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?	**Requires Improvement**

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 48 people living at the home.

People's experience of using this service and what we found

Following the last inspection, the registered manager left the service. At the beginning of the pandemic there was limited management and leadership in the home. This led to concerns and feedback we received was that people's care needs were not being met. This was addressed when members of their quality team were put in the home to help start making the improvements. A new manager started in July 2020.

People told us they felt safe and that staff were kind and helpful. Risk assessments were in place to help promote people's safety and the new manager checked that staff worked in accordance with the assessments and accompanying care plans. Unexplained injuries were recorded, investigated and any actions needed taken. However, these were not always reported to the local authority or to CQC.

Some people and relatives said at times the home needed more staff as people had to wait for the toilet for example. People told us they had their needs met. We saw that people looked comfortable and staff were responding to them as needed. The manager and staff knew people well. Care plans had been updated to better reflect people's needs and help promote their rights and welfare.

The manager and staff team told us that it had been challenging during the pandemic, but they felt it had helped create better teamwork. People told us they had not been affected greatly during the pandemic. There were some delays in visiting due to testing and control measures which needed to be in place, however this was being addressed. Personal protective equipment was worn appropriately by most staff and good hygiene systems were in place. The manager took action in educating staff should they not follow safe working practice.

The environment had improved and there was ongoing refurbishment plans to continue these improvements.

We were told by people, relatives and staff that things at Osbourne Court Care Home had improved and the new manager had implemented training, systems and guidance to help address previous concerns.

The manager was working closely 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.

Rating at last inspection

The last rating for this service was requires improvement (published 19 June 2020) and there were multiple breaches of regulation. We issued the provider with a warning notice stating they must make the improvements by 30 April 2020. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Why we inspected

We undertook a targeted inspection to follow up on the concerns we had at the last inspection and 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.

We found no evidence during this inspection that people were at risk of harm from these concerns.

Please see the safe section 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 continue to monitor information we receive about the service until we 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Osbourne Court Care Home

Detailed findings

Background to this inspection

The inspection
This was a focused inspection to check whether the provider had met the requirements of the warning notice we issued following the last inspection. We will assess all of the key question at the next comprehensive inspection of the service.

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 had applied 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
We gave five minutes notice so we could clarify the services COVID-19 Personal Protective Equipment (PPE) practice for visiting professionals and identify persons who were shielding so we could respond accordingly.

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 work 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 used all of this information to plan our inspection. We had requested information from the provider prior to the inspection and this information was used as part of the inspection plan.

During the inspection

We spoke with six members of staff including the registered manager. We spoke with four people who used the service and received feedback from six 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.

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.

At our last inspection the provider had failed to 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

Systems and processes to safeguard people from the risk of abuse
• At our last inspection we found that systems to monitor, report and investigate unexplained injuries was not robust.
• 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 had not always reported these incidents to us or to the local authority safeguarding team.
• Staff were aware of what signs of abuse to look out for and how to report any concerns they had.

Assessing risk, safety monitoring and management
• The manager was frequently around the home ensuring staff were working safely. When needed, on the spot training was offered. For example, staff were given guidance about how to assist someone who required pureed meals.
• People at risk of falling were monitored. When needed remedial action to reduce risk was taken. For example, moving bedrooms so staff could quickly respond to people's needs and provide additional engagement to keep people stimulated.
• People told us they felt safe. Relatives also told us they felt people were safe. One relative said, "I feel they are doing a good job ensuring [person's] well-being and safety is looked after."
• Pressure care was being delivered appropriately and fire procedures and assessments were in place.
• Staff had received training and guidance in relation to supporting people when they become distressed. As a result, these incidents were reducing.

Staffing and recruitment
• The rota was planned in a way to meet the dependency of those in the home. The manager told us that although numbers of people had reduced, the needs of people in the home were high therefore staffing could not be reduced to reflect numbers.
• Staff were around and were responding to people's requests when needed. However, one relative told us

they were worried that their family member was being left in bed as it saved them time.
• Another relative told us that their family member was often waiting for the toilet for long periods of time and their meal was at times cold when it was delivered to their room. They said, "The staff are very caring and try to be as helpful as they can but there is just not enough of them to fulfil the duties effectively." We were also told that an afternoon cup of tea is missed at times as staff are too busy.
• Some staff on the top floor felt that at times they needed additional staffing as they were rushing around.

We recommend that a system is adopted so that the person is not left waiting. This will reduce the risk of delays and the staff member becoming distracted. We recommend that the service implements a more effective way of delivering meals to rooms to ensure they are hot and hot drinks are provided regularly throughout the day.

• Most people told us that call bells were answered promptly and staff were available to them. However, one person told us that they often had to wait for staff to be free to take them to the toilet. We observed on the day this person having their bell answered quickly but the staff member leaving to get a colleague to assist them.
• The manager said that currently the call bell system had no monitoring function. They were in the process of getting quotes to have this updated to allow monitoring of call bell response times.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were 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 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 assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
• Guidance for hand washing, personal protective equipment and infection control were displayed in the service. Staff had access to personal protective equipment which we observed staff wearing appropriately in most cases. However, we did note staff at times had their masks on their chins and under their nose. This was rectified when they observed us watching. We shared this with the manager who told us that appropriate action would be taken to address this.

We recommend the home implement additional checks to ensure staff are wearing PPE correctly, as well as educating the staff team further on the effectiveness of using PPE.

• Relatives told us that control measures in place to help prevent infection coming into the home had meant they missed seeing their family members. One relative told us that communication about this could be improved.
• The manager told us that controlled visits to the home were due to start again now they had not had a positive Covid 19 test for more than 28 days.

Using medicines safely
• At the last inspection we found that medicines were not always managed safely. At this inspection we found that while there was a signature missing, systems had been put in place to address shortfalls.

• We saw that when people were on antipsychotics, reviews were sought from the GP. Care plans for people needing these medicines on an as needed basis included guidance for staff about individual requirements.
• We counted a random sample of medicines and found the quantities to tally with records.

Learning lessons when things go wrong
• The manager had made the findings of the last inspection and internal audits known to staff.
• Meetings, flash meetings, training and supervision had addressed these issues and given guidance to staff.

Requires Improvement

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 Inadequate. At this inspection this key question has improved to Requires Improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture had some more improvements to be made for the delivery of high-quality, person-centred care.

At our last inspection concerns were found in relation to treating people with dignity and respect (Regulation 10)and person-centred care (Regulation 9) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was enough improvement made at this inspection and the provider was no longer in breach of regulations 9 and 10.

Continuous learning and improving care

- The manager was supported by a newly allocated regional manager and they were working to make the required improvements. There was a service improvement plan that was a working record continually updated and added to when needed.
- The manager acknowledged that some areas would not be fully actioned but felt they were making good progress with the action plans.
- The manager had identified additional areas that they wanted to develop and was working with the provider to address these. Additional training had been arranged to help support these areas to improve.
- As a result, we found that people looked better cared for and were more comfortable. The atmosphere was more relaxed, and people were spoken to and listened to, so this helped promote their dignity. One relative said, "Overall I feel very positive about Osbourne court and the care it provides."

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

At our last inspection concerns were found that people's rights were not always promoted. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was enough improvement made at this inspection and the provider was no longer in breach of regulation 11.

- At the last inspection we found that the service was not inclusive, empowering or person centred.

Feedback from relatives at the beginning of the pandemic was there was no leadership or management presence in the home and communication was poor.
●In July 2020 a new manager had been appointed and feedback about this change was positive.
● The new manager and their team had worked on addressing shortfalls in the home, discussing issues and learning from previous concerns. Systems had been put in place to reduce the risk of reoccurrences. For example, there was a spreadsheet in place and training delivered relating to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected. This was supported by the appropriate assessments and best interest decisions.
● People and staff told us that the new manager was visible in the home, checking how things were and guiding staff. One person said, "I told [manager] about a problem and she sorted it." A relative told us, "Osbourne court is very positively improving with the appointment of the new manager [Name]."
● Staff were at daily meetings with the manager to be kept informed of any issues and remedial actions. One staff member said, "[New manager] is lovely, out and about checking on things, encourages reporting of any issues or problems, the flash meetings are really good, can talk about any issues."
● A visiting health professional told us that often the manager was around the home and knew the people they supported well. They said, "I feel it is improving, this manager is good, proactive. Staff know people well now, and they are responsive to things shared by us."

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

At our last inspection concerns were found in the quality assurance and breaches found as part of this inspection, this was a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was enough improvement made at this inspection and the provider was no longer in breach of regulation 17.

● At the last inspection quality assurance systems were not used effectively and the manager and staff were not motivated to provide a good standard of care. At this inspection we found that this had improved.
● While we found the new manager to be open about how things were in the service and recorded any issues for review, we found at times that the required statutory notifications were at times missed. For example, in relation to unexplained injuries. They told us, "I apologise for that, it was an oversight."
The provider must ensure that all notifiable events and incidents are reported to the appropriate authority when needed.
● The service was now using the quality assurance audits appropriately. There was a service improvement plan which included the areas found to be needing improvement.
● The manager provided guidance and leadership for staff. We found that improvements had been made and the culture in the home was better. For example, staff approach was more caring, and care plans included clear information about people's needs and how staff should support them.
● The manager kept in touch with people and their relatives and feedback about communication was positive. One relative said, "Communication with me has noticeably improved and the staff are now always pleased to see you when visiting."

Working in partnership with others
● At the last inspection we found that the registered manager did not agree with the local authority findings even though our inspection found the same issues. At this inspection we found that the new manager was

open to feedback and using this to improve the service.

- The new manager 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 wanted to use this to improve and develop the service further.