Vauxian Hotels Limited

Osborne Lodge Rest Home

Inspection report

30 Osborne Road
New Milton
Hampshire
BH25 6AD

Tel: 01425618248
Website: www.osbornelodgecare.co.uk

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23 January 2019

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Osborne Lodge is a care home without nursing. It is a family run care home offering accommodation for up to 34 older people living with a range of health and social care needs. A small number of people were living with dementia. People in care homes receive accommodation and their care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. This inspection took place on 21 and 23 January 2019 when there were 25 people using the service.

In this report the name of a registered manager appears who was not in post and not managing the regulatory activities at this care home at the time of the inspection. Their name appears because they were still registered as manager on our register. A new manager had been appointed in November 2018 and has applied to the Care Quality Commission to become registered. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

At our last inspection we rated the service as overall 'Requires improvement'. This was because staff had not been consistently deployed in such a way as to ensure that people received their care safely and in a timely way. Some further improvements were needed to the records relating to people's care and support and to embed robust management arrangements. At this inspection, our findings continued to support a rating of 'Requires improvement'.

Some records relating to people's care continued to be incomplete or inaccurate and were not stored securely. Whilst there were systems in place to monitor and assess the quality of service, these were still not being fully effective in delivering all the improvements needed to achieve a rating of 'Good'.

Whilst people received their medicines as prescribed, there were shortfalls in relation to how some medicines were stored and some medicines records were incomplete or inaccurate.

We were not consistently able to ascertain what action had been taken to mitigate new or developing risks or in response to incidents or accidents.

The provider had made improvements which ensured that there were now consistently sufficient staff deployed to meet people's needs.

Overall, staff had received the training and support they required to meet people's individual needs. A number of staff did not have up to date safeguarding training, but they were able to demonstrate an understanding of how to identify abuse and to explain the actions they would take if they identified any concerns. The manager is arranging for this training to take place.

Staff felt well supported by the leadership team and had been receiving periodic supervision and an appraisal to check to they understood how to perform their role and responsibilities effectively.

People were supported to maintain their health and well-being and had access to a range of healthcare services when they needed them.

People were treated with dignity and respect and staff were kind and caring in their interactions with people. People received care that was centred on them as an individual.

Friends and family could visit their family members at any time. They were confident they could raise concerns or complaints and these would be dealt with.

People were positive about the activities provided. Plans were in place to develop these further, including in the wider community.

Families told us that people were supported to have a dignified and pain free death. We have made a recommendation about further developing end of life support planning.

Staff were positive about the new manager. They told us morale was improving and that they felt more positive about their role.

The service worked in partnership and collaboration with other key organisations to support care provision and joined-up care.

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.

We were not consistently able to ascertain what action had been taken to mitigate new or existing risks or in response to incidents or accidents.

Whilst people received their medicines as prescribed, there were shortfalls in relation to how some medicines were stored and some medicines records were incomplete or inaccurate.

The provider had made improvements which ensured that there were now consistently sufficient staff deployed to meet people's needs.

The home was visibly clean and tidy and there were no malodours. Overall, staff were observed to follow good infection control measures.

Staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them.

Is the service effective?

Good

The service continued to be rated good.

Is the service caring?

Good

The service continued to be rated good.

Is the service responsive?

Good

The service continued to be rated good.

Is the service well-led?

Requires Improvement

The service continued to be rated as requires improvement.

Some records relating to people's care continued to be incomplete or inaccurate and were not stored securely.

Whilst there were systems in place to monitor and assess the

quality of service, these were still not being fully effective in delivering all the improvements needed to achieve a rating of 'Good'.

Staff were positive about the new manager. They told us morale was improving and that they felt more positive about their role.

The service worked in partnership and collaboration with other key organisations to support care provision and joined-up care.

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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 checked 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.

The inspection was unannounced. On the 21 January 2019, the inspection team consisted on one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the 23 January 2019, the team consisted of an inspection manager and an inspector.

We had last requested a Provider Information Return (PIR) in June 2018. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection, we reviewed this PIR and all the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with ten people and two people's relatives. We spoke with five care staff, the activities coordinator, the manager and deputy manager and the provider. We also observed people interacting with staff. Following the inspection, we received feedback about the service from two community health and social care professionals.

We looked at care plans and associated records for four people. We reviewed other records including a range of audits, accident and incident forms, staff rotas, five staff files, supervision and training records and records of medicines administered to people.

Requires Improvement

Is the service safe?

Our findings

Whilst people told us they felt safe living at Osborne Lodge we found mixed evidence with regards to the effectiveness and safety of some elements of risk management.

We were not always able to ascertain what action had been taken to mitigate new or existing risks or in response to incidents or accidents. For example, one person had lost a significant amount of weight over the last three months, but we were unable to ascertain what had been done in response. We discussed our concerns with the manager and since the inspection, the person has been reviewed by their GP, offered a fortified diet and a programme of weekly weight monitoring has been put in place. Staff were monitoring the food and fluid intake of another person. The records relating to this were not consistently completed and this limited their effectiveness as a monitoring tool aimed at managing the risk of poor nutrition. One person was experiencing swallowing difficulties and had been assessed as needing a modified diet. Information relating to this was inconsistent. The manager has subsequently taken action to update this person's care records.

People's care plans contained a range of risk assessments. For example, if they had been identified as having a high risk of falling, a falls risk assessment was in place. There was evidence that following falls, staff had referred people to external agencies for guidance and support such as falls prevention teams. The manager was also re-implementing additional records to more clearly demonstrate what follow up actions, or monitoring, was undertaken following a fall, which help to ensure that the person's condition has not deteriorated. Nationally recognised tools were being used to assess people's risk of skin deterioration or poor nutrition. People also had basic care plans in place to provide guidance for staff on how to manage risks associated with health conditions such as diabetes and epilepsy. The service had a system to record and analyse any accidents or incidents to help identify any trends or themes.

The service was caring for a small number of people who would be at risk were they to leave the premises without assistance. We were concerned that the security of the premises was not currently adequate to safeguard these people and have asked that further risk assessments be completed in relation to this and action taken where necessary. Since the inspection, the manager has confirmed that additional security measures are being put in place starting on 4 February 2019. The risk assessment for the open stair case did not fully reflect all of the potential risks that might occur. We have asked that this be reviewed.

Whilst some checks and water sampling were taking place to assist with the effective control and management of Legionella bacteria, the risk assessment in place was not robust enough and did not provide assurances that all the required checks were taking place. We have asked that this be reviewed and the new risk assessment shared with us.

Other health and safety checks were carried out to make sure the building and equipment within it were maintained and serviced as required to make sure people were protected. These included regular checks of fire safety, gas and electrical systems. Each person had a personal emergency evacuation plan (PEEP) which detailed the assistance they would require for safe evacuation of the home. The provider also had a

business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service.

Whilst people received their medicines as prescribed, there were shortfalls in relation to how some medicines were stored and some medicines records were incomplete or inaccurate. For medicines which were kept in boxes rather than a monitored dosage system, commonly known as a blister pack, staff maintained a running balance of the remaining stock on the person's medicines administration record (MAR). This is important to maintain effective stock control and helps in identifying any discrepancies or medicines errors. We identified a number of instances where this stock balance was incorrect. Checks showed this to be a recording error.

When undertaking a spot check of the controlled drugs (CDs) kept within the service, we found that one controlled drug being stored in the CD safe was not recorded in the CD register and was therefore not accounted for anywhere within the service. Most medicines were stored in a locked medicines room for which the temperature was being monitored daily. However, a second trolley was stored upstairs in a corridor. The temperature of this was not being monitored. This is important to ensure that the medicines remain effective. A number of MARs had been handwritten, but had not been countersigned by a second staff member to check for accuracy and in line with best practice guidance. Most people had protocols in place for the use of 'as required' or 'PRN' medicines, however, we noted that some of these would benefit from being more detailed and person centred. When staff were administering PRN medicines, no record was made as to the reason why. This is important to help staff monitor any ongoing health needs that might require a review by healthcare professional. Records showed staff had completed training in the safe management of medicines and assessments of their competency had been completed. To address these shortfalls, the manager is arranging additional training and appointing a medicines lead to oversee improvements with regards to medicines records.

Our last inspection had identified concerns with regards to the numbers of staff deployed in the evening. Target or planned staff levels were not always being met and the deputy manager was often being required to provide direct care and support which meant they were not available to attend to their management responsibilities. This inspection found that improvements had been made. Rotas showed that planned staffing levels were being met, although this was sometimes with the use of agency staff. Where agency staff were used, these were wherever possible, the same workers which helped with continuity. We observed and people confirmed that there were suitable numbers of competent staff on duty. One person said that when staff were called, "They attend straight away" and another said, "Sometimes there are too many staff, there is the right amount every day". A health care professional commented positively on staffing saying there were "Plenty of staff with a good skill mix so it always appears there is someone around who knows each resident when we visit".

Staffing levels were reviewed based on the changing needs of people using the service. The manager was able to articulate plans to increase staffing in a systematic way as the number of people being accommodated in the new extension increased.

In most cases all of the relevant checks had been completed before new staff were employed. One person did not have a full employment history and this information is being obtained by the manager.

The home was visibly clean and tidy and there were no malodours. Overall, staff were observed to follow good infection control measures. There were currently no cleaning staff deployed to cover weekends and so this remained the responsibility of the care staff. The manager plans to review how the housekeeping hours

are used to try and support cleaning staff being available across seven days. The manager is undertaking additional training and will, moving forward, act as the infection control lead. They will ensure that an annual infection control is produced. This statement is required under legislation and reports upon any outbreaks of infections and the lessons learnt and action taken.

Staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them. The manager was aware of their responsibility to liaise with the local authority should safeguarding concerns be brought to their attention.

Good

Is the service effective?

Our findings

People and their relatives felt that the care and support being provided achieved good outcomes and promoted a good quality of life. One person said, "The home is the best thing since sliced bread" and another said, "This is a very nice place, I am happy here". One visitor told us their family member was "Quite a different lady" and that there had been a "Massive improvement" since coming to the home, where they were eating better and being looked after.

Each person had a set of care plans which covered a broad range of needs such as communication, personal care, mobility, nutrition, night support, spiritual needs, oral health and eye sight. Staff told us the care plans were helpful and told them how best to support people. However, we did find examples where records relating to people's care and support contained some inaccuracies or omissions and we have talked about this further in other sections of this report.

Most staff had received regular training opportunities to keep their knowledge up to date. The majority of training was provided through staff watching DVD's. Moving and handling training was face to face. The training covered a range of areas including first aid, food hygiene, health and safety, dementia care, fire safety, Mental Capacity Act 2005 and infection control. Some training relevant to the needs of people using the service took place, for example, most staff had completed training in the prevention and care of pressure areas and two of the senior team had undertaken training in end of life care. The manager had plans to appoint additional champions or leads in specific areas such as medicines and access additional training for them so that they could act as role models to the staff team.

We did note that a number of staff did not have up to date safeguarding training, but they were able to demonstrate an understanding of how to identify abuse and to explain the actions they would take if they identified any concerns. The manager has arranged for safeguarding training to take place.

No ongoing training was currently provided in subjects such as equality and diversity and dignity. We recommend that the registered provider consult guidance such as that produced by Skills for Care on the recommended learning and development opportunities for staff working in health and social care to inform their training programme.

New staff completed a suitable induction that included working alongside experienced staff and learning about the needs of people and a range of health and safety requirements. Records showed that one member of staff, who was new to working in a care setting, had not been enrolled on the Care Certificate course in a timely manner. The Care Certificate is a nationally recognised set of induction standards which staff working in health and social must adhere to. The manager reassured us that, moving forward, all new staff, where relevant, would now be enrolled immediately on the Care Certificate at a local college.

In addition to training, staff also received supervision and appraisals which gave them protected time to reflect on their care practices and development needs. Staff told us they felt supported to carry out their roles effectively.

We observed that staff provided people with choice about how their care was provided. For example, people could choose to have lunch in their room or the dining room or to take part in any planned activities. Where people were able, they had signed consent forms to have their photographs taken or for information about their needs being shared with other professionals. We did note that the current consent forms did not fully reflect legislation regarding consent should the person be unable to give this for themselves and did not include the use of CCTV which covered all the communal areas. The manager had identied this and is taking action to address it. Where people had appointed a representative to manage their affairs, copies of the documents confirming this had been retained within the service.

We saw some examples where staff had completed a mental capacity assessment to clarify where a person could consent to an aspect of their care such as the use of an alarm mat or leaving the home without support. Mental capacity assessments form part of the Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We did note that in the case of one person, there was a lack of supporting documentation for the use of covert medicines in line with the MCA 2005 and the provider's own policies and procedures. The manager is taking action to ensure that all the required legal steps are now being undertaken.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). The manager understood their responsibilities in relation to DoLS and had applied for appropriate authorisations where required.

Where necessary staff worked effectively with a range of other healthcare professionals to help ensure that people's healthcare needs were met. This included GP's, community nurses, and speech and language therapists. People were also supported to attend dental and optician appointments and a chiropodist visited the home on a regular basis. A health care professional confirmed to us that people were referred to them in a timely and appropriate manner.

People were positive about the food. One person said, "The best thing about living here is the food" and another said, "There is a choice everyday". A relative told us, "The standard of food is really good". Each person had a nutritional needs assessment which described the type of food and fluids they required and the level of assistance they needed to eat and any specialist equipment they might need. People were offered drinks throughout the day and freshly baked cake or fruit as snacks. Whilst there was no menu on display, each day two freshly prepared lunch time meals were provided for people to choose from. In addition, people could choose an alternative if they wished such as a jacket potato. Supper was a light meal such as bubble and squeak or a pasta bake. There were always sandwiches available too. Most people chose to eat their meal in the dining room where the tables were laid with cloths, napkins. A range of drinks were served including wine. There was a little conversation between people and with staff, but overall the lunchtime experience was a quiet affair. Food was served to each person individually and was prepared in a way which met their specific needs, for example, people had different portion sizes and one person who did not eat meat had an alternative provided.

We observed a staff member supporting one person to eat and drink, this was done in a very person-centred manner. They readily chatted with the person about what they were going to have for their own lunch and very patiently encouraged the person to eat. We also, however, noted some missed opportunities for people to be supported with their nutritional needs. One person living with dementia was encouraged to sit at the

table for their meal, but after 25 minutes of waiting for their meal, they got up and left. They later had their meal alone. We were concerned that the person had missed the chance to share a positive mealtime experience with others. Another person was assisted to use the bathroom during their meal and their lunch was returned to the kitchen to be kept warm. When they returned, they were served their pudding. We reminded staff that their main meal was in the kitchen.

Overall, the design and layout of the premises was appropriate for people's needs and there was evidence that the provider continued to invest and update the premises. For example, in 2018, the provider completed an extension to Osborne Lodge accommodating a further ten beds, although these were yet to be fully utilised. There were 32 single rooms and two twin rooms each of which had an ensuite toilet and wash basin. Two assisted baths and a wet room were also available. There were two communal lounges, a dining room and hairdressing salon. People were encouraged to make their own room homely with their own belongings. People also had access to pleasant outdoor spaces. There was some evidence that technology was used to support people's care, for example, call bells and pendants were available in each to enable people to summon help and equipment, such as alarm mats which were used to monitor people's safety. We recommend that the manager consult best practice guidance on the use of signage aimed at supporting people living with dementia to remain as independent as possible.

Good

Is the service caring?

Our findings

People confirmed that staff treated them with compassion, kindness, dignity and respect. One person told us, "The staff here are friendly and helpful" and another said, "They [staff] seem a happy bunch, it is a happy home". The compassionate approach of staff had been commented on in a thank you letter received by the service which read, 'Our family have been overwhelmed by the kindness, care and support you and your fantastic staff have given us'. Another thank you letter spoke of 'special attention being given lovingly'. A healthcare professional told us, "They [staff] always appear very friendly and supportive to residents".

We observed staff interacting with people throughout the day and it was evident that staff and people enjoyed good relationships. For example, we saw one person approach a care worker and cup their hands around their face and give them a kiss. Another care worker approached a person and told them how smart they looked, they then stroked the person's hair in a tender manner. We observed that staff spoke to people kindly, respectfully and cheerfully including whilst they were completing tasks such as cleaning for example. The kind and patient approach of staff was commented on by many relatives, for example, one relative said, "Their [Staff] behaviour and empathy is what I really trust. They know [all] residents' quirks and funny ways".

Our observations indicated that overall staff listened to people and respected their choices and wishes, encouraging them to be involved in making everyday decisions about the care and support provided. We observed staff encouraging people to make choices about what they would like to do and what they wanted to eat. We saw a small number of interactions which we noted could be more person centred. For example, staff asked people if they had finished their meal, but then removed their plate before waiting for the person to respond.

Staff spoke proudly about their role and their commitment to working within the home and caring for people in the best way possible. For example, one staff member said, "I love my job, I couldn't imagine working anywhere else" and another said, "I love being around them, they all have their favourite things they like to do". A third staff member said, "I love the residents, seeing their faces light up when you come in, I love it…. I try to make the best out of everyday".

People using the service were encouraged and supported to develop and maintain relationships with people that mattered to them. We observed that visitors were welcomed and they too had a good relationship with staff. Staff had enabled relatives to stay overnight to be close to their family member which they had valued. Special occasions were celebrated and the success of these had been commented on by family members. For example, one had written to say, 'Thank you for making [person's] 90th birthday so special, many thanks to [deputy manager] for making a delicious cake'.

Staff were mostly mindful of people's privacy and dignity. One staff member told us, "We make sure curtains aren't wide open and give people a dignity towel for their lap when helping with personal care". We did observe on two occasions when we were visiting people in their rooms, a staff member entered without knocking. The manager reassured us that he would be reminding all staff of the importance of protecting people's privacy at all times.

Staff told us that people were encouraged to remain as independent and to be involved in the running of the home. For example, one staff member said, "If you prompt [person] she will do her own teeth, one lady likes to hoover, so we give her that task to do".

People had care plans which briefly described their religious or spiritual beliefs and representatives of local churches visited the home monthly.

Good

Is the service responsive?

Our findings

Overall care plans provided a good, person centred record of the person's needs. The care plans viewed contained information about the person's life before coming to live at the service such as their interests and hobbies. They also contained some specific, individual information, about the person such as their preferred daily routines. For example, the care plans included information about preferred portion sizes at mealtimes and whether they liked to have cup of tea before retiring to bed and the number of pillows they liked on their bed. People had communication plans which described the ways in which they communicated and how they might best understand information due to being hard of hearing or having sight loss. Our observations and discussions indicated that staff knew people well and knew how to meet their needs. They knew how and where people liked to spend their time and the things that were important to them. The person-centred approach of staff was commented on by a health care professional who told us, "A very personal service is given to residents… [there is] a family feel…. a very pleasant atmosphere which is made by the staff".

During the inspection, we saw people taking part in an exercise session led by an external provider and also enjoying a quiz. One person was doing a jigsaw and others were content reading. One person said, "I like playing games, doing jigsaws and anything with a ball". Another person said, "I like singing, it was a real treat when a harpist came. In the warmer weather we can sit outside We even had a lunch outside when was warm enough. We went to a nursery, in our coats, to see the Christmas decorations, Christmas was very good". This person also told us that they enjoyed the visits from therapy dogs. A third person told us that they wished there was a visiting library. We spoke with the new activities coordinator who told us they planned to support people to join the local library who would then supply the home with a range of books on a two-monthly basis.

Whilst people told us they enjoyed the activities provided, these had for the last few months been on more of an ad hoc basis and no planned schedule of activities and events was in place at the time of our inspection. People and staff told us there had also been a reduction in trips out to local places of interest using the provider's minibus which was shared with another home. This had in part been due to staffing challenges, but on the first day of our inspection, a new full-time activities lead had started within the service. We observed them visiting people and asking them about what activities they preferred, they told us of their plans to organise pub lunches, trips to the New Forest and making bird feeders. The manager also told us about their vision for more person centred and individualised activities, including accessing the wider community for leisure and volunteering opportunities for example. The home had a range of outdoor spaces which they anticipated could be used by people for therapeutic hobbies such as growing vegetables and tending to small animals.

We did note that daily records continued to be mainly focussed on the provision of practical support and not on people's social or emotional wellbeing. The manager told us they had already identified this as an area needing to be improved and had plans to revise the daily records to facilitate this.

People had access to a detailed service user guide which included a 'Charter of Rights'. This set out a commitment to ensure that people were supported to maintain a good quality of life, be as independent as

possible and to have their religious, cultural and political needs accepted and respected. The feedback we received from people indicated that their care was provided in keeping with these values.

People knew how to provide feedback about their experiences of care and both the manager, their deputy and the provider spoke with people regularly to check they were well and satisfied with their care. This was evidenced by one person who told us, "If I needed to complaint I would talk to the [provider]". Where complaints had been received, these had been investigated and responded to.

Questionnaires and surveys had been used to seek feedback about the service in 2018. We did not see any evidence which showed how the outcome of these had been shared with people or staff and we could not see how the feedback was being used to improve the service and so this is an area which could be developed. Records indicated that a residents and relatives meeting had been in October 2018. This had been used as an opportunity to seek people's views about staffing levels, activities they would like to take part in and the food.

The manager was aware of the Accessible Information Standard (AIS) and there was information in people's care plans about their communication needs and staff were aware of these. Talking books were accessed for people with sight loss. To further embed an awareness of this within the service, the manager told us a folder would be set up to sign post people and staff to a range of options for accessing information in a variety of formats. They told us that if required information would be translated into other languages and large print and pictorial prompts would be used. The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

There was evidence that staff worked effectively with healthcare professionals to ensure that people could have a pain free and dignified death, remaining at the home if this was their wish. Staff had empowered relatives to be involved in providing people's end of life care which they told us they valued. For example, one relative told us, "Staff have been helping me by talking through what is happening and what will happen next, I have been allowed to help with their hygiene and oral care. I know from personal experience that helping a loved one in this way is very important to close relatives, I will be forever grateful for what they have done…they have really been going above and beyond". A health care professional praised the end of life care provided saying, "This has always been an excellent part of this care homes support skills". We did note that people's decisions about their preferences for end of life care were not always documented and this is an area where care plans could be developed further.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives were positive about the leadership of the service. One relative said, "The residents seem genuinely happy here, the management and staff are very open, there is nothing to hide at any time".

Our last inspection had identified shortfalls in records relating to people's care and support. This inspection continued to find similar concerns. For example, some medicines records were incomplete or inaccurate. We also found some concerns in relation to the effectiveness of monitoring records such as food and fluid charts and falls registers. One person was receiving their medicines covertly, but there was a lack of supporting documentation in relation this and the approach was not reflected in their medicines plan. We found other examples where care plans did not fully reflect people's current needs. We also found that records relating to people's care and support were not stored securely meaning the manager and registered provider could not ensure the safety and security of people's confidential and personal information.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

There were systems in place to monitor and assess the quality of service and some of the audits completed were comprehensive and covered a broad range of areas. However, these were still not being fully effective in delivering all the improvements needed to achieve a rating of 'Good'. In the case of some audits, it was not always clear what evidence the audit was reviewing. The recent health and safety audits had stated that all relevant fire safety signs were displayed. We found this not to be the case. One of the questions on the dignity audit was about whether people were involved in recruitment. This had been consistently answered yes, however, this was not the case. The provider's pharmacy supplier had completed an audit in the service in November 2018. This had identified problems with handwritten MARs not being countersigned, we still found this to be the case in January 2019. Where audits had identified that a process or improvement was needed, there was no action plan in place to describe how this was to be achieved.

To assist with developing a more robust programme of quality assurance, we recommend that the audits would benefit from being aligned to the key lines of enquiry to assist in identifying compliance with the Regulations and fundamental standards. We also recommend that the manager and registered provider develop a service improvement plan to assist in identifying, prioritising and implementing improvements, the resources needed to achieve this and the timescales for completing these.

Following our last inspection in August 2017, the provider had made changes which meant that the manager of Osborne Lodge was no longer also responsible for managing one the provider's other services. They had also ensured that the deputy manager became supernumerary to the staffing numbers allowing them too to focus on the leadership of the service. These were positive changes. The current manager had started at the service in November 2018. However, prior to this, there had been an extended period where there had been several management changes within the service. It was our view that many of the concerns or areas for improvement this inspection noted were linked to lack of a stable leadership and upon the ability of successive managers to continue to embed systems and processes to drive improvements. Staff told us they

had recently gone through a period of not always feeling engaged or motivated and that morale had been low. However, since the new manager had been appointed, staff consistently told us, morale was improving and that they felt more positive about their role. For example, one staff member said, "It's a strong leadership team now" and another said, "[Manager] has brought more of a structure, its improved in the last few months". A third staff member said, "There has been a massive change, morale has gone up, [manager] wants to know what's going on, we are listened to now". Staff were optimistic that the new manager would continue to improve and develop the service and seek their involvement in this process. One staff member said, "[Manager] is good for this place…I can go to him for anything, he comes around every day…[Deputy] is good too, things are being dealt with, I would hate it if [Manager] was to leave".

Some new developments had already been established. The manager had made changes within with the staff team to ensure that each staff member employed was able to demonstrate the right values and approach to care including compassion and kindness. The staff we spoke with all had a good understanding of the providers and managers vision and values and were committed to providing a homely, safe and person-centred place for people to live. Feedback from people and their relatives indicated that the care provided met their needs, was person centred and reflected their preferences. A new daily system for allocating staff to support specific people and undertaken certain tasks had been put in place to ensure staff were clear about their role and responsibilities.

The manager was developing links with other agencies and community organisations to help keep up to date with best practice and local initiatives. For example, they had arranged for a representative of the local clinical commissioning group to visit. As a result of this, plans were being put in place to implement initiatives such as escalation tool aimed at helping staff recognise that a person may be experiencing a physical deterioration allowing a prompt response to be made by health care professionals. The manager was also looking to implement The Red Bag Scheme. This is aimed at improving communication between care homes and hospitals. When a person is admitted to hospital, they are sent with a red bag containing standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items. To maintain their continuing professional development, the manager was meeting with other registered managers to share ideas and knowledge. Throughout our inspection, the manager was receptive to our feedback and wherever possible took immediate action to make improvements for people who used the service.

The service worked in partnership and collaboration with other key organisations to support care provision and joined-up care. This included people who used the service, their families and representatives, GPs, community nursing teams and other health professionals.

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 17 HSCA RA Regulations 2014 Good governance The provider had not maintained securely, or consistently, an accurate and compete record of the care and treatment of each service user.