staff were aware of the importance of identifying and recording any safeguarding incidents and these had been investigated. There were enough staff to meet the people's needs and appropriate recruitment processes were in place.

The provider had notified us of any events which had occurred at the service and we saw the last inspection rating was visibly displayed within the home.

The provider had worked with relevant health care professionals and developed a positive relationship in meeting people's needs.

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

Rating at last inspection. The last rating for this service was Good (Published 11 February 2019)

Why we inspected
We received concerns in relation to safeguarding people and about practices in relation to Covid within the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.
You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation safe care and treatment and the governance oversight at this inspection. We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection

Follow up
We will request an action plan from the provider and meet with them following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Osmaston Grange

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 Care Act 2014.
As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
One inspector and an assistant inspector were on site. An Expert by Experience completed telephone calls to family members off site. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Osmaston Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
We gave a short period notice of the inspection because we required some information before we entered the home to assess risks related to Covid-19. This information was provided promptly.

What we did before the inspection
We reviewed information we held about the provider and liaised with other health and social care colleagues. We used this information to plan our inspection.On this occasion we did not ask the provider to

complete the required Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make.

During the inspection
Our expert by experience contacted ten relatives. We spoke with five members of staff including the cook, deputy and registered manager. We reviewed a range of records. This included four people's care records and multiple medicines records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk people could be harmed.

Assessing risk, safety monitoring and management, Preventing and controlling infection,

- People were not consistently protected from risks associated with their care and support. Risk assessments had been completed to reduce risks, however some people's care needs had changed and these changes had not been followed up with an updated risk assessment. Therefore, staff were not aware of the action they needed to take. For example, one person required support to reduce their sore skin by being repositioned on a two-hourly basis, however their records showed this should be completed every four hours. This placed the person at risk of further skin damage.
- Prescribed skin creams were not always available for use. We identified that some people required cream which had not been replaced when finished and new cream had not been followed up. This placed people at risk from not receiving the right cream to treat their skin conditions effectively.
- Some people had inappropriate footwear, this placed them at risk of falls or damage to their feet.
- Staff were not always following the latest guidance in relation to Covid 19. We saw that not all staff used an agreed standard of face covering. Online training had been provided in relation to Covid 19, we found not all the staff had completed this and those who had completed it, had not had their understanding reviewed to ensure their competency.
- The environment did not promote good infection control. Some areas of the home had not been deep cleaned following the departure of some people who had used the service. Areas identified for the putting on and taking off personal protective equipment (PPE) were cramped. The area contained a broken pedal bin and a 'used' PPE bin, which was overflowing with used PPE, which had not been consistently emptied when needed. This increased the risk of infection spreading.
- The latest government guidance in relation to visitors to the home had not been followed. For example, visitors did not complete a Covid-19 health check questionnaire, have their temperature taken and were not supported to consistently use face coverings. This meant that people were not protected from the risk of infection.

We found people were not always protected from the risk of harm, injury or an acquired health infection. This was a breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection in respect of improving their infection control measures at the service.

Learning lessons when things go wrong

● Lessons had not always been shared with staff following safeguarding incidents. For example, to ensure people received safe support with meals and snacks.
● We found other areas had been reviewed, in relation to pressure care. Some staff had received additional training. However, further improvement was needed in this area, as we found some staff didn't realise the importance of pressure relief or the importance of applying prescribed creams.

Using medicines safely
● People received their medicine is a timely way. For example, when medicine was required before food or for the person to be sat upright for a period of time, staff knew the importance of this.
● Medicine reviews had been completed so that people received the minimum medicine to manage their health condition.
● Where people had struggled to swallow tablets, these had been changed to a more manageable way of the medicine being taken.
● Some people required medicine on an as required basis, and we saw this was recorded when administered. Where the medicine was for anxiety, we noted staff used distraction technics to reduce the need for medicine.
● We found some incorrect stock amounts and some recording errors. Which meant that there was a lack of effective monitoring and safety checks for people's medicines. We have referred to these in the Well Led section of this report.

Systems and processes to safeguard people from the risk of abuse
● Staff knew the importance of identifying and recording safeguarding incident or any situation which may cause harm.
● Training had been provided to all the staff, this included those who were not directly involved in care, for example, the cook, domestic staff and the maintenance person.
● We saw that when safeguarding incidents had been raised, they had been investigated, however the outcome of these had not always been shared with staff. The registered manager told us they would address this area.

Staffing and recruitment
● At our last inspection in January 2019 we found that the service had not ensured there was enough staff available to support people at meal times. At this inspection we found that improvements had been made and enough staff were available to support people to eat their meal in a timely way.
● There were enough staff to support people's needs, this was supported by comments from relatives and staff. The registered manager demonstrated how they used a care dependency needs assessment tool to calculate the number of staff members needed to provide people's care. This detailed the number of staff needed to support people and their related care needs.
● We saw staff respond to people's needs and checked on people in a timely manner.
● Recruitment processes were robust. Records showed that staff had been recruited safely to ensure they were suitable to work with people.

Requires Improvement

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- There was a lack of consistency in how the service was being managed. Audits had been completed, however; they had not always identified the areas for improvement or change when needed. For example, the medicines audit had not identified potential medicines errors or areas of unsafe medicines practice, which we found at this inspection.
- The infection control audit stated that the carpets were in good repair, however we found the lounge carpet to be uneven and not safely fitted, which was a potential trip hazard. The audit also reflected people had their own slings to use with any hoist equipment that needed to be used to help people move safely when needed. However, we found some slings were used repeatedly for different people and not cleaned in between usage. The sharing of slings places people at a higher risk of infection.
- Care plan reviews had been recorded as 'completed', however not all these had identified the most recent changes in people's needs This meant information had not been shared with staff to ensure these changes were implemented.
- The provider policies had not encompassed up to date Government guidance in respect of the pandemic. We reviewed the specific policies shared with us by the provider and noted they did not always include the latest guidance or ensure that it was being followed in the service for people's safety.

The provider did not consistently operate effective systems to proactively ensure the quality and safety of peoples' care. This meant people were placed at increased risk of harm, injury or infection. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They confirmed action had been taken in relation to infection control measures linked to the required guidance. They had also replaced the carpet in the lounge area.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had not always been open and transparent with people. We saw when a safeguarding incident had been raised, the registered manager had not always shared the outcome with the person's

relative; or with staff to help prevent any re-occurrence.
● The registered manager provided us with the required notifications following any events or incidents within the service, to help us monitor people's safety.
● The provider had displayed the latest inspection report within the home. We noted the providers website was not up to date, so we asked the provider to address this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics,
● There was a mixed response from relatives in relation to the communication about people's care from the provider. Some felt they received enough information, others felt there could be clearer information and better opportunities for them to obtain information or give their feedback.
● Information in relation to visiting during the Covid pandemic was not in line with current guidance and this meant relatives were not aware of the required safety measures for visiting or how to make contact with family. There were limited alternatives offered to support people's contact with their relatives in respect of using technology opportunities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff felt they were listened to and could approach the registered manager or the provider.
● The interactions we observed with people from staff, were person focused and showed staff had a good understanding of the person and their individual likes or characteristics.

Working in partnership with others, Continuous learning and improving care
● Relationships had been established with relevant health care professionals to inform the care of people with long term health conditions.
● We saw how relationships had been maintained throughout the pandemic. When professionals had visited, entries in the care logs had been recorded to reflect any required actions.
●The registered manager had used the results of their falls audit, to inform and make improvements to people's safety related care needs. For example, using the information to identify any patterns or trends. We saw sensor mats were in place and referrals were made to relevant health professionals to obtain further guidance to reduce the risk of people falling. However, some areas had not been identified in relation to uneven floors or poor fitting footwear.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people were safe from the risk of pressure care and the risks relating to infection control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have established systems and processes to ensure the safety and measures were used to drive improvement. Communication with people using the service and those important to them had not always been established to share how the home was being managed and the level of care.