

Four Seasons 2000 Limited

Osborne Court Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Osborne 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. Osborne Court provides accommodation with nursing and personal care for up to 55 people. The home operates on two floors, providing nursing and personal care on the ground floor and personal and nursing care predominantly for people living with dementia on the first floor. At the time of our inspection 38 people were living in the home.

At the last inspection in July 2017 the service was rated Requires Improvement. We found breaches in four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to management of medicines, management of risks, people's care and treatment, staff supervision and quality assurance systems. We issued requirement actions. Following the inspection, the provider sent us an action plan telling us how they would make the required improvements.

We carried out a comprehensive inspection on 7 and 8 August 2018. At this inspection, we found sufficient improvements had been made and the legal requirements had been met. We found further improvements were needed and where improvements had been made, these needed to be consistent and embedded in the service.

Overall, the service has remained as Requires Improvement.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Sufficient numbers of staff were deployed at the time of our visit. Records showed sufficient numbers were not always deployed. Staff performance was not always effectively monitored.

There were improvements in the management of medicines. Further improvements were needed to make sure shortfalls were promptly identified and addressed.

Staff demonstrated a good understanding of safeguarding and whistle-blowing and knew how to report concerns.

People were helped to exercise support and control over their lives. People were supported to consent to care and make decisions. The principles of the Mental Capacity Act (MCA) 2005 had been followed.

Incidents and accidents were recorded and showed that actions were taken to minimise the risk of reoccurrence.

People's dietary requirements and preferences were recorded and people were provided with choices at mealtimes.

Staff were kind and caring. People were being treated with dignity and respect and people's privacy was maintained.

An activity programme was offered and provided entertainment and engagement to people in communal areas and in their rooms.

Systems were in place for monitoring quality and safety. These had not always been effective and did not identify all shortfalls.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service remains requires improvement.

Improvements had been made to the management of medicines and overall, people received their medicines safely. Further improvements were needed to make sure systems in place identified all shortfalls and that prompt actions were taken.

Staff had received training and knew how to identify and act on concerns and protect people from harm and abuse.

The provider employed agency staff to increase staffing levels which, on occasions were not sufficient to meet the needs of people living in the home.

Accidents and incidents were reported and actions taken to reduce recurrences.

Recruitment procedures were in place. Improvements were needed to make sure appropriate checks were completed before staff started in post.

Requires Improvement ●

Is the service effective?

The service remains requires improvement.

Improvements were needed to ensure staff received sufficient support and supervision.

The service complied with the requirements of the Mental Capacity Act 2005 (MCA). People were asked for consent before care was provided. Where best interest decisions were made, these were recorded. Where people were deprived of their liberty, this was undertaken in line with legal requirements.

People were provided with sufficient food and fluids. Nutritional needs and preferences were recorded and people were given choices at mealtimes.

People had access to a GP and other health care professionals.

Requires Improvement ●

Is the service caring?

Good ●

The service remains good.

People were involved in making decisions about their care.

Staff were caring and treated people with compassion and kindness.

Is the service responsive?

Good ●

The service has improved to good.

Care was personalised and responsive to individual needs.

A complaints procedure was in place and this was easily accessible.

Is the service well-led?

Requires Improvement ●

The service remains requires improvement.

Systems needed to be strengthened to make sure all shortfalls were promptly identified and acted upon.

Improvements were needed to make sure staff were properly supported to express their views and feel confident they would be listened to.

Systems were in place to assess, monitor and mitigate risks to people.

A registered manager was in post. People could provide feedback and express their views.

The registered manager recognised their responsibilities about notifications required by the Commission.

Osborne Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a comprehensive inspection of Osborne Court Care Home on 7 and 8 August 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by one inspector and an expert by experience on 7 August 2018 and one inspector on 8 August 2018. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at the information we had received about the home. We looked at the notifications we had received. Notifications are information about important events that the provider is required to tell us about by law. We also used information the provider sent to us in their Provider Information Return (PIR). This is information we require providers to send to us at least once each year, that gives key information about the service, what they do well, and improvements they plan to make.

At the time of our inspection, there was an on-going safeguarding investigation following concerns raised about staffing levels, use of agency, clinical and care practices, environment and activities. This was being investigated by the local authority safeguarding team and we have not referred to this investigation again in our report.

During our visit we spoke with 12 people who lived in the home and 6 visitors. We spent time with people in their bedrooms and in communal areas. We observed how people were being cared for and supported.

We spoke with the provider's regional manager, resident experience care specialist, a unit manager and 13 staff that included registered nurses, care staff, maintenance, housekeeping, laundry, activity and catering staff.

We observed medicines being given to people. We checked how equipment, such as pressure relieving equipment and hoists, were being used in the home.

We looked at five people's care records in detail and checked other care records for specific information. We looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with staff and people who used the service, survey results, complaints records and other records relating to the monitoring and management of the care home.

Is the service safe?

Our findings

At the last inspection in July 2017 we rated this key question as Requires Improvement. This was because medicines were not safely managed and risk management was not always sufficient and did not always mitigate risks to peoples' safety. These were a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection sufficient improvements had been made in these two areas to meet the legal requirements. However, further improvements were needed to make sure changes were consistent and shortfalls promptly identified and acted upon. This key question continues to be rated as Requires Improvement.

The provider had introduced a '10-point checklist' for staff to complete at the end of shifts to make sure key aspects of medicine administration, such as signing for medicines that had been given, was completed. The checklist had not been fully completed the day before our inspection. and we noted gaps on the Medicine Administration Record sheets (MARs) for that day. We brought this to the attention of senior staff at the time. In addition, the 10-point checklist noted that 'Where there are hand written entries they have been double signed in full.' One person had their medicines hand-written and the entry was not double signed. This shortfall had not been picked up and addressed when the checklist was completed.

Where people were prescribed medicines to be taken PRN or 'when required,' such as pain relieving medicines, the records provided guidance for staff about the circumstances in which the medicines may be needed. This meant people could be confident they would receive these medicines when they were needed. We checked at random two prescribed medicines for PRN administration and found that stock amounts were not accurately maintained.

Homely remedies were available for people to take if needed. These are 'over the counter' medicines the provider and the GP agreed could be given for short periods of time or as 'one offs' without the need for a prescription. The provider had a protocol in place. This was not being fully implemented and stock amount records were not accurately maintained for the medicines we checked.

Some people were prescribed topical creams that were applied to their skin. Topical MARs included details of the cream, the frequency of application required and body charts to show where the creams were to be applied. These were kept in people's rooms and the records signed after care staff had applied the prescribed creams.

We observed medicines being given to people by registered nurses and senior care staff who had received appropriate training. The staff showed an awareness of people's needs and preferences. We heard people being asked if they were ready to take their medicines and they received the support needed. One person told us, "I refuse to have my medication when I am eating. I have had my breakfast so the staff will bring them to me now." We heard staff asking other people if they were ready to take their medicines and confirm how they would like to take them. MARs provided details of the person, their photograph and details of allergies.

Systems were in place to record the amounts of medicines received into the home. Medicines were stored safely in each of the two floors within the home. Arrangements were in place to store medicines that required additional security and medicines that required cool storage. Records were also in place to record medicines that were disposed of.

We checked the records for a person who received their medicines covertly. This meant they did not know the medicines were being given. At our last inspection, covert medicines were not being given safely and the provider's protocol was not being followed. The decision to administer medicines in this way had not been taken in consultation with other health professionals and the decision-making process had not been recorded. At this inspection, the medicines were being given in their best interests, in consultation with the person's GP, pharmacist and relatives and was fully recorded.

People and relatives told us they felt safe in the home. Comments included "I am ok here. I don't like the front door being locked, but I suppose it keeps us safe," "I feel safe as houses here. The staff make sure me and everyone else are always all right," and, "Yes, my relative is safe, can't fault the staff."

Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They could give examples of signs and types of abuse and what they would do to protect people, including how to report any concerns. The care home had a whistle-blowing policy that provided guidance for staff on how to report concerns in the workplace.

Risk assessments and risk management plans were in place. At our last inspection in July 2017, we found shortfalls because actions were not always in place to minimise risks to people's safety. At this inspection, risk management plans were in place where risks had been identified. These included risks associated with moving and handling, eating and drinking, choking and falls. In addition to risk management plans 'clinical hotspot' stickers in the care plan highlighted where significant risks were present.

Accidents and incidents were recorded and actions taken to reduce future risks of injury. For example, one person had fallen on several occasions. The frequency of their safety checks had been increased to half hourly at night. These were recorded. Their bed had been moved to enable easier access and a sensor alarm was in place on their chair and bed to alert staff when they moved.

Six people or relatives commented specifically about staffing levels in the home. Comments included, "Plenty of staff here, you never have to wait for someone to come," "Sometimes they don't seem to answer the bells very quickly. That doesn't occur all the time," and, "Often I think there isn't enough staff working, not all the time," and, "Enough staff, however, depending on which staff are working. Sometimes it's not as settled as it could be."

Care staff all commented about staffing and a typical comment was, "We're often short staffed. Some staff don't speak to each other which makes it worse. If we are short, we're just told we have to cope. The staffing was awful last month." Staff told us they had still provided the personal care people needed, but they did not have time to talk with people or as one member of staff said, "To do the little extra's that people need." The resident experience care specialist told us the planned staffing numbers were agreed with the registered manager. They told us the current agreed levels were higher than the provider's staffing tool stated was needed.

We checked the staff rota's and the agency returns. These showed that during the most recent 28-day period, there were 17 days where the home was fully staffed, with the support of agency staff. The shortages on 11 days were all in the first 14-day period. This meant there was a period of time, as staff had noted,

where staffing was not sufficient. However, we were assured by the improving rotas for the weeks after our inspection agency staff had been confirmed to cover where there were known shortfalls.

Improvements were needed to make sure staff were safely recruited. We checked three staff files. One was fully completed and included application forms, proof of identity and references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Additional checks were completed to make sure registered nurses had current registration with their regulatory body, the Nursing and Midwifery Council. Two files contained one reference. The resident experience specialist told us the provider required two references prior to staff starting in post. Following the inspection, they confirmed that actions had been taken, in consultation with the provider human resource department, in response to the shortfall we identified.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella control, electrical and gas safety, lift maintenance and hoist checks had been completed. Fire safety measures and checks were in place. A new fire alarm system had been installed in one area of the home. The fire drill training records for a three-month period prior to the installation works had been lost. The maintenance staff told us that due to the lack of records, they were undertaking fire drill training for all staff that would be completed before the end of August 2018.

Personal emergency evacuation plans were recorded for each person. They provided guidance about how people could be moved in an emergency if evacuation of the building was required. A business continuity plan was in place and this set out the procedures to be followed in the event of an emergency, such as power failure or significant equipment failure that caused disruption to the normal running of the home. This meant people could be confident their care needs would continue to be met in the event of such a situation occurring.

The environment was clean throughout. We spoke with a member of the housekeeping team who described their role and responsibilities. We observed staff using gloves and aprons when needed which showed good infection control practices.

A redecoration programme was in place. An area of the first floor was not occupied and was being redecorated. This included redecoration of bedrooms and hallways. This programme of redecoration showed the provider's commitment to investing and making improvements to the environment. Vacant rooms were made ready to welcome new people moving into the home, with a selection of toiletries in a small welcome box. Outside the home, we saw people and visitors making use of the garden area, which was laid to lawn and easily accessible.

Is the service effective?

Our findings

At our last inspection in July 2017 we rated this key question as Requires Improvement. We found that staff were not supported with supervision to make sure they were competent to carry out their roles. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the legal requirement had been met. However, we found that further improvements were needed and this key question continues to be rated as Requires Improvement.

At the last inspection, staff told us they did not receive supervisions, either 'at all' or 'on a regular basis.' At this inspection, supervisions were planned and mostly undertaken. They needed improvements to make sure they were in line with the provider's policy to, 'attend a two-way supervision process at various times each year.' It was clear from discussions with staff that this was not yet being fully achieved. The following comments summarised the views of most staff. "We only get supervisions when we're being told off" and, "I didn't even meet with the manager, they gave me a sheet to sign." The regional manager told us training had been provided for senior staff members to become supervisors. A plan was in place to make sure supervisions and an annual appraisal were undertaken in 2018 in line with the provider's policy requirements.

When new staff started in post they completed an induction programme and shadowed colleagues to gain practical experience. The induction programme incorporated the care certificate, a national training process introduced in April 2015. This was designed to ensure staff were suitably trained to provide a basic standard of care and support.

Staff told us they were provided with regular electronic update and refresher training for topics such as fire safety, moving and handling, safeguarding, mental capacity act, infection control and food safety. The registered manager completed an action/improvement plan which was reviewed on 3 August 2018 by the regional manager. This noted that staff had not all completed their required refresher training and a plan was in place to ensure completion.

People and relatives were supported to express end of life wishes and, if they had been discussed, were recorded in the care plan. Relatives were also involved in discussions when DNACPR's had been agreed. This is a way of recording a decision not to resuscitate a person in the event of a sudden cardiac collapse. The registered nurses we spoke with told us they were not aware of a protocol relating to provision of end of life care if the use of a syringe driver was needed to provide pain relief. One registered nurse told us they had received training at their other place of work but would not feel confident that other staff or agency staff would have the required professional competency to undertake this clinical intervention. We brought this to the attention of the regional manager. The provider did have a protocol in place which the regional manager told us would be introduced to relevant staff, with further training provided, if needed.

We checked the records for four people who had been assessed and needed assistance to move or change position on a regular basis. The records stated the frequency people needed to be supported to change

position and had been fully completed in the records we checked. This meant people could be confident they received care and support when they needed it, to minimise the risk of skin damage.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People had been assessed for their capacity to consent to specific aspects of their care. When they lacked capacity to consent, best interest decisions were made in consultation with relevant others, such as relatives or GP's. People told us that staff asked before they provided support. We heard staff asking people for consent before they provided support to people on several occasions throughout our inspection. For example, we heard people being asked, "Are you ready to get up now?" and, "Would you rather I came back later?"

People who lack capacity 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 procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. Files were maintained on each of the two floors of the home that confirmed who had authorised DoLS and who had DoLS applications completed by the service that were waiting to be processed by the local authority.

People using the service and relatives told us they felt staff were knowledgeable and understood their needs. Comments included, "The staff appear well trained. They seem to know what they are doing" and, "Yes, I think the staff are well trained. They know how to handle my [name of person]." Staff told us they received sufficient mandatory or essential training to enable them to carry out their roles. They told us they completed computer based training and commented they would welcome additional training specific to people's needs, with one member of staff commenting, "We learn things like how to clean the catheter and change the bag from one another."

People were supported with food and fluids. We received mostly positive feedback from people about the quality of the food served and feedback included, "The food is really good, you get a good choice and always plenty to eat," and, "The food is nice here." We observed meal service, to people in the dining rooms and in their rooms. The tables in the dining rooms were laid in advance. People were offered a choice of meal, and for people unable to make decisions in advance, meal 'sample' plates were shown to help them make a choice from two meal selections. Staff provided support to people as needed. Meal service was not rushed. We saw one person being assisted to eat their meal that was pureed. The meal was well presented, with each component having been separately blended. People were offered choices of cold drinks for during their meal, and hot drinks were offered at the end of meal service.

A selection of fruit squashes, 'hydration stations' and bowls of fruit were available at various places in the home for people to help themselves to.

We spoke with catering staff who could tell us about people's individual needs and preferences, likes and dislikes. They told us they were provided with 'diet notification forms' when new people moved in to the home. They told us they also spoke with people and attended daily heads of department meetings and were kept updated about changes in people's needs.

Care plans contained nutritional assessments and people's weights were monitored. When people had lost weight, support and advice was sought and people were referred to the GP.

People were supported to access the healthcare services they needed. One person told us, "I see the doctor often as I have bad legs. Then the nurse comes in." For people living in the home who received personal care only, their clinical needs were met by visiting district nurses. For people living in the home who received personal and nursing care, their clinical needs were met by registered nurses employed by the provider. Arrangements were in place for people to receive support from other healthcare professionals such as opticians and chiropodists. Staff in the home spoke positively about the support and guidance they received from the dementia well-being service.

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. They told us they had good relationships with staff and were well cared for. Comments from people and relatives included, "Everyone is wonderful. I love them all, they all look after me," "The staff are lovely, kind and nice. I would recommend them to anyone," and, "The staff are friendly and sociable, but they don't get involved in things they don't have to." One person did say that, "The staff are mostly good, but some can be rude. On the whole not too bad."

Throughout the two days of our inspection, we observed people being treated in kind and respectful ways. Staff were helpful and friendly and people looked relaxed and comfortable in their presence. They provided reassurance and emotional support to people when needed. From our conversations and observations, it was clear that staff had developed trusting relationships with people they were looking after.

Staff communicated in ways that were meaningful to people. We heard several terms of endearment being used throughout our inspection. For example, we heard people being called 'my lovely' 'sweetie' 'beautiful' 'lover' 'darling' and, 'grandad.' This communication was well received by the people we observed. They all responded positively to staff, with smiles or equally friendly 'banter' in response. Staff also supported people with gentle touches or a reassuring touch. The methods of communication and terms of endearment were not referred to in the care records. This meant people may not always be addressed or communicated with using their preferred names and communication methods. We spoke with senior staff who told us they would enhance the care records to take people's preferences into account.

Staff spoke positively and affectionately about the people they provided care for. Comments included, "I just love looking after the resident's here, and, "It's so nice to see people having a good day."

Staff clearly knew people well and could describe people's personal histories, interests and preferences. For example, one person preferred to get up in the early hours of the morning, because this was what they did during their working life. This was reflected in the care plan that recorded, 'my preferences' 'how to support me' and 'what's important to me.' It was noted, 'I like to get washed, changed and shaved early in the morning because this was part of my working day pattern'. Staff were aware of the person's needs and preferences and told us the night staff supported the person to get up at their preferred time.

Care staff told us how they made sure people's dignity and privacy was promoted and maintained. They made sure people were fully covered and that others didn't enter rooms when they were supporting people with personal care. We saw that staff knocked on bedroom doors before they entered the room. This showed that people's rights to privacy were respected. A relative commented, "I cannot fault the staff. They are lovely and try to do their best. They are kind and considerate."

People told us they were asked and felt involved in decisions about their care and how they liked to spend the day. We heard one person asking staff to place a chair by their bedroom door. This was to deter other people from walking, uninvited into their room. The person told us, "They're good as gold. They help me and do what I need."

People's rights to a family life were respected. Visitors were made welcome at any time. We saw visitors arriving at different times during the two days we spent in the home.

Compliment cards and letters had been received in the home. We read the following extracts from two of the cards received. 'We just want to say thanks so much for all the care you gave our Mum. You are a lovely team so keep up the good work. It is a very hard job but people like you make such a difference. The main thing is, keep smiling' and, 'Thank you for the care that you gave to our mother. Especially for the kindness shown after losing my dear sister and at the end of life and death of Mum.'

Is the service responsive?

Our findings

At our last inspection in July 2017 we rated this key question as Requires Improvement. We found that people's care and treatment did not always meet their individual needs. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient improvements had been made and the legal requirement had been met. The rating for this key question has improved to Good.

People told us they were involved with care planning and that care was responsive to their individual needs. One person said, "I talk to the staff about my care plan, but no one else", and a relative told us, "I see and read my relative's care plan all of the time. Staff take time to keep you informed, they listen to your point of view."

Before new people moved into the home they were assessed by the registered manager or senior staff to make sure their care needs were known. Care plans were designed to reflect individual needs, choices and preferences. Care was planned and records were checked and reviewed monthly. In addition, records were kept in people's rooms and these included 'my journal' booklets that provided personal details such as people's backgrounds, careers, likes and dislikes and family histories.

Care plans provided details of people's physical, mental, emotional and social needs and how those needs were met. For example, one person's records provided details of their personal care requirements and that they 'like to wear trousers' 'likes to have money in purse' and 'enjoys company but also happy at times to sit and listen to the radio.' Another person's care plan noted, 'has glasses but does not wear them'. The dementia partnership support team had reviewed the person's care and noted, 'Overall, all care interventions were very person-centred.'

Where people had additional, specific needs, such as support with their urinary catheters, the records did not always provide specific detail of the care needed. We brought this to the attention of the resident experience specialist at the time.

Activities and engagement were provided for people in communal areas and in their rooms. On the first day of our inspection, the person in charge and the staff had expected the activity coordinator to be on duty that day. They were not aware the member of staff would not be working that day. A church service took place on this day. On the following day, the activity coordinator was on duty in the home. They sang with people, offered manicures and visited people in their rooms. They told us about their weekly activity programme and how they were hoping, with the support of an additionally recruited activity coordinator, to expand the programme to provide regular activities at weekends. They told us about the local nursery school children who visited each week and said this was a 'highlight' and people looked forward to their visits.

A complaints procedure was in place that was readily available to people and relatives. We received a complaint about care from a relative on the second day of our visit, and a care concern from a member of staff that we passed on to the resident experience specialist to investigate and address. People told us they

would be confident that concerns could be raised and they would be addressed with one person commenting, "I have no complaints at all, but if I did I would speak with the manager." However, one relative told us, "We have made complaints in the past and they are not always sorted out in the home. The manager (at that time) advised me to write to head office." Information from the complaints file was sent to us after our inspection. This showed that, overall, complaints were managed in accordance with the provider's policy. Eleven complaints had been received since the beginning of 2018. Seven were resolved within the timescales expected by the provider, two had exceeded the timescales but were now resolved, and a further two, raised during the inspection, were being looked into.

Is the service well-led?

Our findings

At our last inspection in July 2017 we rated this key question as Requires Improvement. We found that quality assurance systems did not identify the shortfalls we had found and actions were not always taken to mitigate risks or to make improvements. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made, for example, in medicines management, risk management, personalised care planning and supervisions. The legal requirements have been met. Further improvements were needed as we have reported in the safe and effective domains. However, the provider had recognised this as we have reported below. This key question continues to be rated as Requires Improvement.

Systems were in place that identified shortfalls, and a range of audits and monitoring checks were completed by the management team. However, we still identified shortfalls. For example, the provider had introduced a quality monitoring '10-point checklist' to monitor and check medicines management. The checklist had not been fully completed the day before our inspection. Therefore, gaps in staff signatures to confirm they had administered medicines, had not been identified or acted on. In addition, the provider's quality assurance had not identified other shortfalls we noted in the safe section of this report. The provider had recognised further improvements in medicines management were needed. They told us in their PIR, completed in July 2018 that one of the improvements they planned to make in the next 12 months was, 'To implement a robust management system, to ensure all audits are completed, and daily, weekly tasks are adhered to.'

The provider also told us in their PIR that they had a supervision matrix in place and that, 'With three managers and heads of departments all have been given a responsibility to ensure regular supervisions had been carried out.' In addition, the registered manager's on-going action/improvement plan provided details with target dates for completion of improvement actions needed. From the conversations we had with staff, it was clear the system still needed to be fully implemented and embedded to ensure staff felt supported with a programme of supervision and appraisal to enable them to carry out their roles effectively.

There was a registered manager in post. We did not meet them because they were on leave during the week of our inspection. We were told by the regional manager the registered manager had resigned and was leaving their post at Osborne Court in October 2018.

People and relatives told us the registered manager was 'approachable' and 'supportive'. Feedback included, "You can see them anytime when you're in the home or just ring up." We were told there were opportunities to provide feedback, and surveys were readily available for people to complete at any time. The most recent results, with a survey focus on food and drink, showed a high level of satisfaction. One area that scored lower, was in answer to 'Is there a variety of menus?' A member of the catering team told us the menus were being reviewed and changed. This showed that feedback was used to make improvements.

We saw that actions had been taken in response to shortfalls the provider identified in their monitoring systems. For example, the review of training compliance for August 2018 identified shortfalls in training.

Actions were in place, graded from red to green to confirm the importance of the actions required. For example, one of the actions was for the registered manager to monitor training daily. This was to make sure that the provider's target for staff completion of refresher training of 95% was achieved.

The overall feedback from eight staff was they did not always feel supported or listened to by the management team. They told us they felt there were conflicts and a lack of trust within the staff teams and that supervisions, in their opinion, were often used, 'just to tell us off.' Staff told us they did not feel valued. We brought this to the attention of the regional manager during the inspection.

Staff meetings were held and we read the minutes from recent meetings that referred to difficulties between staff groups in the home. The minutes did not include a plan of how the above culture and conflicts were to be addressed. One member of staff told us, "We had a meeting planned for last week, but it was cancelled at the last minute. I don't know why."

Staff were asked to complete 'colleague engagement' surveys. We read the surveys from the surveys for June, July and August 2018. The overall scores had reduced each month, in response to questions such as; I feel part of a team, I have the knowledge and tools I need to do a good job and I trust my manager to do the best for me and the home. There were no specific actions in the registered manager's action plan that related to addressing the staff issues noted above.

Staff reward systems were in place and we saw copies of 'VIP awards' that had been awarded to staff. Nominations were submitted each month and the registered manager chose the member of staff most deserving of the award. The award recognised the staff contributions in accordance with the provider's values of being respectful, trusted, caring and making a difference.

The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.

At our last inspection in July 2017 we rated this key question as Requires Improvement. We found that quality assurance systems did not identify the shortfalls we had found and actions were not always taken to mitigate risks or to make improvements. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made, for example, in medicines management, risk management, personalised care planning and supervisions. The legal requirements have been met. Further improvements were needed as we have reported in the safe and effective domains. However, the provider had recognised this as we have reported below. This key question continues to be rated as Requires Improvement.

Systems were in place that identified shortfalls, and a range of audits and monitoring checks were completed by the management team. However, we still identified shortfalls. For example, the provider had introduced a quality monitoring '10-point checklist' to monitor and check medicines management. The checklist had not been fully completed the day before our inspection. Therefore, gaps in staff signatures to confirm they had administered medicines, had not been identified or acted on. In addition, the provider's quality assurance had not identified other shortfalls we noted in the safe section of this report. The provider

had recognised further improvements in medicines management were needed. They told us in their PIR, completed in July 2018 that one of the improvements they planned to make in the next 12 months was, 'To implement a robust management system, to ensure all audits are completed, and daily, weekly tasks are adhered to.'

The provider also told us in their PIR that they had a supervision matrix in place and that, 'With three managers and heads of departments all have been given a responsibility to ensure regular supervisions had been carried out.' In addition, the registered manager's on-going action/improvement plan provided details with target dates for completion of improvement actions needed. From the conversations we had with staff, it was clear the system still needed to be fully implemented and embedded to ensure staff felt supported with a programme of supervision and appraisal to enable them to carry out their roles effectively.

There was a registered manager in post. We did not meet them because they were on leave during the week of our inspection. We were told by the regional manager the registered manager had resigned and was leaving their post at Osborne Court in October 2018.

People and relatives told us the registered manager was 'approachable' and 'supportive'. Feedback included, "You can see them anytime when you're in the home or just ring up." We were told there were opportunities to provide feedback, and surveys were readily available for people to complete at any time. The most recent results, with a survey focus on food and drink, showed a high level of satisfaction. One area that scored lower, was in answer to 'Is there a variety of menus?' A member of the catering team told us the menus were being reviewed and changed. This showed that feedback was used to make improvements.

We saw that actions had been taken in response to shortfalls the provider identified in their monitoring systems. For example, the review of training compliance for August 2018 identified shortfalls in training. Actions were in place, graded from red to green to confirm the importance of the actions required. For example, one of the actions was for the registered manager to monitor training daily. This was to make sure that the provider's target for staff completion of refresher training of 95% was achieved.

The overall feedback from eight staff was they did not always feel supported or listened to by the management team. They told us they felt there were conflicts and a lack of trust within the staff teams and that supervisions, in their opinion, were often used, 'just to tell us off.' Staff told us they did not feel valued. We brought this to the attention of the regional manager during the inspection.

Staff meetings were held and we read the minutes from recent meetings that referred to difficulties between staff groups in the home. The minutes did not include a plan of how the above culture and conflicts were to be addressed. One member of staff told us, "We had a meeting planned for last week, but it was cancelled at the last minute. I don't know why."

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