Crown Care II LLP

# Osborne House

## Inspection report

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## 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
Osborne House is a modern, purpose built nursing and residential care home. The service was providing personal and nursing care to 52 people aged 65 and over at the time of the inspection.

The service can support up to 74 people over three floors, each of which has separate facilities. The top floor specialises in providing residential care to people living with dementia and nine people were on this floor. The middle floor provides nursing care and had 21 people receiving support. The ground floor provides general residential care and had 22 people living there at the time of the inspection.

People's experience of using this service and what we found
We looked at the whole service during the inspection; the care and support given to people on the ground floor and top floor was sufficient to meet people's needs. The outcomes of our report mainly reflect the care and support practices of the nursing unit on the middle floor. Throughout the report we have referenced where our judgement is specific to the nursing unit. All other judgements relate to the whole service.

Nursing unit
Insufficient numbers of experienced and competent staff had impacted on all aspects of the care being delivered. There was a lack of effective organisation amongst the senior staff, which meant new and inexperienced staff were working without sufficient guidance and support.

Care records were not completed in a consistent manner. Some records were not up to date and documentation was not fully completed. Staff said they did not have time to read the care records.

People's privacy and dignity was not promoted through staff practice. The care and support delivered to people were task based and did not meet their needs. People were not being supported to wash or bathe on a regular basis which meant their skin integrity was put at risk and they appeared unkempt.

Staff lacked the knowledge and skills to effectively manage the behaviours of people living with dementia. This put people and others at risk of harm.

All three units
The recording and administration of medicines was not managed appropriately in the service. People did not always receive their medicines as prescribed by their GP.

The induction, supervision and training programme for staff was not robust and did not adequately enable them to carry out the duties they were employed to perform. The provider did not monitor this which meant people were at risk of being cared for by staff who lacked the knowledge, competency and skills to meet their needs.

The lack of effective leadership, oversight and management meant the quality assurance and monitoring processes within the service were not used to drive improvement. The assessment, monitoring and mitigation of risk for people with regard to basic care needs such as medicine management, bowel care, personal hygiene and pressure care was not carried out effectively. This meant people's health and safety was put at risk.

We received positive feedback from people and relatives on the residential and dementia units about their care and support. People on these two units were treated with dignity and respect.

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

Rating at last inspection
The last rating for this service was good (published 29 May 2019).

Why we inspected
The inspection was prompted in part by notification of a specific incident. During which poor care practices were observed. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of risks to people who may experience distress or anxiety and staff approach to safety during personal care. 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.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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

During and after our inspection we found that the provider took action to improve the quality of the service. The manager worked with the staff to stop institutionalised practices and improve the quality of life for people who used the service.

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

Enforcement
We have identified breaches in relation to the provision of safe care and treatment, safeguarding people from harm and abuse, staffing and good governance at this inspection. Please find 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

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 of 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.

# Osborne House

**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.

Inspection team
The inspection was carried out by an inspection manager and two inspectors on day one. Two inspectors continued the inspection on days two and three and two members of our medicines team completed the inspection on day four.

Service and service type
Osborne House 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 did not have a manager registered with CQC at the time of this inspection. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

There was a new manager in post who had applied to be registered with CQC at this service. They were a registered manager employed by the provider elsewhere who was transferred to manage this service at the time of our inspection. We have referred to them as "The manager" throughout this report.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

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 all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and three relatives about their experience of the care provided. We carried out observations of people's care and visited all three floors of the service.

We spoke with 19 members of staff including the nominated individual, manager, deputy manager, quality development manager, nurses, care staff, ancillary staff and agency workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included three people's care records and two staff files in relation to recruitment. We looked at 16 staff files in relation to induction and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

The medicines team reviewed 17 medicine administration records and 10 care plans. They spoke to six staff. (manager, deputy manager, medicines lead, carer nursing floor, carer dementia unit and downstairs residential).

Inadequate

# 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 inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People experienced improper treatment due to degrading care practices on the nursing unit. For example, people were not afforded the opportunity to use the toilet and were expected to empty their bowels and bladder into continence pads even when they had the ability to use the toilet.
- Organisational abuse occurred on the nursing unit because routine practice was that the majority of people remained in bed 24 hours per day when this was not always required. People did not have the opportunity for social stimulation and were not supported to have an everyday life such as using the toilet, eating meals at the dining table or spending time outside.
- People's personal care needs were neglected. For example, one person had not had their hair washed for many weeks and their toe nails were extremely long and overgrown. They said these were painful. Other people had unclean hair that they had not been supported to brush.

The evidence of degrading care and treatment on the nursing unit, which did not meet people's needs, was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following discussions with the nominated individual, by day three of the inspection the care and treatment of people had improved. More people were being assisted to get out of bed and baths and showers were taking place.
- One family member was pleased with the care their relative received on the residential unit. They said their relative was well looked after and safe.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Staff on the nursing unit lacked the knowledge and skill to support people living with dementia effectively to prevent anxiety and enhance their feelings of wellbeing. People routinely displayed anxiety and would scratch or hit out at staff and the staff did not know how to prevent this from happening. Records were not always made of such incidents and therefore the provider had failed to recognise or act to improve the situation for staff and the people they supported.
- There was a lack of guidance for staff when people's behaviours escalated. Management plans were in place but these were not evaluated around effectiveness.
- Care plans and risk assessments were not in place or up to date. For example, where people were on high risk medicines.
- Where accidents or incidents occurred, they were recorded by staff and reviewed by the management team. Where lessons could be learnt to reduce the likelihood of a reoccurrence the management team had not always ensured staff practice was altered to achieve this. For example, one relative said, "[Name] has developed a black heel whilst they have been in here. They are in a lot of pain from this." We observed that

one of the person's heel protectors was incorrectly placed leaving their other heel at risk of pressure damage. We reported this to the manager who took action to adjust the placement of the heel protector.
● The provider did not ensure health and safety risks were assessed and monitored to keep people safe from harm. For example, new staff lacked awareness of the fire evacuation procedures. The documentation of fire drills and false alarms was incorrect, and action was not taken when it was recorded that staff performance during drills was not satisfactory.

Risks to people were not being assessed or monitored appropriately and had led to poor care and treatment. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff spoke cheerfully with people on the dementia unit and caught people's attention through conversation, before entering their rooms to deliver personal care. People were put at ease and their dignity was maintained with thoughtful care and support.

Using medicines safely
● Medicines were not managed safely. People were at risk because nurses did not store or administer medicines safely. For example, nurses were not correctly signing when they had administered medicines to people. We therefore were unable to determine from the records if people had received their medicines as prescribed.
● Nurses had completed medicine competency checks and meetings to discuss medicine administration errors and improve performance had taken place. However, poor practice around medicines continued, indicating the action taken so far had been ineffective.
● Controlled Drugs (CD) are medicines that are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. Pain relief patches were stored and documented accurately in the CD register. However, the recording of how patches were applied and removed was inconsistent and did not protect people from harm.
● Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments. We checked records for four people and found staff had not applied their creams as they had been prescribed in all cases.
● Some medicines are considered high risk; we looked at care plans for three people and found that the plans did not provide enough information to protect people from harm. For example, people who were prescribed oral anticoagulants.

Poor storage, recording and administration of medicines meant people were at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The member of staff who was the medicines lead took positive action by contacting GPs regarding people's medicines reviews. Due dates for people's injections were documented on the medicine records. Protocol sheets for 'as and when' required medicines had been reviewed to ensure they were person-centred and, during our inspection, were filed into people's notes.

Staffing and recruitment
● There were not enough suitably qualified, experienced and competent staff on the nursing unit to meet people's needs.
● Inexperienced care staff and agency workers on the nursing unit demonstrated a lack of knowledge and understanding of people's care needs. They were not reading care plans and did not understand how to support basic needs such as bowel or personal care. Many had not worked in a care environment before and

relied on verbal instructions from senior staff to know what to do.
● There was ineffective organisation of staff on the nursing unit, which impacted on people's quality of life. People who could have got up, were left in bed and had not received effective personal care. Staff told us they had insufficient time to get people up, assist them with eating and drinking and give them general care.

The lack of experienced and competent staff meant people did not receive effective care. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People on the dementia unit experienced positive interventions from staff. They were offered a warm drink and given encouragement and assistance with drinking these.

Preventing and controlling infection
● Staff followed appropriate infection prevention and control practices and wore plastic aprons and gloves when giving personal care. Premises were clean and there were no malodours.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At this inspection the quality of the service had deteriorated. People were at risk of avoidable harm. There was evidence of a lack of team-working between the nursing staff, care staff and management team. This had resulted in people receiving poor quality care.
- Staff lacked the knowledge and skills to recognise risks to people's health and safety. Poor oversight of staff induction, training and supervision meant staff were not being supported, especially new staff and agency workers. There was a lack of structure and guidance, from senior staff, for junior staff to follow. This had not been identified and acted upon by the provider until after a serious incident in the service.
- Medicines management was poor, with nurses not correctly storing or administering medicines. Medicine audits had picked up evidence of poor practice. However, there was a failure from the provider and management team to take effective action and improve practice.
- Staff did not deliver person-centred care because they had not read the care plan or received a robust induction. The lack of oversight and monitoring of staff practice meant this had not been identified or addressed.
- Systems and processes were not operated effectively to ensure the service was assessed or monitored for quality and safety. This led to breaches of regulation in relation to safeguarding people from abuse and improper treatment, the provision of safe care and treatment, good governance and staffing.

The lack of effective monitoring and oversight of the service, meant people did not receive effective care and treatment and were at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- During the inspection the nominated individual and the manager were responsive to our feedback and took positive action to improve care and support for people.

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The registered manager left their post in August 2019. There was a new manager in place, who assisted us with the inspection. Relatives said the manager was making positive changes to the service.
- People and relatives were kept up to date with general events happening in the service through meetings

and letters. They had received information about the serious incident leading up to our inspection.

Working in partnership with others

● When professionals were involved in people's care staff worked in partnership with them. At times staff were not proactive in seeking professional involvement to ensure people's needs were met.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Care and treatment was not provided in a safe way for people who used the service. Risks to people's health and safety and the mitigation of those risks were not sufficient to keep people safe from harm, including those around medicines management and competent staff.<br><br>Regulation 12 (1) (2) (a-c) (g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider failed to ensure people were protected from abuse and improper treatment.<br><br>Regulation 13 (1-7) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Governance and record keeping processes were ineffective in monitoring and improving quality and safety of the service, assessing and mitigating risks to people who used the service and maintaining an accurate, complete and contemporaneous record in respect of each person using the service.<br><br>Regulation 17 (1) (2) |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>In-sufficient numbers of suitably qualified, competent, skilled and experienced staff who could meet the needs of people who used the service and keep them safe at all times were employed. Staff did not receive appropriate support, induction and training to enable them to carry out the duties they were employed to perform.<br><br>Regulation 18 (1) (2) (a) |