Richard Wraighte

The Old School House

Inspection report

38 Merafield Road
Plympton
Plymouth
Devon
PL7 1TL

Tel: 01752330470
Website: www.theoldschoolhousecarehome.co.uk

Date of inspection visit:
11 July 2022

Date of publication:
13 September 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Old School House is a residential care home providing accommodation in one adapted building for up to 36 older people who require personal care. The service specialises in supporting people living with dementia. At the time of the inspection 32 people were living at the home.

People's experience of using this service and what we found
People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People and staff told us there were insufficient staffing levels to meet peoples' needs safely and effectively, we observed staffing levels to be insufficient. People did not always receive there medicines as prescribed.

We were not assured the service was following safe infection prevention and control procedures. Some people's care records were lacking in guidance for staff on reducing the risks associated with people's on-going health needs.

In some of our observations we witnessed staff being kind and compassionate towards the people they supported. However, we also noted that people were not always treated with dignity and respect at all times.

People were protected against the employment of unsuitable staff because the provider followed safe recruitment policies and procedures. People were protected from potential abuse by staff who had received training and were confident in raising concerns.

We have made a recommendation about The Mental Capacity Act (MCA).

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 16 July 2021)

Why we inspected
We received concerns in relation to staffing, risk management and the quality of care provided. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
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 COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, caring and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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 will take further action if needed.

We have identified breaches in relation to staffing, medicines, risk management and good governance.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

The Old School House

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 Health and Social Care Act 2008.

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
The inspection activity was completed by one inspector and an Expert by Experience (ExE). An EXE is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Old School House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Old School House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the 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 used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time with and spoke with nine people living at the service. We spoke with 10 members of staff including the manager and the provider. To help us assess and understand how people's care needs were being met we reviewed seven people's care records.

We also reviewed a number of records relating to the running of the service. These included staff recruitment records, medicine records and records associated with the provider's quality assurance systems. We looked at policies and procedures.

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks associated with people's on-going health needs, were not always managed appropriately.
- One person was at risk of having seizures. This person did not have risk assessments or care plans in place to guide staff in the event of a seizure taking place. We could not be satisfied that all necessary steps to reduce the harm associated with this person's care had been taken.
- One person required the use of a Catheter. This person did not have a specific care plan in place to guide staff to support the person appropriately. We noted that some guidance was available in the persons care records, however this guidance was not always followed. For example, we observed that the person's catheter was incorrectly placed causing it to not work properly.
- Care plans and risk assessments were in place for people who had been assessed as at risk of pressure sores. However, the system designed to ensure people were repositioned regularly and appropriately was not being consistently used by staff. This increased the risk of people developing a pressure sore.

We found no evidence that people had been harmed however, the provider and staff did not ensure the risks associated with peoples care needs were reduced. These concerns were a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Using medicines safely

- People did not always receive their medicines as prescribed. One person had run out of a medicine and had not received their prescribed dose for six days. The provider had initially taken some action to obtain this medicine, however actions had not been followed up effectively which resulted in this person not receiving their medicines as prescribed. This placed the person at increased risk of relapsing from their medical condition.

The failure to ensure people received their medicines as prescribed was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

- We observed staff administering medicines to other people in line with their prescriptions. There was accurate recording of the administration of medicines.
- Staff had been trained in administering medicines and their competency was checked regularly to ensure they followed best practice.

Preventing and controlling infection

- The provider did not promote safety through hygiene practices within the service. The premises were not

always clean. For example, in one person's bedroom we observed a heavily soiled and dirty chair. We raised this with the manager who took action to remove the chair.
● We noted in one area of the service the floor was sticky, and part of the flooring had come loose and was raised. This could harbour bacteria and be an infection control risk.
● The toilet bowls in two communal bathrooms were heavily stained. This was noted throughout the inspection indicating that these toilets had not been cleaned in a timely manner. We brought this to the attention of the provider who took immediate action to address this concern.

This failure to promote safety through hygiene practices within the service was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● 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 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 satisfied the provider's approach for visitors to the service was in line with the current government guidance.

Staffing and recruitment
● People told us there were not enough staff to meet their needs. Comments included "There's never anyone here to look after us", "It's like this most times, you just have to sit and wait for someone to come" and "There is never any staff".
● Staff told us there were not enough staff to always meet people's needs. One staff member said, "No, not enough staff on every shift for the level of care. It is impacting on the residents, the level of care I would say is still there but later in the day when we could be spending more time with people like sitting and talking with them or walking in the garden with them, that is when we struggle".
● Throughout our inspection staff and managers were rushed in their duties and task orientated. This meant staff were continuously focused on their next duty and did not have time to spend quality time with people and deliver individualised care and support. A staff member told us, "In the morning there are enough staff, there are six staff but in the afternoon when it drops down to three it is more difficult and that is when we do not have time to sit and speak to people. It is a lot more hectic and you feel it is one task after another."
● The manager and provider used a 'dependency tool' when carrying out ongoing assessments on people's care needs. The purpose of the dependency tool was to support the manager to calculate the right ratio of staff against people's needs.
● We found inconsistencies in how this tool was being completed and reviewed. This meant the provider could not be assured the service had the correct ratio of staff to support people effectively. Through our conversation with the manager, it was clear they did not fully understand how to complete the dependency tool effectively.

The failure to have insufficient numbers of staff to meet people's needs was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to ensure staff were recruited safely and records confirmed a range of checks

including references, disclosure and barring checks (DBS) had been requested and obtained prior to new staff commencing work in the service. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was not always working within the principles of the MCA. One person received their medicines covertly. This is when medicines are hidden in food or drink without the knowledge or consent of the person receiving them.
● There was evidence that this decision had been made in the best interests of the person, however the provider had failed to formally assess the persons capacity to consent and involve a pharmacist in the decision making process.

We recommend the provider consider, The National Institute for Health and Care Excellence's (NICE): Giving medicines covertly: A quick guide for care home managers and home care managers providing medicines support and take action to update their practice accordingly.

● In most cases where people did not have capacity to make specific decisions, the appropriate assessments were in place and staff acted in people's best interests.

Systems and processes to safeguard people from the risk of abuse
● Despite our findings people told us they felt safe. One person told us, "I do feel safe and looked after I just wish there was more staff about". Another said, "I have felt safe since I have been here".
● The provider had safeguarding policies in place and the new manager and staff reported concerns accordingly. We saw information was available around the home for staff to refer to about how to report safeguarding concerns.
● Staff told us they would report concerns to their manager immediately. One staff member said, "I would go straight to (new manager). (Safeguarding information) is all written up on the posters if we wanted to contact someone externally. If (new manager) did not listen, we would go to CQC (The Care Quality Commission)".

Learning lessons when things go wrong
● There was a system in place to record accidents and incidents.
● The manager ensured they reflected on occurrences where lessons could be learnt. The team used this as an opportunity to improve the experience for people.
● Staff knew how to report accidents and incidents and told us they received feedback about changes and learning resulting from incidents at team meetings and on an individual basis.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence. Ensuring people are well treated and supported; respecting equality and diversity

- We observed an incident where a person was not treated with the dignity and respect they deserved during an episode of incontinence.
- During the incident the person was shouting out for help to a staff member. The staff member consistently ignored the person leaving the inspection team to intervene and seek additional help from other staff members. This meant the person was left in an undignified state way longer than they needed to be and were exposed to others.
- We spoke with the staff member involved in the incident and asked why the person was ignored. The staff member explained that the person was ignored because they often shouted for help. They told us,"(Person) is always shouting out for help for no reason".
- One person required the use of a Catheter. Staff had failed to follow the guidance in the person's care records which meant their catheter had leaked leaving the person in an undignified state.

We raised these concerns immediately with the new manager and providers representative who took immediate action to address these concerns with staff.

The failure to treat people with dignity and respect at all times was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- In some of our observations we witnessed staff being kind and compassionate towards the people they supported. For example, during the lunch time meal one person became upset and agitated, a staff member took the time to reassure the person which made the person less anxious.
- Staff demonstrated through talking with us that they understood people's diverse needs and respected equality.

Supporting people to express their views and be involved in making decisions about their care

- Care plans were completed with people to ensure they reflected their wishes. In particular what was important to them had been identified.
- Care plans contained guidance on how to support people with their communication needs. Staff understood people's individual communication styles.
- Personal records were stored securely and only accessed by staff on a need to know basis. Staff understood their responsibilities for keeping personal information about people confidential.

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The service did not have a registered manager. 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. The service had a new manager in post that had not yet completed their application to register with the CQC.

● The systems in place to monitor the quality of service were not always effective. For example, the concerns that we found in relation to risk management, medicine management and MCA had not been identified by the provider.

● Oversight of the service in respect of staffing had not been effective, as highlighted in the safe section of this report. This lack of oversight also impacted on the service's ability to deliver personalised care as highlighted in the safe and caring sections of this report

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

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. The provider was aware of their responsibilities. We found the provider had notified the Care Quality Commission of significant events, which had occurred.

Continuous learning and improving care.

●The new manager had an action plan to take forward improvements to the service based on findings from quality audits. However, we noted multiple areas where action towards making improvements had not started despite the time that had passed. This was because the new manager was spending a lot of their time supporting people and staff and not having time to focus their efforts on making progress on the action plan for the service.

● We found an open and transparent culture, where constructive criticism was encouraged. The new manager, deputy manager and staff were enthusiastic and committed to further improving the service. However, this was impeded by the staffing situation within the service.

● The service worked in partnership and collaboration with a number of key organisations to support care provision, joined-up care and ensure service development.

●Where appropriate advice was sought, and referrals were made in a timely manner to ensure people

experienced continuity of care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The provider understood their responsibilities.

● The new manager told us they understood their responsibility under the duty of candour to be open and honest when things went wrong.

● Throughout our inspection visits, the new manager was open and honest.

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

● Due to our findings in the safe and caring sections of this report we could not be assured that the culture of the service consistently promoted good outcomes for people.

● The new manager had been in post for five months. During this time, they had worked hard to improve aspects of the service. For example, ensuring staff were up to date with training. However, they had not had enough time to implement the changes needed to bring the service to the required level of compliance.

● Staff spoke positively about the new manager and the culture they had started creating. They told us, "She is a phenomenal manager. I cannot rate her high enough. She is very approachable and anything you need she is there. If there are any discipline issues she deals with them and puts the residents above anything else." and, "I like (new manager) and I get on with her and she is doing the best she can with what she has got. Obviously she could do with more staff which would make the home much better" and, "I enjoy the management here and feel I could go to them with anything. I feel like they would get things done if I approached them and I feel they are open to what I am saying. They have been checking in on me and asking me if I am happy with everything and how I am doing".

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

● Staff told us how low staffing could impact negatively on their morale. However, they told us the new manager was impacting on morale in a positive way, they told us that they were involved in the development of the service, through discussions at staff meetings and handovers.

● People and their relatives had opportunities to provide feedback through surveys, the manager also had an open door policy which provided a chance to raise any comments as and when people needed to.

● From our observations and speaking with staff, the leadership team demonstrated a commitment to providing consideration to peoples protected characteristics.

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 did not always promote safety through hygiene practices within the service. People did not always receive their medicines as prescribed. Risks associated with peoples care needs were not always reduced.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor quality and safety were not always effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was insufficient staffing to meet people's needs.