Four Seasons Homes No.4 Limited

Osbourne 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Osbourne Court Care Home is a care home providing accommodation for up to 69 older people, including people living with dementia. At the time of the inspection there were 40 people living at the home.

People's experience of using this service and what we found
People told us they felt safe and that staff were kind. Risk assessments were in place to help promote people's safety. However, these were not always up to date and staff did not always work safely or in accordance with these plans. Staff did not always support people safely when they were at risk of choking.

Unexplained injuries were recorded, investigated and any actions were taken to respond to these. However, these were not always reported to the local authority or to CQC. This had been a concern at previous inspections and had not been resolved.

Several staff had not attended a fire drill and some staff were not clear on evacuation procedures. Staff training needed to be completed with only 60% of training achieved for the home.

People and their relatives told us they felt there were enough staff to meet their needs. We saw examples of staff responding to people and meeting their needs promptly. However, we also found instances where their needs had not been met and staff approach was not person centred. Further training and development was needed to support people with behaviours that may challenge. The management team acknowledged that care plans still required work to ensure accuracy and guide staff in having a person-centred approach. However, we found that progress was slow in completing this work.

Infection control in relation to managing Covid-19 was not robust. Staff and members of the providers management team were observed not following guidance and wearing masks correctly. Staff were observed carrying out communal staff Covid-19 testing in dining rooms even though there was a designated testing room. There remained some areas of the environment that needed replacing, repairing or decoration to ensure they could be cleaned effectively. Work was slow in regard to refurbishment even though it had been raised previously by CQC and the local authority.

The manager started in December 2020. Some people knew who they were, some relatives said they had seen them in passing. Staff were unable to give any examples of the changes since they started. They told us they do see the manager around the home. Governance systems were in place, but they had failed to identify or address the issues found on this inspection.

The manager was working with the local authority to reflect on the current practice within the service to ensure that lessons were learned and to make improvements where needed. However, progress was slow and there were a number of actions outstanding and reoccurring.

Rating at last inspection
The last rating for this service was requires improvement (published 28 October 2020).

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about the care people were receiving. A decision was made for us to inspect and examine those risks.

As the combination of previous risks and new information we received covered all the key lines of enquiry in Safe and Well Led, we widened the scope of the inspection to become a focused.

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

Please see the safe and well led sections of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Osbourne Court Care Home on our website at www.cqc.org.uk.

Follow up
We will request an action plan for 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 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 was not safe.

Requires Improvement

Is the service well-led?

The service was not well led.

Inadequate

Osbourne Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was undertaken by two inspectors.

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

The service had a manager who was applying to be registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who had worked with the service. We did not request a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We had requested information from the provider prior to the inspection and this information was used as part of the inspection plan. We used all of this information to plan our inspection

During the inspection

We spoke with six members of staff, the manager and the regional support manager. We spoke with three people who used the service and received feedback from three relatives. We also spoke with two visiting professionals and contacted the local authority for their feedback. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed records relating to people's care and quality assurance systems.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● We observed instances where staff did not work safely. For example, one person who was assessed as at risk of choking, was being assisted to eat while their head was laying back and staff continued to put food in their mouth, even when we raised our concerns.

● Another person who was high risk of choking was assisted by a new staff member without reading or following their care plan and without having the correct knowledge for supporting the person. We needed to intervene and alert the manager in both instances due to the level of risk to people.

● Care plans relating to choking risk were not always in place and the information was not always shared. For example, one person had increased from low to medium risk and staff were not aware of the risk. In addition, the diet form for kitchen staff use still stated they were at low risk.

● Records showed and staff told us some people had a behaviour that may challenge others. Staff we spoke with gave different information on how they responded to these needs. We checked care plans and risk assessments and found this did not provide comprehensive guidance for staff to keep people safe.

● One person was in their wheelchair and challenging staff verbally. Staff responded by moving them to the corridor and leaving them unsupervised which was not the approach agreed in the person's care plan. A second person was sat in their room for three hours with their head between their knees. We asked staff how they would support this person, but both dismissed this and told us they were not allocated to this person so did not intervene and that we should speak with the nurse. When the nurse did go to support this person after xx minutes, they put them to bed, but did not offer any personal care even though their trousers were wet. Care notes later received stated the person had refused personal care all day. Throughout three hours of observation by an inspector, no personal care was offered.

● We found where risk assessments were completed, they were not always an accurate assessment. For example, a dietician had recorded a person as medium risk of malnutrition due to recent weight loss. The assessment completed by the service did not include this in their nutritional assessment.

● People at risk of failing were monitored. We saw the remedial actions were taken to help reduce the risk of a reoccurrence.

● People told us they felt safe. Relatives also told us they felt people were safe. One relative said, "I feel [person] is safe, they are good to them."

● Fire procedures and assessments were in place. However, we found that personal emergency evacuation plans needed more detail to ensure clear information was in place relating to how a person should be moved in an emergency situation and one care plan had the wrong person's PEEP recorded.

● Some staff told us they had not attended an evacuation fire drill. We reviewed the record of staff who had attended a fire drill. We found out of 61 staff available for a drill, only 16 staff had attended a fire drill this year.

Preventing and controlling infection

● Guidance for hand washing, personal protective equipment and infection control were displayed in the service. Staff had access to personal protective equipment. However, on our first visit we saw three staff members using their own cloth masks and the manager was not aware and on both visits we saw a number staff with their masks on their chins and under their nose. We also noted that members of the provider's management team did not follow their policy and national guidance with regards to wearing masks.

● In addition, even though there was a designated testing room, staff Covid-19 swabbing was being carried out in communal areas with colleagues against the provider's policy. These concerns were raised at the time of our visits.

● Staff did not follow good practise when taking their breaks and we saw staff eating their lunch in communal areas having removed their PPE. We also observed staff going outside for a break but they did not replace their mask or sanitise their hands on returning to the building.

●The manager told us that the most recent Covid-19 outbreak in the home was contributed to by a staff member not completing testing on arrival to work but later in their shift when they tested positive and went home. On our first visit we were not asked to take our temperature or demonstrate we had carried out Covid-19 testing. We raised it as a concern. On our second visit our temperature was checked, and we were asked to show proof of Covid-19 testing.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections.

● We were not assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were not assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were somewhat assured that the provider's infection prevention and control policy was up to date.

Practices in the home had failed in consistently promote people's safety and placed people at risk. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● At our last inspection we found that the provider did not always report these incidents to us or to the local authority safeguarding team.

● At this inspection while we found that systems in place recorded unexplained injuries and a member of the management team completed an investigation, the provider still did not always report these incidents to us or to the local authority safeguarding team.

● We found 13 examples of unexplained bruises and or skin tears recorded on an incident log for the period of March to May. While we saw that action was taken within the home to investigate, treat injuries and update moving and handling training staff, this was not reported externally to the local safeguarding team or the CQC. The manager told us that in their opinion there were not reportable. However, the injuries were all unexplained and the investigations by the manager could not determine the cause of injury.

● Staff were aware of what signs of abuse to look out for and how to report any concerns they had.

Staffing and recruitment

● People told us there were enough staff to meet their needs. One person said, "They come when I ring my bell." Relatives told us from what they could see on recent short visits there seemed to be staff around. One relative said, "When we visit staff pop in to offer [person] a drink."

● Staff were around and were responding to people's requests when needed. Staff told us they felt there were enough of them but at times it was busy due to the dependency of people. For example, for people needing to use the hoist for transferring and for those who needed assistance to eat.

● During the inspection we saw staff responded to people's care needs in a timely way. However, we saw at lunch time that staff deployment did not enable staff to spend enough time with people.

● Due to people's complex needs, the medicines round took the nurse two and a half hours to complete. They told us this was because people needed encouraging to take their medicines which took time. However, this led to people not always having their medicine at the prescribed time. For example, one person who required a twelve-hour gap did not have this period between administration. This was because of the deployment of staff did not support timely administration of medicines.

● Newly employed staff underwent an induction and were supervised by an experienced member of care staff. However, the registered manager did not ensure they were competent prior to supporting people independently.

Using medicines safely

● We saw medicines had been stored safely and records indicated people had received their medicines. Staff were trained to administer medicines safely and their competency was reviewed. However, we observed unsafe practice when a staff member carried two unlabelled medicine pots together while waiting for a person to be ready to take their tablets.

● We checked six people medication administration records [MAR] and found these were complete with no errors. Stock held tallied with the MAR indicating people had received their medicines, where people refused, this was recorded.

● Where people were given their medicine covertly, staff had sought authorisation from a doctor and pharmacist and ensured the appropriate legal consent was obtained.

● End of life medicines were in place in readiness to support people to have a pain free and dignified end of life. When people required medicines to be administered on an 'as and when required' basis there was guidance in place for staff to follow. These however lacked enough detail to instruct staff when to give one or two tablets, or how people unable to verbally communicate would indicate they were in discomfort.

Learning lessons when things go wrong

● The manager stated they had shared the findings of any visits and inspections from professional agencies and internal audits with staff to help ensure they were up to date with changes or events. This information was shared through discussion while walking round, meetings and notices displayed.

● Staff spoken with were unable to tell us they formally learned lessons from incidents. Staff were not aware of safeguarding concerns raised and the outcome of those. For example, a person had recently left the building in an unsafe way, but staff spoken with were unaware and discussions had not occurred to minimise recurrence and to improve practise.

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 Requires Improvement. At this inspection this key question has 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements and How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The manager was open about the service and recorded any concerns for review, we found at times that the required statutory notifications were not submitted. For example, in relation to unexplained injuries. This had previously been identified as an issue. The provider had not ensured that all notifiable events and incidents are reported to the appropriate authority when needed.
- There were quality assurance systems in place. This included a manager walk round that checked all areas relating to care and safety. The had not identified any issues. Audits were completed and some actions arose as a result of these. Some were signed as being completed. However, progress for the ongoing concerns and shortfalls did not demonstrate the priority to make improvements.
- The concerns we identified in Safe had not been identified through the quality assurance systems. Walk rounds and audits had not identified the safety concerns and risks to people and had not addressed the care plan shortfalls to make sure risks were mitigated.

Continuous learning and improving care

- The manager was supported by a newly allocated regional manager and they told us they were working to make the required improvements. The manager told us there was a service improvement plan. However, the record that was provided was a plan resulting from a previous CQC inspection. The plan did not include any information relating to the current running of the home, meetings, accidents Covid-19 or the actions needed from the ongoing monitoring from the local authority.
- The previous inspections had highlighted the need to report unexplained injuries to the relevant agencies. We found at this inspection this was still an issue indicating limited learning from previous concerns raised in this area.
- There had been a number of areas identified through inspections and visits with the CQC and the local authority. The service was in the safety and improvement process with the local authority. Support and advice had been given over a number of months but there had been insufficient improvement. We found that care plans still required much more input to ensure accurate and clear information was in place and the environment was still in need of refurbishment.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people and Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and staff told us that the new manager was available in the home, checking how things were and guiding staff. One person said, "I see [manager] walking round." A relative told us, "I am aware of who she is, only in passing, she hasn't introduced herself." Another relative said, "The staff are very good at keeping contact, I don't hear from the manager directly." However, we found that the manager and regional support manager were surprised by the shortfalls we found which indicated they had not been around the home and observed mealtime practice or robustly checked staff masks.
● The management team told us about changes and improvements that had been made. However, we were unable to find impact to demonstrate these changes. For example, we found that training was an area that needed more input as training was only 60.6% compliant. We reviewed training for the care staff on duty on the day of our second visit and found many of them did not have full or up to date training.
● Staff were observed to have positive interactions with people in many cases. However, we found that choices such as for the menu that day and times to go to bed were made for people. One staff member told us they completed the menu choice form for lunch themselves as they knew what people like. They said, "Older people don't really like burgers" Without considering that some people may want to choose this option. All but two people downstairs were given the pulled pork option and not given the opportunity to make their own choices.
● Staff culture did not always display good outcomes for people. One person in the dining room required encouragement to eat their meal. However, staff did not sit with this person to spend the time needed with them to ensure they ate their lunch. They told this person they needed to eat, gave them five minutes to do so, and then gave them a yoghurt. This was because a staff member was not allocated to support people in the dining room.
● It was noted in resident meeting notes by one person stating they would like the choice of food. We also found that according to care notes, people were starting to be encouraged to bed after 5.30pm. It was not reflected in care plans that this was their choice.
● Staff had regular contact and meetings with the manager to be kept informed of any issues and remedial actions. However, some staff said they did not feel informed.
● Visiting professionals told us there had been a significant amount of support from them and so far, there had been very slow progress in making and sustaining the improvements needed.

We found that in the management, leadership and the quality assurance systems in the home were not effective. Therefore this was a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Working in partnership with others
● The management was working with the local authority and the CQC to address any shortfalls.
● During the pandemic the provider had been working with Public Health England to help ensure they were up to date with guidance.
● The manager was open to feedback and was keen to move the service forward.

This section is primarily information for the provider

Action we have told the provider to take

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

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

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured governance and leadership systems were robust and had failed to make or sustain improvements.

The enforcement action we took:

We imposed conditions on the provider's registration to help ensure improvements were made.