Four Seasons Homes No.4 Limited

Osbourne Court Care Home

Inspection report

Park Drive
Baldock
Hertfordshire
SG7 6EN

Tel: 01462896966
Website: www.fshc.co.uk

Date of inspection visit:
16 March 2022
31 March 2022

Date of publication:
10 May 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Osbourne Court Care Home is a residential care home providing accommodation with personal and nursing care to up to 69 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 34 people using the service.

Osbourne Court Care Home accommodates up to 69 people in one adapted building over two floors.

People's experience of using this service and what we found
People's safety was not always well managed. We saw records had missed entries in regard to repositioning and the use of thickener in people's drinks. We also found that fire drills were not fully completed and records to be used in the event of a fire were not accurate.

Infection control practices were in place and staff knew what they needed to do. However, we were told by relatives and professionals, and we also observed, staff did not always wear PPE appropriately. The service was experiencing another COVID-19 outbreak.

Medicines were not always managed safely. We found minor shortfalls on the day of our visit. However, the local authority had been supporting the home with medicines and had identified a number of significant concerns. These were reported as safeguarding concerns.

The management systems in the home were in place, however had not been effective to address the shortfalls. There were mixed views from relatives and staff about the management and leadership in the home. There was ongoing work since our last inspection and the local authority had also raised concerns for the service to work through. We found that there had not been enough improvement and as a result people were at risk of harm.

Lessons learned were recorded and actions implemented. However, progress was slow. The management team told us that there had been several areas to work on, but they were committed to making the improvements. There had been work done to develop relationships with visiting health and social care professionals and they were keen to work in partnership with them.
People told us that their needs were met, and staff were nice. They told us they felt safe. Relatives gave mixed views about the standard of care but also told us staff were friendly. Concerns mainly related to staffing levels and lack of permanent staff in the home and they said this impacted on people's care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. We observed staff supporting staff in a way they liked and offering choice. We also saw that there was work ongoing in relation to mental capacity assessments and best interest decisions. However staffing shortfalls at times hindered people's experiences.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 10 September 2021).
We imposed conditions to help drive improvement at the last inspection and the provider has been providing us with their improvement plans in accordance with the requirements of the conditions.

At this inspection we found there was insufficient improvement and the conditions remain in place.

Why we inspected
We received concerns in relation to staffing, unsafe care and the environment. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Requires Improvement to Inadequate based on the findings of 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 COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
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. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing, notifications and governance systems at this inspection.

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Osbourne Court Care Home

Detailed findings

Background to this inspection

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

Service and service type
Osbourne Court Care Home 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.

Registered manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.
At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 16 March 2022 and ended on 7 April 2022. We visited the location on 16 and 31 March 2022.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
We spoke with three people who used the service and received feedback from five relatives about their experience of the care provided. We spoke with 12 members of staff including the regional manager, registered manager, deputy manager, nurses, care workers, agency care workers, housekeepers and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included five people's care records and multiple medication records. 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.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to manage the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● There were individual risk assessments in place for people and these were reviewed monthly. However, at times the information did not link through the whole care plan. For example, one assessment said a person was low risk of choking and another page stated they were medium risk. This meant that staff could review the wrong page and give a person unsafe care.
● We noted that there were some instances where people had not been repositioned as needed. For example, some people had no entries relating to repositioning since the previous day. This placed people at increased risk of developing a pressure ulcer.
● One person's risk assessment stated that that due to being medium risk of choking they must be supervised when eating. However, the person's room was at the end of a corridor and we observed them alone with a sandwich and no staff were available to check on them.
● For people who had their drinks thickened, there was information available for staff to do this safely and staff were aware of who needed this. However, we noted there were gaps in records about the use of thickener, so we were unable to tell if this was used consistently as required.
● Fire safety checks were carried out. However, some staff told us they had not taken part in a fire drill. We reviewed the fire drill training records and found 15.7% of staff had not attended recent evacuation training and 15 of the 36 staff had not attended a recent fire drill. We also found that not all agency staff working in the home had been through the fire and evacuation procedures. Staff knowledge around fire safety was an area identified as an area for improvement at the last inspection and this had not been satisfactorily addressed.
● The emergency evacuation bag did not have the correct amount of people recorded on the resident's occupancy list. There was one person missing from one unit and an additional person on the other unit. This had not been reviewed weekly as required. This meant that in an emergency they could not be sure they had safely evacuated everyone living in the home.

Preventing and controlling infection
● We were not assured that the provider was using PPE effectively and safely. We observed two staff members with their masks below their chin. They adjusted them when they saw us. Feedback from the local

authority was that they had also witnessed masks below staff member's chins. A relative told us, "I have spotted a mask be pulled down a couple of times." This was a concern as it had happened on many occasions and the home was experiencing another COVID-19 outbreak. We were also told that sometimes staff go from room to room without using the PPE in line with current guidance.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Relatives told us checks were carried out when they visited. However, we were let into the building by a staff member who did not carry out any checks, such health checks, to ensure we were safe to enter. The local authority team advised that staff had not checked them on every visit either.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. However, there was no risk assessment in place for people with a positive result for their bedroom doors being open.

Due to people's safety not being consistently promoted through safe care and robust infection control, this continued to be a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● People and relatives told us that visiting was happening when the service was not in a lockdown for an outbreak of COVID-19. Following the day of our inspection we were advised that the home had gone into a lockdown. One relative was concerned that visiting would stop completely. The registered manager gave assurances that relatives who were essential care givers or those with a family member at the end of their life would still be able to visit.

● The registered manager also said that outside visits and window visits could continue. However, we noted that for those who were cared for in bed, particularly upstairs would struggle to have these visits if staffing issues prevented them from being facilitated.

Staffing and recruitment

● At our last inspection we raised concerns about staffing levels and deployment in the home. At this inspection we found that there remained issues with staffing in the home.

● People and relatives told us that staff were kind and attentive but at times they needed to wait for support. When asked if there were enough staff to support their family member one relative said, "Definitely not. A case in point here is that [person] only receives, on average, one shower and hair wash a week. The rest of the time wet wipes are used to clean them. This is not hygienic. Without this basic requirement not being met, infections occur which could have been avoided. This is totally unacceptable. I have had to clean her myself on many occasions due to the lack of staff at the time."

● Staff told us that they were very dependent on agency staff and at times this impacted on people. One staff member said, "The other day I came in and people hadn't been repositioned all day." However, they went on to say that when the shift was staffed with permanent staff, people had their needs met well. Another staff member told us, "I am often on my own with all agency staff."

● We saw that the staff were busy moving from one person to the next. While the permanent staff were friendly and chatty when supporting people, they did not have time to spend time with people outside of

care tasks. We saw that they led agency staff and needed to instruct them in all tasks. This meant often agency staff members were following them rather than assisting people unsupervised. This meant people waited longer for assistance.

● We discussed this with the management team. They said they introduced allocation and handover sheets which gave agency staff clear guidance on how to support people. We asked for a copy of this to be shared with us. However, this did not include who was at risk of choking or mobility information for most people. We also noted that one person was noted to need encouragement with personal care. We saw them in bed with their trousers and underwear around their ankles, and a strong smell of urine, for over three hours. The registered manager told us they were unwell and had been refusing care. However, there was no record of these checks in their care notes.

● We also raised the point about the number of people being supported in bed. Staff told us they had not been able to provide their personal care yet. This had also been a theme throughout local authority and visiting health professional visits. The registered manager told us that this had improved. However, we could not be assured that this would be consistently achieved.

● The registered manager advised that they were still admitting new people to the home. We queried this due to the ongoing staffing issues at the home. They stated that they only admitted people who they had assessed as being able to meet their needs. However, this added the risk of increased pressure on current staffing levels as there were already shortfalls in care provision.

There were insufficient skilled staff deployed to effectively meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated activities) Regulations 2014.

Using medicines safely

● The registered manager had asked the local authority to support the home. The registered manager was planning on completing work to improve the use of medicines prescribed to be taken when needed, and ensure the system was working safely.

● The local authority made us aware of concerns in relation to the management of medicines. As a result, safeguarding referrals had been made. These concerns related to missed medicines, over sedation, required medicines not being in the building and covert medicines procedures not being followed.

● We reviewed a sample of medicines on the day of our visit. Most of the medicines we reviewed were correct, one had a missing signature. Medicines were stored securely, however a member of agency staff had left the keys in the medicines trolley within the locked room.

Systems and processes to safeguard people from the risk of abuse

● People and most relatives told us they felt they were supported safely. One relative said, "I think [person] feels safe and I know standard things like medication and food are always good." However one relative told us they felt their family member was not safe as the staff did not support them well with their complex needs. We are following up on this concern.

● Training relating to safeguarding people from abuse had been provided and information was displayed. However, not all staff were able to tell us how they would report concerns relating to risks of abuse externally.

● The management team had not always reported to us allegations of abuse raised by the local authority. We were made aware about the concerns from the local authority.

Learning lessons when things go wrong

● The management team told us they reviewed all events and incidents to see if there was any learning to take from them. The registered manager told us that they shared this with staff through meetings and supervisions. Some staff confirmed learning was shared with them.

● There was a lesson learned form to be completed after events and incidents which captured actions taken as a result. The registered manager sent us an example of the form completed. This related to the mealtime experience. They told us these were actions they were implementing now following a recent safeguarding issue, mealtime audits and there being a new chef. We met the new chef and they told us about the plans that were due to start.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Inadequate. At this inspection the rating for this key question has remained Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

● At our last inspection we found the service to be in breach of regulation 12 and 17. There were failures to promote people's safety and this was not identified or addressed within the provider's governance systems. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● Following our last inspection, we imposed conditions on the provider's registration to help them improve and keep people safe. The conditions required the provider to ensure staff were trained and competent in risk areas. These conditions included fire evacuation, moving and handling and choking. They were also required to report to us monthly. This monthly report did not reflect the shortfalls we identified on the inspection.
● At this inspection, while we found that they have met some aspects of the conditions imposed by us, there were insufficient improvements to fully meet the conditions. As a result, care provided continued to not be provided in a consistently safe way in addition there were increased concerns relating to staffing.
● There were governance systems in place, but these failed to address the shortfalls. Action taken had not ensured staff worked safely and people always had their needs met. This placed people at increased risk of harm.
● The management team were sharing findings from their audits and checks with staff. They explained the implications of not working within guidance and regulations. However, even though they had been aware of issues within the home, action they had taken had not been effective to address the shortfalls. For example, in relation to fire safety, repositioning people at risk of pressure damage and the lack of consistent staffing within the service. We continued to have concerns about safety and management of risks.
● Most staff told us that the management team were often in the office and rarely gave support and guidance in the home. They stated they did not provide physical support when staffing levels were low or when trying to embed a good culture in the home.

● Some relatives felt standards of care needed to be improved. They told us how staffing and lack of standards had impacted on people's care and welfare. There were also concerns from people and relatives about the lack of activities and stimulation for people. Many people who were cared for in bed had little interaction and people living with dementia sat in the lounge with no supervision and a TV. The management team told us they had been trying to recruit an activities organiser since August 2021 and they had planned some events, However, these were few and far between and there was little consideration of how the lack of things to do on a daily basis could be addressed while waiting for new staff to start.

There were continued issues within the governance and management of the home, and this impacted on people's safety, wellbeing and staffing. Not enough work had been done to improve the standards of care and systems in the home. Therefore, this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● We found there had been events in the home that were notifiable. For example, safeguarding referrals and broken-down heating. We had not received these statutory notifications. The registered manager told us they would send them retrospectively.

Failure to send the required statutory notifications is a breach of Regulation 18 of the Registration Regulations 2009.

● Following the previous inspection, a new registered manager and a new deputy manager were appointed. Feedback from people, relatives and staff about this management change was mixed. One relative said, "I know who the manager is. They have always dealt swiftly with concerns and keep us updated on visiting issues if someone has COVID-19. I like the management very much." One staff member said, "I feel sorry for them, there is so much that needs to be addressed."
● Some staff felt that their approach could be improved. They said there was a fear of speaking up as the management team were intimidating. Professionals involved with the service gave mixed views.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The management team were aware of areas that needed to be improved to ensure care provided and people's experiences were consistently to a good standard. They were working through action plans that had been developed. This included training and guiding staff and carrying out additional checks.
● However, some observations we made, and some relative feedback was that there was still some way to go before care was always at an acceptable level. One relative said, "I feel that it could be run better, but this would only happen with more staff. The current staff spend more time completing paperwork than actually 'caring' for the residents. This is not their fault, but it is something that they have to do. At the moment [due to the lack of staff] and from what I have seen, this is more of a 'tick box' attitude than a 'caring' one."
● We did observe permanent staff to be attentive and committed to providing good care for people. One staff member said, "I care about these residents, the permanent staff team are thorough."
● Some people told us that members of the management team checked with them to see how things were going.
● The registered manager told us that they had been working on engaging with relatives more. Relatives told us that they had not found this to be the case as the registered manager was so busy but told us they were confident to speak up if needed. One relative said, "When [registered manager] first arrived she initially kept everyone informed with a weekly newsletter about things going on in the home. Unfortunately, due to the amount of other work [registered manager] is currently having to do to improve the home, these are only

coming out every three to four weeks. I feel that I can discuss my concerns with her, but she is always very busy." Another relative said, "They don't ask for feedback but know they would happily accept it. It's pretty well run."

Continuous learning and improving care

● The management team shared findings from audits and inspections with the staff team to help raise awareness and address the areas in need of improving. For example, record keeping and the mealtime experience.

● The registered manager had requested input from the local authority to help drive and sustain improvements in their medicines systems. As a result, areas of concern were identified, and they had set about making the changes.

Working in partnership with others

● The registered manager had linked in with a local care provider's association to help support recruitment and provide training opportunities.

● The provider was working with the local authority to help address shortfalls they had identified in the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to ensure that the required notifications were sent to us.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people's safety was consistently promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that their governance and management systems identified and addressed shortfalls in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People did not always receive appropriate and timely support as staffing in the home did not meet people's needs.