The Old School House Limited

The Old School House and Courtyard Nursing Home

Inspection report

Main Road
Gilberdyke
Brough
North Humberside
HU15 2SG

Tel: 01430441803

Date of inspection visit:
29 June 2017

Date of publication:
06 November 2017

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

We carried out an unannounced focused inspection of this service on 29 June 2017. This was because we had received information of concern about the management of medicines and inadequate staffing levels. At the last inspection on 28 October 2015 the service was rated as Good.

This report only covers our findings in relation to the Safe and Well-led domains. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for The Old School House and Courtyard Nursing Home on our website at www.cqc.org.uk

The Old School House and Courtyard Nursing Home is registered to provide care and accommodation for up to 42 older people. The home was previously registered to provide nursing care and residential care but now only provides residential care. The home is divided into three areas; The Courtyard, The Old School House and The Bungalow. The home is situated on the main road in Gilberdyke, a village in East Yorkshire. All of the accommodation is on one level. On the day of the inspection there were 36 people living at the home, including three people who were having respite care.

There was a manager in post who had been registered with the Care Quality Commission since 5 May 2017. 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. We will refer to the registered manager as 'the manager' throughout this report.

Prior to the inspection concerns had been shared with us about the management of medicines. Audits had been carried out by the pharmacy used by the home and by an NHS pharmacy technician. Numerous recommendations had been made following these audits, including the storage and recording of controlled drugs (CDs). Some of these recommendations had already been actioned but others were outstanding. On the day of this inspection we identified concerns about the storage and recording of controlled drugs. The record of the number of pain relief patches in stock for one person did not match the actual number of patches stored in the CD cupboard.

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

Although we found that there were sufficient numbers of staff on duty, we observed that there was a lack of presence in two units at certain times of the day. This was discussed with the manager who told us they would re-consider the deployment of staff to ensure there was a staff presence in each area of the home.

Service user risks were well managed and recorded. The manager was following the local authority guidance on safeguarding adults from abuse.

Accident and incidents were recorded and were audited to check for any patterns that might be emerging or any improvements that might be required.

On the day of the inspection we found the home to be clean and hygienic. There was sufficient personal protective equipment (PPE) available for staff and there were sufficient numbers of domestic staff on duty. Infection control audits had been carried out. However, we found that the laundry room did not have distinct 'clean' and 'dirty' zones. The manager told us on the day following our site visit that signs had been placed in the laundry room to make sure staff could easily identify the separate zones.

More evidence was needed to show that any shortfalls identified in audits had been addressed to ensure the necessary improvements had been made. Although satisfaction surveys had been carried out, we noted that there was a lack of analysis of the feedback. This feedback could have been used to make improvements to the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was not consistently safe.

Some improvements had been made in medicines management but errors had occurred in the recording of controlled drugs.

Although we found sufficient numbers of staff were employed, the deployment of staff needed to be reconsidered.

Risks in respect of people who lived at the home were well managed and safeguarding policies and procedures were being followed.

Is the service well-led?

Inspected but not rated

The service was not consistently well-led.

There was a registered manager in post who understood the needs of people who lived at the home.

Satisfaction surveys were being carried out but more analysis was needed so the feedback could be used to make improvements to the service.

Audits were being carried out but some lacked information about required actions and when these had been completed. The home's medicines audits had not identfied the concerns found by other auditors.

The Old School House and Courtyard Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection took place on 29 June 2017 and was unannounced. The inspection was carried out by one adult social care inspector.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the provider. Notifications are documents that the provider submits to the Care Quality Commission to inform us of important events that happen in the service. The provider was not asked to submit a provider information return (PIR) before this inspection. The PIR 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.

On the day of the inspection we spoke with the manager, the deputy manager, a senior care worker and the organisation's quality manager. We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for three people who lived at the home, quality assurance records, health and safety records and the records of medicines management.

Inspected but not rated

Is the service safe?

Our findings

Prior to the inspection we had received concerns about the administration and storage of medicines. This information had been shared with other health care professionals and, in response to this, audits had been carried out by a NHS pharmacy technician and by the home's pharmacy supplier.

Staff had been advised following the NHS and the pharmacy audits that two staff needed to make an entry in the CD register recording when medicines had been returned, and that this should correspond with an entry in the returns book. The NHS audit also recorded that the CD register was not numbered correctly. On the day of our inspection we saw that a CD register with a number printed on each page was in use. The name of the person, the name of the drug, the strength of the drug and the form of the drug (for example, liquid) was also recorded in the CD register. In addition to this, we saw that clear details of CDs to be returned to the pharmacy had been recorded in both the CD register and the returns book.

However, we identified a concern in respect of the recording of CDs. The CD register recorded there were five pain relief patches in stock for one person. When we counted this person's patches, we found there were nine in stock. The staff member who had 'booked in' the medicines on that occasion told us they had counted the patches and had then been called away to deal with an emergency, and they forgot to enter the details in the CD register. This meant that, although staff had been advised to take particular care with the recording of CDs, errors continued to be made.

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

There were three medicines trolleys stored in the medicine room and these contained blister packs along with boxes and bottles of medicines. Blister packs were colour coded to denote the time of day the tablets needed to be administered. The trolleys were clean and tidy. We checked records on medication administration records and saw there were no gaps in recording and that codes to record when medicines had not been given had been used correctly. The balance of 'as and when required' medicines were being recorded. The NHS audit identified that staff were checking the dates on medicines in the medicine room and in people's bedrooms, and recorded that this was excellent practice.

The outside temperature had been very high for a few days prior to the NHS inspection and their audit identified that the temperature of the medicine room and the medicine fridge were on occasions slightly higher than recommended. Staff were advised to contact their pharmacy supplier whenever this occurred to ensure that medicines continued to be safe to use, and to record these contacts. There was no record to show action had been taken in respect of this advice. However, it had also been recommended that a blind was used on the window to reduce the temperature of the medicines room and this had been actioned. The manager had also purchased a digital thermometer and had ordered an air conditioning unit to help alleviate these concerns. The temperatures of the medicine room and fridge were within recommended parameters on the day of our inspection.

The audit completed by the NHS had been carried out on 16 June 2017 and we saw that some of the recommendations made had already been carried out by staff at the home. One recommendation was that the returns book should record the details of each CD to be returned and the sheets should be signed by the pharmacy driver. At our inspection we saw that CDs were clearly recorded on the returns sheet and the latest returns sheet had been signed by the pharmacy driver. Another concern was that the stock of medicines in boxes and bottles were stored on open shelves. Staff told us there were plans in place for the room to be extended and to be fitted with more lockable cupboards for the storage of boxed and bottled medicines.

We checked the care plans for three people who lived at the home. When risks had been identified, action was taken to minimise potential risks without undue restrictions being placed on people. We saw risk assessments in respect of falls, diet and nutrition, pressure area care and the use of bed rails. The manager told us that, if people were known to display behaviours that could put themselves or others at risk of harm, their care plan recorded advice for staff on how to minimise the risk. We saw an example of this in one person's care plan. This person also had one to one support from staff during the times of day they were found to be the most anxious.

When people had been assessed as being at risk of choking or at risk of malnutrition, records evidenced that speech and language therapists or dieticians had been contacted to request advice on how to reduce these risks. Details of people's special dietary needs were recorded in their care plan, on a chart in their bedroom and in the kitchen to ensure that this information was easily accessible. When people were at risk of developing pressure sores, they had been provided with pressure relieving equipment such as mattresses and cushions, and were assisted with positional changes to reduce the risk.

Safeguarding incidents had been recorded; the seriousness of incidents had been considered and alerts submitted appropriately to the local authority.

On the day of the inspection we saw there were six care workers and a senior care worker on duty. The manager told us that three care workers were based in The Courtyard, two care workers were based in The Old School House and one care worker was based in The Bungalow, where people were more independent. However, on the day of the inspection we observed that there were times during the day when there was no staff presence in The Old School House and The Bungalow. The manager told us that there was a domestic assistant in The Bungalow most mornings who would be able to summon help from a care worker in an emergency, and we saw that emergency call bells were located throughout the area.

The manager also told us that there was a deputy manager on shift in addition to the staff recorded on the rota, and an additional one or two senior care workers on shift from 8.00 am until 5.00 or 6.00 pm Monday to Friday. They were able to assist care workers on shift during periods when they were the busiest. The manager told us they were in the process of recruiting additional staff. This was to ensure they were able to have six care staff on duty at all times without using agency staff.

In addition to care staff, there were two domestic assistants, a laundry assistant, a cook and a kitchen assistant on duty. This meant that care staff were able to concentrate on supporting people who lived at the home.

On the day of the inspection we saw that people did not have to wait for attention. Although we saw there were sufficient numbers of staff on duty, we concluded the deployment of staff needed to be reconsidered to ensure there was a staff presence in each unit throughout the day.

Accidents and incidents were recorded in care plans and in a separate accident / incident record. These

showed that appropriate action had been taken when people had been involved in an accident or incident, such as the emergency services being called and any treatment that had been required. Records were recorded and analysed each month to help identify any patterns that might be emerging or improvements that needed to be made.

We reviewed service certificates and these evidenced that equipment and systems had been appropriately maintained. We saw several references indicating the emergency call bell in The Bungalow needed to be repaired. The manager sent us information following the inspection to confirm that the required part to repair the call bell had been ordered and would be fitted by the contractor during week commencing 3 July 2017. Checks on window opening restrictors and bed rails were carried out by the home's maintenance person.

There was a fire risk assessment in place and in-house fire tests were carried out by the home's maintenance person once a week to check that fire safety equipment was in good working order. Fire drills were carried out on a regular basis and people had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to leave the premises in an emergency.

No unpleasant odours were detected during the inspection and the bathrooms and toilets we viewed had been maintained in a clean and hygienic condition. We discussed with the manager how improvements could be made to the laundry room to create more distinct 'dirty' and 'clean' zones. The manager contacted us following the inspection to inform us that signs had been placed in the laundry room to make this clear to staff. Cleanliness audits (rather than an infection control audits) were carried out each month.

Inspected but not rated

Is the service well-led?

Our findings

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. These were either provided for us on the day of the inspection or sent to us following the inspection. In addition to this, the current ratings for the service awarded by CQC were clearly displayed in the home, as required by regulation.

We found the manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. The submission of notifications allows us to check that the correct action has been taken by the registered persons following accidents or incidents.

We saw that people who lived at the home and relatives were 'in and out' of the manager's office throughout the day. It was clear that the manager and deputy manager understood people's individual needs and that people felt comfortable speaking with them.

The registered manager carried out quality audits to monitor that systems at the home were working effectively and that people received appropriate care. These included audits on medicines, cleanliness and accidents and incidents. We discussed with the manager that some of these audits needed to contain more evidence of any actions that were needed to improve the service and when they had been completed. The quality manager told us that they had designed a new audit form that would address this. Despite audits being carried out on medicines, mistakes continued to be made in the recording of CDs and numerous recommendations had been made by the health care professionals who had recently carried out audits. This led us to question the effectiveness of the audits that were being carried out by staff at the home.

A survey had been distributed to people who lived at the home, relatives and staff in January and May 2017. We were told that feedback from the May survey was in the process of being analysed and would be shared with people at the next 'family' meeting (a meeting for people who lived at the home and their relatives). The quality manager told us they had devised a 'You Said / We Did' form to share information from surveys with people in an easily accessible format and we saw examples of these were displayed at the time of the inspection.

We saw that the previous family meeting had been held in January 2017 and the minutes recorded that people had been told about the forthcoming renovations of the home, activities and the 'residents' fund. People received a newsletter in January and April 2017. This was another way of keeping people informed about events at the home.

The manager told us that health care professionals had also been given satisfaction surveys to complete; they were waiting for these to be returned so the feedback could by analysed.

We noted that some relatives had signed consent forms in respect of photography and the administration of medicines on behalf of people who lived at the home. We advised the manager that consent forms could only be signed by a relative when they had a legal right to make decisions on the person's behalf. If this was

not the case, it would be preferable to leave the form unsigned and record that the person did not have capacity to give consent.

Meetings were held for staff, including separate meetings for catering staff and senior staff. Minutes of staff meetings showed that staff were kept informed about important issues, such as the management of medicines.

The values of the service were recorded in the home's statement of purpose. These included that people would be protected from harm, abuse and exploitation, would be supported to develop as individuals and to lead as fulfilling and independent lives as possible, would be encouraged to contribute to the community and would not be discriminated against.

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 Care and treatment had not been provided in a safe way for service users in respect of the proper and safe management of medicines. Regulation 12 (2) (g)