

## Osmaston Grange Care Home Limited

# Osmaston Grange

### 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

Osmaston Grange is registered to provide personal care, nursing care and accommodation for up to 80 people across two buildings. At the time of the inspection only one of the two buildings were open providing accommodation and residential care to people either on a permanent basis or for short-term care, as required. Nursing care is no longer provided at Osmaston Grange.

On the day of our visit 30 people were using the service aged 65 and over. The open building in use can support up to 40 people.

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

The provider had a process for monitoring the home which included audits, however we found these had not consistently picked up on areas which required improvement.

Medicines were not always managed safely, and some aspects of safety were not always managed to reduce the risks of harm or impact on people's dignity.

Lessons in some areas had been learnt, however there was not a system or ongoing approach to ensure areas of concern did not reoccur.

Partnerships had been developed with health and social care professionals, however, there continues to be an inconsistent approach to ensuring peoples care needs were being met.

There was sufficient staff to meet people's needs and they had received training for their role. However, training in managing behaviours which challenged had not been made available which would have supported some staff in this area.

Staff understood how to raise a safeguarding's and we saw any concerns raised had been investigated. Relatives were overall positive about the experience their family members received.

The provider completed notifications and responded to any concerns we raised. There was a positive culture within the home and environmental improvements had contributed to making the home feel more welcoming.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

Rating at last inspection (and update) The last rating for this service was requires improvement (published 20 April 2021) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made, however further improvements were required, and the rating remains requires improvement and the provider was still in breach of the regulations.

#### Why we inspected

We undertook this focused inspection to check whether the Warning Notice we previously served in relation to Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. These were in relation to concerns we had about infection control and the environment. We saw improvements had been made in these areas, however identified other areas which required further monitoring. The overall rating for the service has not changed following this targeted inspection and remains requires improvement. This report only covers our findings in relation to the key questions safe and well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remains requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Osmaston Grange on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safety and oversight relating to the governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

#### 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?**

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

Details are in our well-Led findings below.

**Requires Improvement** ●

# Osmaston Grange

## 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

This inspection was completed by one inspector, a nurse specialist and an Expert by Experience. A nurse specialist has nursing knowledge to review these areas of the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

#### Service and service type

Osmaston Grange 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 registered manager registered with the Care Quality Commission in addition to a nominated individual and 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

This inspection was unannounced.

#### What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We spoke with local commissioners and health care professionals and used all of this information to plan our inspection.

#### During the inspection

We spoke with two people who used the service about their experience of the care provided. We spoke with eleven members of staff including the provider, registered manager, senior care workers, care workers, domestic staff and the chef.

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

#### After the inspection

Our Expert by Experience contacted relatives and representative of twelve people using the service. We continued to seek clarification from the provider to validate evidence found. We looked at training data and further quality assurance records. We requested policies and additional information from the provider.

# 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 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 robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

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

- Medicine was not always managed safely. We found one person had not received their pain medicine for three weeks, the person was unable to express their discomfort and could have been in pain during this period.
- Some people had as required medicine for pain or anxiety. Protocols were not always in place and this meant staff were not provided with the guidance as to when to administer the medicines to ensure it would meet the required need.
- When medicine was administered covertly (this is when the person is not aware they are receiving their medicine). There was no clear process which had considered any possible impact on the medicine integrity when given in different foods.
- Peoples care plans had not always been followed. For example, the care plan stated the person required the support of one staff for personal care. We saw this person did not receive care from the staff and this meant it had impacted on their level of hygiene and their environment.
- Lessons had not been consistently learnt in relation to medicine and managing risks.
- Fire safety records had not been maintained. We found two people living in the home did not have a personal emergency evacuation plan, and another person no longer used the service. This meant should there be a need to evacuate the service, some people may not be accounted for or others have their needs met for a safe evacuation.

The provider had failed to ensure that people were protected from the risk of harm and there continues to be in breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection, to update fire evacuation records and address the medicine errors.

- Risks were managed. We saw risks had been reviewed following falls or incidents and longer-term solutions considered to reduce the risks.

#### Preventing and controlling infection

- At our last inspection we raised concerns in relation to infection, prevention and control. At this inspection we saw improvements had been made.
- 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.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
- We were assured the staff had all been vaccinated as required.

#### Systems and processes to safeguard people from the risk of abuse

- People had been protected from the risk of harm. We saw staff had received training and understood what and how to raise concerns. One relative told us, "[Name] has lived there for many years now. We are very pleased with the care and they are very happy living there."
- When safeguards had been raised these had been investigated and shared with the staff.
- The service has had a high level of safeguards, however some of these have been attributed to the number of new admissions. This is due to the home supporting discharges to reduce people staying longer than required in hospital. We have discussed this with the provider, and they are reviewing their assessments to ensure any risks are proportionately managed.

#### Staffing and recruitment

- There were enough staff to meet people's needs.
- All the staff we spoke with reflected on the levels of staffing being adequate to support the current level of people's needs.
- The provider had a dependency tool which was used to consider each person's needs and the staffing support they required. This was revisited when the people using the service changed.
- The provider had a process for ensuring that staff were recruited safely. Records showed that pre-employment checks were undertaken prior to staff commencing employment. Staff had Disclosure and Barring Service (DBS) checks in place. The DBS is a national agency that keeps records of criminal convictions.

# 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 remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to ensure oversight and good governance. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The governance oversight was not always in place to ensure a robust and consistent approach to managing risks and ongoing improvements.
- Audits had been completed; however, they had not always identified all the areas which needed addressing to ensure people safety. For example, in relation to medicines or daily environmental checks.
- Audits and information from the last inspection had been used to make other improvements and we saw medicine stock was now correct and many aspects of the environment had been improved. However, we were not assured of an ongoing approach in ensuring lessons were learnt and considered to ensure they did not reoccur.
- We saw there was sometimes a delay in the responsive action following incidents, for example when people entered other people's rooms without consent. This meant people remained at risk or there was an impact on their dignity.
- We reviewed the handover documentation and found not all the required information had been shared. For example, on a specific date not all falls, or incidents had been recorded. This meant people could be at risk of not getting the required checks or supported needed following a fall or incident.
- Staff had received training to reflect the care certificate. However, it was identified that staff required training in supporting people with behaviours which challenged. We found this training had not been made available and some staff felt this training was needed to ensure the required support was being provided for some people using the service.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a continued breach of regulation 17 (Good

Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- The provider worked with health and social care professionals; however, we found the relationship was not always consistent with a shared understanding on people's needs.
- Health care staff had raised concerns around some people's needs not being met. The registered manager had addressed these, however there was still a lack of a consistent approach.
- The provider was working towards an agreed protocol to improve this area of communication and understanding.

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

- People, relatives and staff had been consulted on the service.
- Staff told us they felt they could raise concerns and they would be listened to. We could not be assured staff had received updated information about the home and any new guidance may not have been consistently shared as they had not had regular meetings.
- Overall people and relatives were happy with the service. We saw when people had raised concerns these had been addressed. For example, the carpet had been replaced in the lounge due to it being uneven and making wheelchair movement difficult.
- Relatives we spoke with shared positive comments about the staff, one said, "They are all very nice, very polite. They keep me informed all the time."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a relaxed friendly feel at the service, we saw people and staff reflecting their relationships with friendly greetings and understanding people's needs.
- Relatives we spoke with said staff were kind and responsive. One told us, "The staff are, and always have been, very caring people. They make sure [name] looks their best. You can hear the kindness, when they are speaking to other people too."
- People were supported to spend their day as they wished. We saw some people chose to stay in their rooms and other people enjoyed the communal spaces. Within the communal spaces there was some entertainment, for example singing and craft items, which people enjoyed.

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

- Notifications were completed, this meant we were able to monitor the service and review the actions taken following any incident or event.
- The provider continues to respond swiftly to any concerns raised and put changes into place.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The provider had not ensured medicines were administered accurately and in accordance with the prescriber instructions. Fire safety was not always in place. Risk to peoples personal safety was not always managed.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Effective systems were not always in place to assess, monitor and improve quality of care.