Osmaston Grange Care Home Limited

Osmaston Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 31 October and 16 November 2017 and was unannounced. The service was registered to provide accommodation and nursing care for up to 80 older people. On the first day of our inspection 57 people were using the service.

We had previously inspected Osmaston Grange on 11 & 12 October 2016; when the service was rated inadequate overall. We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Repeated breaches of legal requirements were found in respect of Regulations 12 and 17. This meant the provider had continuously failed to ensure environmental cleanliness and hygiene and the effective management and oversight of the service; to ensure the quality and safety of people's care. Warning notices were issued. Breaches of Regulations 11 and 18 were also identified. This meant people were not fully protected from the risk of unsafe or ineffective care; because the provider's arrangements for staffing and to obtain people's consent or appropriate authorisation for their care were insufficient. As the overall rating was 'Inadequate' the service was therefore placed in 'Special measures'.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to breaches.

We carried out a focused inspection carried out on 27 February 2017 and 3 March 2017 to check the provider had followed their plan and to confirm they now met legal requirements. At this inspection we found sufficient improvements had been made to rectify the breaches identified during the previous comprehensive inspection. Considerable improvements were found to have been made or were in progress in relation to environmental cleanliness; hygiene and repair. We found significant improvements had also been made to the quality and safety of people's care through revised management and staffing arrangements. Further improvements to fully embed this were either planned or in progress with reasonable timescales identified for achievement. The service was found to be no longer in breach and was rated 'Requires improvement' in the three areas we looked at; safe, effective and well led.

Since the last inspection concerns and safeguarding issues have been raised by relatives, health care professionals and the local authority regarding inconsistent care practices and staffing levels.

At this inspection we found significant changes since the previous inspection with the residential unit now completely separated from the nursing and dementia unit. Each unit now had an acting manager and staff team and was run totally independent of the other. Both acting managers were new in post. We saw some improvements had been made to the physical environment and infection control procedures.

However ongoing concerns were identified, particularly in the nursing and dementia unit, which included inconsistent staffing levels and issues regarding staff recruitment, retention, training and support. We also found shortfalls related to quality monitoring systems, risk management and record keeping, which included poorly maintained care plans and risk assessments.

Communication was not always effective, although the acting manager, in the nursing unit, had held a residents and relatives meeting during their first two weeks in post. Monitoring audits had not been undertaken for two months and care plans, including risk assessments had not been reviewed or updated to reflect people's changing needs. This included shortfalls in monitoring weights, fluid intake, bowel movements and positioning charts.

Accurate records were not always kept. There were gaps in records such as food, fluid and positioning charts. People were not always referred to healthcare professionals according to their individual needs. Care plans were not consistently maintained and did not always provide staff with accurate and updated information they needed to support people. We found inconsistencies in relation to where information was recorded and consequently how accessible this information was to care staff. Whilst the individual records contained care plans and risk assessments relating to all aspects of daily living, we found detailed information about how to care for people was embedded within an extensive set of paperwork and it was not clear as to what the up to date care requirements for each person were.

Although as previously documented, two acting managers had recently been appointed; there was no 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.

People had not been referred to the falls team after suffering multiple falls. We saw records of treatment provided for people who had pressure ulcers did not give information whether the wounds were healing or deteriorating. Air mattresses were not set to the correct setting to be beneficial for people with pressure areas. Safeguarding referrals to the local authority were not always made.

There were suitable recruitment procedures and required employment checks were undertaken before staff began to work at the home. Staff did not always have the training they needed to provide appropriate support for people.

The staff did not consistently understand their role in relation to the Mental Capacity Act 2005 (MCA) and how the Deprivation of Liberty Safeguards (DoLS) should be put into practice. These safeguards protect the rights of people by ensuring, if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Where people needed decisions to be made on their behalf, best interest records did not record what the decision was.

People were not always provided with personalised care and support and there was a lack of stimulation and meaningful activities.

Quality monitoring systems were inconsistent and where shortfalls in the service had been identified, actions were not always followed up to monitor improvements.

We found six breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 during our inspection. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that

providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

People were not kept safe from the risks of abuse and avoidable harm. There was not always sufficient staff to meet people's care and support needs.

Safe and consistent systems were not always followed for the management of medicines. Risks to people were inconsistently managed and assessments did not always contain enough information to keep people safe. People were not always moved safely when hoists or wheelchairs were used.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have the skills and knowledge to meet people's needs. They were not always aware of the requirements of the Mental Capacity Act 2005. Consent to care was not always sought in accordance with legislation and guidance. People had mental capacity assessments in place but best interest decisions were not recorded.

Staff did not maintain accurate records where people were identified 'at risk' in relation to pressure ulcers. People's nutritional intake was not always recorded.

People did not always receive the support and assistance they required to eat their meals.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they were happy with the care they received However they did not always receive personal care and support when they needed it.

People were not consistently supported to participate in

designing or reviewing their care

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive consistent personalised care that was responsive to their needs. People were not supported to communicate effectively. People did not always receive support to take part in activities within the home and in their community.

Staff did not always have the awareness or information they needed to be able to support people whose behaviour sometimes challenged others.

People and their relatives were confident concerns and complaints would be investigated and responded to.

Is the service well-led?

Inadequate

The service was not well-led.

Previous inspections have shown non-compliance with regulations. The provider has not made sufficient improvements following these inspections. Concerns identified at this inspection related to breaches from previous comprehensive inspection s.

Quality monitoring systems were inconsistent had not identified all of the shortfalls we found. Where audits had identified shortfalls, actions had not always been followed up to monitor improvement.

Acting managers were new in post and consequently much of their responsibilities were described as 'work in progress'

Osmaston Grange

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 October and 16 November 2017 and was unannounced. The inspection was brought forward due to information of concern being raised. On the first day, the inspection team comprised two inspectors, one nurse specialist advisor and one expert by experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of service. The second day of the inspection was undertaken by three inspectors.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. We sought the views of the local authority commissioning teams. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. The concerns they raised with us included staffing levels and safe care practices.

On this occasion we did not ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we offered the provider the opportunity to share information they felt relevant with us.

We spoke with: seven people who used the service, eight relatives, four visiting health care professionals, seven care staff, two qualified nurses, the two acting managers, the assistant director and the provider. We spent time observing care and support in the communal areas. We observed how staff interacted with people who used the service.

We looked at a range of records related to how the service was managed. These included five people's care records, three staff recruitment and training files, and the provider's quality auditing system.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection, in October 2016, we identified repeated breaches of legal requirements, in respect of Regulations 12 and 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This meant the provider had continuously failed to ensure environmental cleanliness and hygiene and the effective management and oversight of the service; to ensure the quality and safety of people's care. We subsequently issued the provider with warning notices for the breaches, which told them they were required to become compliant and by when. We also found breaches of Regulations 11 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This meant people were not fully protected from the risk of unsafe or ineffective care; because the provider's arrangements for staffing and to obtain people's consent or appropriate authorisation for their care were insufficient.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the identified breaches. On 27 February and 3 March 2017 we carried out a focused inspection to check the provider had followed their plan and was meeting legal requirements. We found sufficient improvements had been made to address the shortfalls and therefore the service was no longer in breach of regulations. However, since the last inspection we received a range of concerns and safeguarding issues which had been raised by relatives, health care professionals, a whistle blower and the local authority regarding inconsistent care practices and staffing levels.

During this inspection we received some positive comments regarding whether people felt safe at Osmaston Grange. One person told us, "Yes I do feel safe; there's no reason not to.'' However people and their relatives we spoke with expressed concerns regarding inconsistent staffing levels and the potential impact this had. One person told us, "There aren't enough staff. If I want the toilet I can wait and wait. The staff do their best and it's not so bad in the afternoons when it's less busy.'' One relative told us, ''I'm not sure there are enough staff. For example [family member] wanted to go to her room but we had to wait for staff to be available to help. I also wonder why two or three go on break together.'' Another relative said, "I feel [family member] is only safe because she is less mobile now. She's had a few tumbles since she's been here but now she can't get out of bed by herself."

We found there were inconsistencies in staffing levels and staff deployment, particularly in the nursing and dementia units. For example, on the first day of our inspection, there were three care staff on duty on the dementia unit in the morning but two in the afternoon as a member of care staff had rung in sick. This meant there was delay where two people were needed to assist someone in bed as staff were required in the lounge. Staff from the nursing unit had to come and help out. Staff we spoke with told us staffing numbers were not always adequate to meet people's needs. They told us that this affected how often they could provide activities and one to one support to people. There were two care staff on duty on the afternoon of our inspection visit. We saw one person who needed two people to assist them had to wait until a member of staff was made available from the nursing unit. This was to ensure other people were not left unsupervised whilst their support was provided. One relative we spoke with told us, "'I have concerns about the number of agency staff and the mix with permanent staff. There are not enough staff on duty, and there are too many residents with higher needs. I don't know where everyone (staff) is!' Another relative described

staffing levels as, "Variable." An external health professional also told us there were insufficient staff and they sometimes had difficulty in finding staff on their visits.

On our second day, in the nursing unit there was one nurse and five care staff plus someone on induction. In the afternoon, staff told us someone had rang in sick and the acting manager in the nursing unit had not arranged another member of staff to provide cover, "So we're short." We saw there was one nurse and three care staff, (one of whom was from the local agency) and one had been moved from the dementia unit, which had reduced the number of staff in that unit from three to two. The agency staff we spoke with said, "I have been here five times now, so I'm getting used to the people and their routines." As an example of the unsettling impact of an inconsistent staff team, we asked the staff member, who had been asked to provide cover, to describe a person's care needs. They told us, "Sorry I don't know [person], I usually work downstairs. (In the dementia unit)". This demonstrated staff did not always have the necessary knowledge to meet people's needs

One member of staff told us, "It can be very stressful when we're short staffed. People are individuals and all have their different needs. They like to take their time and it's not their fault we don't have enough staff." Another staff member described how some colleagues had persistently called in sick. They told us, "It's really frustrating when the same people ring in sick . . . and they think its okay." A health care professional we spoke with told us there were insufficient staff and they sometimes had difficulty in finding staff on their visits. They told us, "There are just not enough staff. They don't always know what's happening and will often just shrug their shoulders when you ask them something. The high use of agency staff also impacts on the care that people receive as they don't know them well. There are just never enough."

The provider told us staffing levels had recently been increased following consultation with staff. This was supported by a member of staff who told us, "They have increased staffing over the last few days but I'm not sure it's made much difference. Another staff member said, "Staffing would be my biggest concern and the high use of agency staff. We are short and working with agency is hard. They keep telling us they have increased staffing, well they haven't this afternoon have they?" This was supported by a relative we spoke with, who also commented on the use of agency staff and the unsettling impact this can have. They told us, "All the helpers seem to be different. There are two new ones again today that I have never seen before, it upsets me. They used to come and have a chat with you and offer you a drink, but you don't get that now they just seem so busy." They added, "There are staff about but they never interact with people, there is nothing for people to do; just no interaction. It upsets me when they leave the drink away from [family member] so she can't reach it, if you put it up to her mouth she will drink it." This demonstrated sufficient numbers of staff were not deployed to meet people's care and support needs.

We discussed ongoing issues regarding staff recruitment and retention with the acting manager on the residential unit. They told us, "Since I started, staff recruitment has been main priority. I feel strongly that if staff don't want to be here – I don't want them here." They went on to say, "I think the main reason for staff not staying has been the lack of regular support, including mentoring. They have been thrown in at the deep end – but not anymore."

We looked at staff rotas and discussed how staffing levels were determined, with the acting manager on the nursing unit and the assistant director. They confirmed there was currently no dependency tool being used, however the acting manager told us, "We are looking to review the tool used for assessing dependency levels. So I have just decided everyone is high needs." We asked how this related to staffing levels and staff deployment. The acting manager said, "I don't really know, I just make sure there are enough staff." The assistant director showed us a dependency tool currently used in other services within the company. However, they explained this was not currently being used at Osmaston Grange, as the provider was

currently liaising with the local authority regarding the appropriate wording and terminology of a dependency tool. They also had no supplementary tool in place to determine staffing levels, based on identified dependency levels. This meant the provider did not have a systematic approach to determine the number of staff required in order to meet the needs of people using the service and keep them safe at all times.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found risks to people were not consistently managed in a safe way. For example, where incidents and accidents, including falls, had been recorded, there was no evidence of any subsequent action being taken, such as individual care plans, including risk assessments, having been reviewed. One entry in the accident and incident file, on 18.08.2017 described a fall as, 'unwitnessed but [Name] may have leant forward and fell from their chair to floor'. We found there was no relevant risk assessment, care plan or follow up action. A member of staff told us, "[Name] does this a lot, we get her up first so she is the lounge that way we can always see her' 'There should always be a member of staff in the communal area at all times." However, during the second morning of our inspection, before 10am, we observed this person in the lounge in their chair without any staff present on three separate occasions.

We saw records showed three occasions, on 4 August and 9 & 20 October 2017 when the person had been found on their bedroom floor, on a crash mat, having fallen from a low bed with no bed rail. We saw there was a risk assessment in place that the person, 'MUST' have their bed rails up when in bed; this was because the person was at high risk of falls). Staff we spoke with confirmed the person had bed rails in place. When we discussed this with the acting manager, they told us, "It was before I worked here." We explained the last recorded incident wasn't. They replied, "I don't know then, ask the nurse." The nurse showed us their relevant notes which stated the person had been checked and was fine. A member of staff told us, "It's because we use agency all the time and they don't know what they are doing. From what I heard it was the agency last time they put her to bed and never put the sides up so she fell." We asked to see evidence of any induction provided for agency staff who worked at the service; this was not produced despite having been requested three times. We found no action had been taken after each fall to review, amend and update the risk assessments and to investigate why the bed rails had not been used correctly to prevent a fall. This demonstrated the provider had taken inadequate action to manage risk and improve the safety of the service for people.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we reviewed the procedures in place regarding the safe management of medicines. We saw medicines were stored within a dedicated room. Separate locked cupboards were in place containing lotions and external medicines, stock medicines and also dressings. Two medicine trolleys were in use. Both were locked and also secured to the wall. The nurse told us these trolleys contained medicines currently in use. We saw all cupboards and both trolleys were tidy and well ordered. Any bottles that had been opened contained the date they were opened. Expiry dates were checked and all medicines were in date.

A drugs fridge was in use. Whilst a lock was available, the fridge was not locked at the time of our inspection. The fridge was clean and contained medicines that required to be stored below room temperature. The operating temperature of the fridge was being recorded daily. Records were checked for October 2017. An entry had been made for each day and the fridge was operating within normal range. Information was

available for staff to explain normal operating range and also what to do if they found the fridge to be operating outside of that range.

On the first day of our inspection we reviewed the Medicines Administration Record (MAR) charts and also observed the lunchtime medication round. Most prescription medications were dispensed from individual carousels for each person. One carousel for each drug. We saw the MAR charts were filed in one order and the carousels were in a totally different order. Whilst the MAR charts each incorporated a photograph of the person, it was difficult to locate each individual MAR chart. This, along with the carousels being in a different order made the medicine round time consuming and created a risk of error.

The nurse undertaking the medicine round told us medicines were usually dispended one by one leaving the trolley in the medicine room. The room had to be locked each time the nurse left the room. On the first morning of our inspection, this resulted in the medicine round taking almost four hours, which meant people did not receive their medicine in a timely manner and the nurse was effectively unavailable during this time. The nurse told us that some morning medicine rounds could take up to four hours, and that the person undertaking the round could be constantly interrupted. Medicine rounds taking this length of time clearly have a potential impact on the timings between doses of some specific medicines and the effect on the recipient could be compromised. The nurse also acknowledged that constant interruptions create a risk of error. This issue was discussed with the acting manager and provider who said they would be addressing the problem.
This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst staff had a clear understanding or what may constitute abuse and how to report it, the provider had not ensured systems and processes had been used effectively. Consequently they had not taken appropriate action immediately upon becoming aware of an allegation of abuse. We saw incidents the provider had not referred to the local safeguarding authority and notified to the commission, as they were required to do. We discussed these incidents with the managers who told us they believed the incidents would have been referred and notifications made to the commission. Where people had been at risk of potential safeguarding concerns, the risks had not been satisfactorily addressed. The lack of referrals to the local safeguarding authority and lack of notifications to the commission meant that external agencies had not been able to have oversight of any concerns to ensure incidents had been handled correctly.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a thorough recruitment policy and procedure in place. Staff files we looked at showed the service operated a safe and effective recruitment system. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified. We saw that the recruitment process also included completion of an application form, an interview and previous employer references to assess the candidate's suitability for the role. This demonstrated the provider ensured suitable staff were employed to help keep people safe.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we checked whether staff understood and followed the principles of Mental Capacity Act 2005 (MCA) to obtain people's consent or appropriate authorisation for their care. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. Staff had received training and most understood the principles of the MCA. The manager had identified from knowledge checks with staff, that some needed further training to help fully ensure this. A related action plan showed this was planned with a reasonable timescale for completion.

During this inspection, we found consent to care was not always sought in accordance with legislation and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's consent to care was sought for most daily personal care activities. However where people lacked capacity to consent to aspects of their care, the MCA was not consistently followed. We saw in individual care plans that staff were not always working in accordance with the principles of the MCA. For example, in one care plan there was a consent form for a flu immunisation which read, 'I give consent for my relative.' The form was dated 16.10.2017 but was unsigned. The nurse told us the relative had been contacted by telephone and had given verbal consent. However we saw no MCA assessment in place and no record of a best interest meeting being held or a decision having been made. We saw in two people's care files there were copies of DoLs applications, one did not have any acknowledgement of receipt, and the other had a receipt dated March 2017. We also looked in the DoLS file kept in the manager's office and saw there were no copies of applications for 2017. Three members of staff we spoke with said they had not undertaken any training on the Mental Capacity Act. We looked at the training matrix and saw all the nurses had received MCA training within the last 18 months; however seven members of care staff had not received the training. This meant that, although training and development provided in some areas was sufficient, it was not fully understood or consistently demonstrated by staff in practice, Care and treatment were not provided in line with the principles of the MCA>.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to access external health professionals when they needed to. For example, in one person's care plan we saw the district nurse had been called to see one person who had an ongoing health condition. A relative told us the service was, "First class," at calling health professionals when required and said they, "Could not be more pleased with the care." However, although the service monitored people's health and care needs, this was inconsistent and issues identified were not always effectively acted upon.

People had not consistently been protected against the risk of poor or inappropriate care because accurate records were not being maintained. There were gaps in records where staff should have documented the care they had provided. This included personal care records, food and fluid records, tools to assess people's risk of pressure ulcers and bowel monitoring charts. Various tools were used to assess the risks to people of malnutrition and skin breakdown. These records, when used together accurately, should give a clear picture of the person's health. Despite being discussed at the previous inspection, the information contained was not being used effectively to inform staff about the care and support people needed.

We found examples of people's care and support needs not being met including shortfalls in their individual care records, including weight loss, fluid balance charts and pressure care. In one care plan we saw a letter dated 25 October from the dietician which stated: 'On waiting list; in the meantime we recommend following nutritional care plan advice, in accordance with the (MUST) guidance. However we found there had been no review of the care plan since the letter arrived, no care plan was in place stating what to do (for example, how to increase a person's nutritional intake. The person's weight was checked weekly but other than that we could see no evidence recommendations were being followed. We saw another person's fluid chart, with the recommended daily amount left blank. It showed 9/11 – 975mls; 10/11 -810 mls;1/11 – 1390 mls; 12/11 -1070mls; 13/11 – 300 mls; 14/11 – 775 mls; 15/11 – 1275 mls A member of staff told us, 'I'm not sure how much she should have, she doesn't drink a lot as she stores it in her mouth. Her mouth is always sore and dry" "I think the nurse reviews it we just record this."

We spoke with a healthcare professional, who had been asked to see this person regarding their dry mouth. However they said staff had not shared concerns regarding the lack of fluid intake and the doctor was therefore unaware. They said they would expect people to be having around 1000mls a day. There was no evidence the fluid balance charts were being reviewed, so when action was needed, none was taken.

We also found similar concerns regarding another person's fluid chart, where the assessed fluid levels required had not been met for seven consecutive days. Again no action had been taken as no one was aware of it. This was someone who was in bed and needed support to drink. From lunch time until we left, three hours later, there was half a beaker of thickened drink that was on their table. We only saw staff offering the person a drink and support at mealtimes. A member of staff we spoke with told us, "She doesn't drink much either."

In another person's care plan we saw there was a pressure wound assessment sheet in place that stated the dressing was to be changed every other day and we saw this was being done and appropriately recorded. However there was no other information, including any Tissue Viability Nurse (TVN) guidance, and no specific care plan. There was also nothing recorded about what dressing to use. A member of staff told us they had contact the District Nurse for advice last week, however as she had been off she didn't know if anyone else had followed this up and we saw there was nothing documented. This lack of effective communication meant individual care provided was inconsistent. A healthcare professional discussed their concerns regarding lack of continuity, particularly in relation to senior staff, and commented on the poor

communication within the service. They told us, "We don't have a great deal of confidence in senior staff, when they say, I don't really know, I've not been here for five days' – as if that is an excuse for lack of knowledge."

We looked at the care records for a person who suffered from leg ulcers. The records noted there was one ulcer on the right leg and large blisters on both lower legs. There were details of what dressings should be used, however there was no information detailing the size or appearance of the ulcer, nor was there a body map or any photographs. Recording the size, shape and appearance of leg ulcers or blisters creates a record of what the lesion looked like at a specific date and time. This record can be referred to at each subsequent wound dressing so that improvement or deterioration of the wound can be clearly noted. This issue was commented on by a healthcare professional we spoke with, who told us, "The senior staff are not always that proactive. For example, during a recent 'ward round' I lifted up someone's bed clothes to see their skin condition had deteriorated in a way we would not have expected and [staff] were not aware of."

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed lunchtime and saw the meal looked appetising. There was a choice on the menu and we saw food was softened or pureed according to people's individual's needs. We saw tables in the dementia unit were bare and without condiments. Drinks were brought round ready poured into a plastic glass. We did not hear anyone offered a choice of drink. We observed people who required assistance were supported to eat. They appeared to enjoy their food and we saw there was minimal waste on people's plates. One person said, "It was a beautiful dinner." A relative told us, "The food is alright," and another said their family member, "Always enjoys the food." This meant people were encouraged and supported to maintain a balanced and nutritious diet.

We saw there was signage available to assist people living with dementia and tactile and sensory equipment was accessible. The décor was themed in different areas, for example one corridor had a film theme and another had a seaside theme. Carpets were clean and there was no malodour. The outside areas were largely neglected and untidy with weeds, leaves and debris. They were uninviting and were clearly unused. A relative we spoke with told us they were disappointed the area outside their family member's room was not able to be used and not easily accessible. Staff confirmed the external areas were not used but couldn't tell us why this was. This meant the environment was arranged to promote people's independence and well-being but outside areas were not well maintained.

Requires Improvement

Is the service caring?

Our findings

In the nursing unit, although we saw staff were caring and compassionate, they often appeared rushed and we did not observe many examples when staff were able to sit and spend time with people. Consequently many interactions were very task focused and usually confined to when people needed specific support, such as using the toilet or moving from their room to the communal lounge. Typical of the comments we received from people regarding this issue included this from a person in the residential unit, "On the whole I get what I need. The staff are okay, one or two are a bit snappy but okay on the whole. Sometimes they hurry me in the morning and I can forget things; this morning I don't have my glasses.''

We received some positive comments and observed some staff cared and supported people with a kind and compassionate attitude. However we found there was a lack of consistency in the caring approach of certain members of staff.

We received some contradictory views from relatives we spoke with regarding the kindness of care staff. One relative told us, "'[Family member] is happy calling this home. Really the staff are good, but there are just not enough. Some staff are lovely but there is in my view a high turnover. They [Staff] treat [family member] with dignity, they don't talk over him and they know him as an individual." They went on to say, "I have seen how they treat other residents. I heard them dealing with a 'stroppy' lady. They kept calm and they never speak in a derogatory way.'' Another relative said, "Most of the staff are caring but I think to some it's just a job. I heard a carer tell a resident who kept saying he wanted to go home, 'Talk to your [relative], they put you in here.' That wasn't very kind."

We observed the care provided in the lounge and dining area of the dementia unit. The atmosphere was calm and people were responded to in a timely manner and were treated respectfully. Care plans showed relatives had been involved, when individuals lacked the mental capacity to be fully involved in their care plans.

We saw staff were polite and respectful when speaking with people. We observed friendly, good natured interactions between staff and the people they supported, which were warm and compassionate. Staff communicated with people effectively and used different ways of enhancing that communication, for example, by touch and altering the tone of their voice appropriately.

A healthcare professional we spoke with described the staff as, "Good, kind and caring to people." However another health professional told us, "The majority of staff here are clearly kind and very caring, I see many entirely caring and appropriate interactions, which I have no concerns about. I am concerned though regarding the lack of continuity of senior nursing staff." They went on to say, "I am worried on behalf of the residents, they are not receiving consistent care."

Although much of the care we observed was task oriented, we saw some examples of the kind and caring approach of staff. We saw a staff member engaged in an individual activity with one person. They were patient and polite and encouraged the person to make choices. A relative we spoke with described the care

provided as, "Dignified." We saw staff respected people's dignity, privacy and choice. Throughout the inspection, we observed staff were courteous, polite and consistently promoted people's rights by listening carefully, offering choices and respecting decisions. For example, during lunchtime we saw a member of staff responded promptly, calmly and sensitively when supporting a person to eat.

All care staff spoken with demonstrated they understood the importance of ensuring people's dignity in care. They were able to give examples of how they did this, such as: explaining procedures, closing curtains, approaching people quietly, and covering people when they received personal care.

Requires Improvement

Is the service responsive?

Our findings

People did not consistently receive personalised care from staff, as they were not always aware of or responsive to their individual care and support needs. The acting manager in the nursing unit said, before moving to the service, a comprehensive assessment would be carried out to establish people's individual care and support needs, to help ensure any such needs can be met in a structured and consistent manner. However they told us that since starting in their role, three weeks ago, they had not assessed anybody and confirmed the service was not currently taking any new admissions.

The acting manager also told us that, since they started, they had faced, "Many challenges," and had prioritised reviews and updates of care plans, which they described as, "Work in progress." They said, as far as practicable, they wanted people to be directly involved in the planning and reviewing of their own care. However they acknowledged this was not always the case at present and this was supported by people and relatives we spoke with and documentation we saw. Individual plans we looked at contained little evidence that people or their relatives had been involved in the care planning process.

One relative we spoke with told us, "No, I don't have anything to do with [family member's] care plan." Another relative said, "I'm aware of the care plan but have certainly not been involved with writing it." Other relatives confirmed they did not contribute to the care plans. However we received some positive comments from relatives who had attended the recent meeting, chaired by the acting manager, and appreciated the opportunity to discuss their concerns. One relative told us, "I am impressed and there was a good turnout for the meeting." Another relative said, "It was a frank meeting with [Acting manager] and I feel assured that things will improve, however I can direct any concerns straight to the regional manager if I feel I need to." This demonstrated the service had started to take an open, transparent approach to discussion with relatives.

Staff we spoke with said they were aware of the importance of knowing and understanding people's individual care and support needs so they could respond appropriately and consistently. We saw care plans contained details regarding people's health needs, their likes and dislikes and their individual preferences. They also contained details of their personal history, interests and guidelines for staff regarding how they wanted their personal care and support provided.

However this was not always reflected in the care people received. For example, in one person's care plan it had been identified they had been a keen sports person and maintained an interest in the sport. However, despite all the current publicity on television and in the newspapers regarding a major event within the person's sporting interest, there was no evidence that anyone had used this opportunity to engage with the person about a clearly identified interest. This demonstrated people's care and support needs were not always met in a structured and consistent manner, in accordance with their identified choices and preferences.

Reviews of people's care were found to be inconsistent regarding the monitoring and recording processes. Individual reviews did not always demonstrate how changes in people's health conditions and the

monitoring of those had been considered in the care planning process. The acting manager in the nursing unit told us, "Each resident now has a named nurse responsible for evaluating their care plan and ensuring it is accurate, up to date and reflects their current and changing needs. They said this system had only just been implemented and described it as, "work in progress." They also acknowledged that, "Not all the nurses are on board with this just yet." This meant people were at potential risk of inconsistent care as their care needs had not regularly been assessed and their care plans did not always reflect their current needs.

People told us they were happy and comfortable with their rooms and we saw rooms were personalised with their individual possessions, including small items of furniture, photographs and memorabilia. People told us they generally felt listened to and spoke of staff knowing them well and being aware of their preferences and how they liked to spend their day.

Throughout the day we observed friendly, good natured conversations between people and individual members of staff; although we saw staff often appeared rushed, they had little time to support and engage with people and most of the interactions were task focused; for example supporting someone to use the toilet or move from their room to the dining area.

We saw people who were being cared for in bed did not have accessible call bells, a member of staff told us this was because, "They couldn't use them." There were no risk assessments in place for this; however staff told us they did regular checks, although we saw no evidence checks were completed. We spoke to one person about this; their call bell was on the wall and out of reach. They told us, "I like a lie in, I'm not a morning person. I have my buzzer I press when I need them [staff]." They went on to say, "[Staff] always forget to give it to me. I will have to shout someone when I see them." This demonstrated people's needs were not always responded to in a timely manner.

There was no activities coordinator employed at Osmaston Grange and staff told us they did not always have time to do organised activities. We saw there was no specified staff role regarding activities at the time of our inspection. There were no activities at all in the morning, very little interaction from staff with people and what there was focussed on assisting people with their care needs. Nothing happened in the morning and in the afternoon the TV was switched on and the radio was on at the same time, making it difficult for people to enjoy either. We spoke with people and their relatives about the provision of activities. One person told us, "There's not much going on now. Last year there were some nice activities, quizzes and painting - that would be nice again.'' A relative told us, "'There is no stimulation, not enough going on. 'My [family member] is not able to be involved with activities, but there hasn't been anything for the last couple of years."

We discussed this issue with the acting manager and assistant director, who confirmed an activities co-ordinator had recently been appointed. They were due to start work the following month and initially would spend time in all three units. They also said a volunteer from the local church was coming in to spend time with individuals and support them with social and recreational activities.

We saw there was a range of tactile objects around the dementia unit; for example, scarves and hats on a hat stand, jewellery, wall hangings, games and woollen items. During the morning we saw some people engaged with these but we saw two people had very little interaction with staff. hey spent most of their time asleep and one person was in a wheelchair until approximately 2.30 pm. Staff we spoke with told us there were some external entertainers such as musicians and visitors from churches and schools who came to entertain people. The TV was on throughout the time we were in the unit, although no-one appeared to be watching it. This demonstrated a lack of stimulation and limited meaningful activities.

People using the service and relatives we spoke with told us they knew what to do if they had any concerns. They also felt confident they would be listened to and their concerns taken seriously and acted upon. One relative told us, "I would go to the manager; we have a good relationship with the management." Another relative said, "I have had no need to make a complaint."

We saw the provider had systems in place for handling and managing complaints. Staff told us that, where necessary, they supported people to raise and discuss any concerns they might have. The acting manager showed us the complaints procedure and told us they welcomed people's views about the service. They said any concerns or complaints would be taken seriously and dealt with quickly and efficiently, ensuring wherever possible a satisfactory outcome for the complainant. We saw a complaints procedure was on display. Records we looked at showed that comments, compliments and complaints were monitored and acted upon. This meant complaints were handled and responded to appropriately and any changes and learning implemented and recorded.

Inadequate

Is the service well-led?

Our findings

Our findings from previous inspections have shown a history of non-compliance with the regulations. During our last comprehensive inspection of the service in October 2016 we found the provider did not have effective systems and arrangements for the management and oversight of the service to ensure the quality and safety of people's care. This was a repeated breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We issued a warning notice to the provider, which told them they were required to become compliant with the repeated breach and by when.

At the subsequent responsive inspection on 27 February and 3 March 2017 we found that improvements made were sufficient to rectify the breach. However, based on the provider's inconsistent history of non-compliance we were not totally confident the improvements made would be sustained. Shortfalls and necessary improvements to the quality and safety of people's care were not proactively identified by the provider and were often prompted by external agencies, including care commissioners, fire safety officers and CQC concerned with people's care at Osmaston Grange.

Significant improvements to the quality and safety of people's care included increased staffing levels, improvements relating to people's safety and need for consent and environmental issues related to cleanliness and infection control. A new acting manager, appointed in October 2016, had introduced revised governance arrangements to regularly monitor the quality and safety of people's care at the service. Ongoing management checks, related management records and our inspection findings showed a comprehensive service improvement plan. This was prioritised against risk, to help ensure people received safe, effective care and ongoing service improvement. Further improvements needed were either planned or in progress with reasonable timescales identified for their achievement. For example, to enable people's safe access to well-maintained garden and courtyard areas of the home; to improve opportunities for people's occupation and leisure and to seek people's views and increase their involvement in their care.

However since the last inspection concerns have again been raised regarding the safety and quality of care provision at Osmaston Grange. At this inspection we found significant changes since the previous inspection with the residential unit now completely separated from the nursing and dementia unit. Each unit now has a manager and staff team and is run totally independent of the other. Both acting managers were new in post, with the acting manager in the residential unit having been appointed in September 2017 and the acting manager in the nursing and dementia units appointed in October 2017. During our inspection we identified various shortfalls, which included failures in safe care practices, inconsistent staffing levels and staff training, planning and delivery of people's care, and following relevant legislation.

We found where accidents and incidents had occurred these were not always analysed as required. For example when people had multiple falls, these had not been investigated or action taken to reduce the risk of reoccurrence. One person had fallen out of bed on several occasions due to the bed rails not always being in place as required. After the first fall no action had been taken and the person continued to be placed at risk. We also looked at records for another person. We saw that this person was not receiving fluids as required. It was also documented this person had a dry mouth, during our inspection they were seen by

the GP with regards to this. The provider had not recognised that this person was not receiving enough fluids and had not shared this with the GP to consider.

We found the systems in place to monitor and improve the quality and safety of services provided were inconsistent. There were no records of any audits having been carried out in August or October 2017. In the audits we looked at for 2017 there was no evidence of any action taken, where gaps or shortfalls had been identified. When we spoke with the acting manager in the nursing and dementia unit they said they were aware of the challenges they faced and confirmed they were having to prioritise the work needed to address these shortfalls. They told us care plans, including risk assessments, had been allocated to individual named nurses, who had responsibility for evaluating these. However, when we looked at these there was no evidence of any reviews having taken place or action taken when these reviews had not occurred. Furthermore we found the lack of effective monitoring clearly impacted on people who used the service and the level of care they received.
Care plans we looked at did not always have the necessary information to support people in an individualised way. For example, one person's moving and handling risk assessment was completed but lacked detail about which slings should be used. This person also had a monthly weight chart in place, however records showed us this person was not being weighed as required. The records of another person indicated they had developed sore skin. There was no information within the records detailing the size or appearance of the ulcers, nor were there any photographs as required, therefore we could not be sure this person was receiving the correct support with this and there was no evidence to demonstrate if this wound was healing or progressing. No audits we looked at identified these areas for improvement. This meant there were not suitable systems in place to monitor and improve the quality of the service.

We saw that audits were completed by the provider however they were not always effective in identifying areas for improvement. For example, we saw a care plan audit was being completed. This did not identify that care plans did not always have accurate information about people's needs or incorrect information in them.

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

We could not be assured that the provider understood the responsibilities of their registration with us. The provider had failed to notify us of reportable incidents that had occurred at the home. This included a safeguarding incident and a serious injury that had occurred. Therefore we could not be assured that the provider was dealing with safeguarding matters in a transparent way.

This is a breach of Regulation 18 (4) (B) of the Care Quality Commission (Registration) Regulations 2009.

We found that the leadership within the service was ineffective, for example, staff told us they did not have the time to spend with people due the lack of staff available which impacted on the time they could spend with people to offer meaningful activities. At this inspection we found that despite concerns raised from our previous inspections few improvements to the provision of the service had been made. Furthermore, when improvements have been made these were not sustained. For example, the lack of effective management and oversight of the service has been raised continually as a concern. At this inspection we have found ongoing concerns and the provider is again in breach of regulations due to leadership being weak across the home. There was a lack of staff involvement within the home which meant staff did not always know their roles. This was demonstrated with the care provided being inconsistent due to the lack of communication and accurate care records. This demonstrated the management systems in place were not driving improvements and were inconsistent.