The Old School House Limited

The Old School House and Courtyard Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

The inspection was unannounced. We previously visited the home on 2 July 2014. We found that the provider did not meet the regulations that we assessed and we asked them to take action. At this inspection we found that appropriate action had been taken to make the identified improvements.

The service was previously registered to provide nursing care but is now registered to provider support and accommodation for 42 older people, some of whom may have a dementia related condition. On the day of the inspection there were 27 people living at the home. The home previously had three units, but the unit known as 'The Bungalow' was closed for refurbishment on the day of the inspection.

The provider is required to have a registered manager in post and on the day of the inspection there was no

Summary of findings

manager registered with the Care Quality Commission (CQC). 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 told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm. However, there were insufficient numbers of staff to ensure that people's needs could be consistently and safely met.

Staff had been employed following robust recruitment and selection processes and this ensured that only people who were considered suitable to work with vulnerable people had been employed.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided by the home.

We observed good interactions between people who lived at the home and staff on the day of the inspection. People told us that staff were caring and this was supported by most of the relatives we spoke with.

Staff received a range of training opportunities although there were gaps in training that needed to be addressed. Staff did not have effective supervision meetings that gave them the opportunity to discuss concerns with a manager.

We received comments from people who lived at the home, relatives, staff and health care professionals about the lack of social activities. However, we observed that this was due to the home being short staffed and not the willingness of staff to spend time with people.

People's comments and complaints were responded to appropriately, but there were insufficient systems in place to seek the feedback of people and their relatives about the service provided, either through surveys or meetings.

The home lacked consistent leadership and this had affected the atmosphere of the home and led to dissatisfaction amongst the staff group.

Summary of findings

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

Staffing levels at the home were not safe.

We found that there were insufficient numbers of care workers employed to ensure that the needs of the people who lived at the home could be fully met. This was a breach of Regulation 22 of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

Staff were recruited following policies and procedures that ensured only people considered suitable to work with vulnerable people were employed. Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation. However, some staff still needed to complete training on this topic.

The arrangements in place for the management of medicines were satisfactory; medication was stored safely and record keeping was accurate.

Is the service effective?

Good

The home provided effective care.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood how to protect the rights of people's who had limited capacity to make decisions for themselves.

People's nutritional needs were assessed and met, and people told us that they were happy with the meals provided by the home. We saw that staff provided appropriate support for people who needed help to eat and drink.

Progress had been made towards staff completing mandatory training, although there were gaps in training for some topics, such as dementia awareness, the risk of falls and food hygiene.

Is the service caring?

Good

Staff at the home were caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions on the day of the inspection.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

People were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

Is the service responsive?

Good

The service was responsive to people's needs.

Summary of findings

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for their care were recorded and these were known by staff.

There was a complaints procedure in place and people were informed about how to make a complaint if they were dissatisfied with the service provided.

People told us that there was a lack of activities available at the home. This was due to the home being short staffed rather than staff's reluctance to provide social stimulation.

Is the service well-led?
The home was not well led.

Requires Improvement

There was no registered manager in post at the time of the inspection. There were two acting managers in place who still had substantive posts elsewhere. They were not able to be at the home every day and this had created a lack of consistency in the service.

There were insufficient opportunities for people who lived at the home and relatives to express their views about their quality of the service provided.

The home and equipment were regularly maintained to ensure the safety of the people who lived and worked there.

CareQuality Commission

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

We visited this service on 9 October 2014 and the inspection was unannounced. The inspection team consisted of an inspector, a second inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the home and information from health and social care professionals. This was a follow up visit so we did not request a provider information return (PIR) from the registered provider.

On the day of the inspection we spoke with ten people who lived at the home, four relatives or friends, five members of staff and the two acting managers.

We spent time observing the interaction between people who lived at the home, relatives and staff. We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for four people who lived at the home, staff records and records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

We had received information prior to the inspection stating that staffing levels had been reduced and that there were now insufficient numbers of staff on duty. We had previously asked the registered provider to inform us how staffing levels were determined. They told us that this was based on the dependency levels of people who lived at the home, including whether they needed the support of one or two staff for mobilising. We were told that staffing levels during the day had not reduced but that staffing levels during the night had been reduced to two staff, with another member of staff 'sleeping in'. Because the home is divided into two units, and most people who live at the home require the assistance of two members of staff to mobilise, we considered these staffing levels to be unsafe. However, the registered person told us that the sleep-in member of staff had not been needed and they considered that this evidenced there were enough staff on duty during the night.

We saw that there was one care worker in 'The Old School House' unit and three care workers in 'The Courtyard' unit during the day. When the care worker in 'The Old School House' required assistance to support someone with personal care or mobilising they had to request support from staff working in 'The Courtyard'. In addition to this, when the care worker in 'The Old School House' took a break, a care worker from 'The Courtyard' had to be asked to move to 'The Old School House' unit to supervise people. Because most people who lived in both units required two members of staff to assist with personal care or mobilising, this meant that there were occasions when the units were left with no member of staff to supervise people's care.

Staff told us they thought there were insufficient numbers of staff to meet the needs of people who lived at the home. One member of staff told us, "The home was previously registered as a nursing home. When the registration changed to residential care, staffing levels were reduced. However, the same people with the same level of needs are still living here." Staff said that senior staff always tried to cover shifts if people were absent due to sickness at short notice, but this was not always achieved. They felt that this resulted in occasions when there were insufficient staff on duty during the day and occasions when people had to wait too long for support.

People who lived at the home told us that there were not enough staff on duty in the mornings and at night. One person told us, "If I ring my bell they usually come promptly but if they turn the light out I know they are attending to someone else and I will have to wait." Another person said, "A handful of staff seem to be here all the time and always busy." A relative told us that there was a "Lack of consistency" and that they saw a lot of new faces, which they thought would be confusing for people who lived at the home.

This meant there had been a breach of the relevant regulation (Regulation 22) and the action we have asked the provider to take can be found at the back of the report.

Staff told us that the activities coordinator had left the home and this was confirmed by the people who we spoke with. People who lived at the home and relatives told us that that "People were missing taking part in activities." We saw that there were short periods during the day when staff were able to spend time with people who lived at the home but this put additional pressure on care staff.

Ancillary staff were employed in addition to care staff. The acting managers told us that there was a cook, a kitchen assistant, a domestic assistant and a laundry assistant on duty each day. This meant that care staff could concentrate on supporting the people who lived at the home.

We spoke with ten people who lived at the home. They all told us that they felt safe living at the home. A visitor told us that their relative would tell them if she had any concerns or felt unsafe, and she had never mentioned anything of this nature to them.

Training records evidenced that 75% of staff (including ancillary staff) had undertaken training on safeguarding adults from abuse. Although progress had been made since the last inspection, nine of the 38 staff had still not completed this training.

The home had safeguarding policies and procedures in place and submitted alerts to the local authority and notifications to the Care Quality Commission (CQC) as required. We saw that care plans included information about any safeguarding investigations that had been carried out and the outcome, including actions that needed to be taken by the home. This showed that managers were open about concerns raised and used these as opportunities for learning.

Requires Improvement

Is the service safe?

Staff who we spoke with were able to describe different types of abuse. Most staff were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation. However, one care worker was less confident about how to report an incident of abuse and we advised the acting managers that they might need to provide additional support for some staff. We checked training records and noted that this person had undertaken training on safeguarding adults from abuse. We also noted that there had been a discussion at the staff meeting on 15 September 2014 when staff were asked if they understood their role in respect of safeguarding. Staff told us they felt all staff within the team would recognise inappropriate practice and report it to a senior member of staff.

Only one member of staff had attended training on behaviour that could challenge the service although 50% of care staff had attended training on dementia awareness and four care staff had attended training on mental health awareness. It was not clear whether these courses had included some advice for staff on how to manage behaviours to reduce the risk to the person and others. We noted that one person's care plan recorded specific behaviour that could challenge the service. The care plan recorded, "(The person) needs reassurance when showing signs of anxiety" but did not include any more detail. However, staff who we observed supporting this person clearly knew how to alleviate their anxiety. We observed staff distracting another person who was agitated; they reduced their anxiety by speaking quietly, reassuring them and holding their hand.

Care plans included assessments that identified a person's level of risk. These included a nutritional assessment, a falls assessment, a mobility risk assessment and a pressure care assessment. These were scored to identify the person's level of risk and included information for staff on how to reduce the risks involved. The assessments and risk assessments had been reviewed regularly.

There was a lack of evidence to confirm that people had been assessed to determine which hoist and sling was suitable for their individual needs. This meant that there was a risk that the correct equipment might not have been used. However, we observed staff when they were assisting people with mobilising and saw this was done safely. Two staff assisted when this was an identified need and they used mobility equipment when required.

We checked the recruitment records for a two new members of staff. We saw two written references and a Disclosure and Barring Service (DBS) check had been obtained prior to the person commencing work. This meant that only people considered safe to work with vulnerable people had been employed.

Staff told us that only senior staff administered medication. We observed the administration of medication on the day of the inspection. We noted that the member of staff did not sign the medication administration record (MAR) chart until they had seen the person swallow their medication. They explained to people what they were doing and gave people a drink of water to help them to swallow tablets. We also saw the senior staff member apply creams for people; they put on disposable gloves then disposed the gloves and washed their hands before they started to assist someone else with their medication.

There were two medication trolleys in use for the two different areas of the home. We saw that trolleys were locked and were stored in locked medication rooms. There was also a medication administration record (MAR) book for each area of the home. We saw that, when people refused medication that was prescribed to be taken 'as and when required' (PRN), a code to record this was used and the reason was usually, but not always, recorded on the reverse of the MAR chart.

We checked the storage and recording of controlled drugs (CD's) and saw that this was satisfactory. Two staff signed the records in the CD book and on the MAR chart. Staff told us that they had been advised to do this in their recent training.

We checked the records for medicines returned to the pharmacy and saw that these were satisfactory. However, medication that needed to be returned to the pharmacy was not recorded in the returns book at the time it was placed into the dedicated container for returned medication, but at the time it was due to be returned. The registered provider needs to be confident that, in the interim period, people could not take medicines from the container.

The acting managers told us that all staff who administered medication had completed refresher training. They said that this included staff who worked during the night; this meant that staff on night duty were able to administer medicines if needed. However, the certificates could not be

Requires Improvement

Is the service safe?

located and the acting managers agreed to forward these to us as soon as possible to evidence that people who were administering medicines were safe to do so. At the time of writing this report these had not been received.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. At the time of our inspection the acting managers were aware that one DoLS application had been submitted and authorised and that another had been submitted by the home. They notified of the outcome of this application following the inspection. This showed us that the acting managers had referred people to the local authority for them to consider whether the measures taken by the service to keep people safe were in accordance with the MCA.

Eight staff had completed training on the MCA and DoLS in either April or August 2014. At the last inspection in July 2014 we had been concerned that people's capacity had not been assessed and there was no clear record of a person's ability to make decisions. At this inspection we saw that each person had a mental capacity assessment in place. These included statements such as, "(The person) has a diagnosis of dementia and does not have any capacity in relation to her needs for care or welfare", "Staff to try to involve (the person) in any care processes and explain what is happening" and "(The person) can retain information long enough to make a decision." We advised the acting managers that the assessments needed to be expanded to include what decisions the person could make for themselves, what decisions they would need support with and who had been involved in the decision making process.

One member of staff who we spoke with gave us a very clear explanation about people's capacity to make decisions and how this could fluctuate. Care plans recorded people's current level of capacity and also asked about a person's 'likelihood of recovering capacity'. This showed us that there was an understanding the people's capacity to make decisions could change and needed to be reviewed. Staff told us that they understood people still had to be consulted and offered choices, even when they lacked capacity.

On the day of the inspection the staff who we asked were not sure how many people who lived at the home had a diagnosis of dementia. Following the inspection, the acting managers sent us information stating that twelve of the 26 people living at the home had a diagnosis of a dementia related condition.

The acting managers were aware of good practice guidance in respect of the care of people who were living with dementia. They were in the process of refurbishing the premises and had accessed information produced by Stirling University to assist them; they had chosen plain carpets (because these are less confusing for people with cognitive impairment) and had started to use memory boxes on bedroom doors and colour coding of doors to aid recognition.

We saw that, when people were able, they had been involved in the care planning process and that their relatives had been consulted when this was appropriate. People had also been asked to consent to the use of bed rails, the frequency of checks during the night, receiving personal care and to the content of their care plan. However, we noted that consent forms were frequently signed by relatives and it was not clear if they had the authorisation to consent, for example, because they had lasting power of attorney for the person concerned. We discussed this with the acting managers who agreed to explore this issue further.

We looked at training records to check whether staff had undertaken training on topics that would give them the knowledge and skills they needed to care for people who lived at the home. We saw staff completed induction training on the topics of health and safety, food hygiene, practical moving and handling and fire safety. New staff told us that they had been supported by more experienced staff when they first started to work at the home, and how this had helped them to become more confident.

The training records evidenced that progress had been made towards staff completing mandatory training, although there were still gaps in training on the topics of the risk of falls, behaviour that could challenge the service, dementia awareness, food hygiene and MCA / DoLS. All care staff had completed training on moving and handling, and that most care staff had completed training on infection control, safeguarding adults from abuse and first aid. All staff who had responsibility for the administration of medication had completed training on the management of

Good

Is the service effective?

medicines. Only 50% of staff had completed training on fire awareness but the acting managers told us that this training was booked for 17 October 2014. This was confirmed to us by other staff who we spoke with.

There was a record of the induction training staff had completed when they were new in post. This included 'shadowing' experienced staff until they were confident about working unsupervised.

A Malnutrition Universal Screening Tool (MUST) and nutritional assessment had been completed for each person who lived at the home; this identified whether people were at risk due to poor nutrition and the level of risk. We saw that people's food and fluid intake was recorded in daily records and that people were weighed on a regular basis as part of nutritional screening. However, we saw that one person had been seen by their GP due to concerns about their weight loss. The GP had advised staff to "Keep an eye" on their weight. Although staff had continued to monitor this person's weight and it had become stable, we were concerned that there was no food and fluid chart in place to closely monitor their food and fluid intake. We saw that some people had been referred to their GP or a dietician when there were concerns about their weight and that the advice given by the dietician had been incorporated into the person's care plan. The staff who we spoke with were aware of people's special dietary needs.

We saw that there was a choice of hot meal or a sandwich at lunchtime with a hot pudding, fruit or yoghurt for dessert. One person told us that, if she did not like what was on the menu, she was asked what she would like instead. People told us that the food was not as good as it used to be. One person said, "The food is not good but I eat it if I want it. My spouse will bring soup in. I don't need a lot to eat." Other people said, "It has gone downhill this year." A visitor told us that their relative was given an alternative if they did not like the dish on the menu. However, we were told that a new cook had just started and we saw a member of staff discussing the new proposed menu with people who lived at the home to obtain their views.

The lounge / dining room in The Old School House unit was light and airy and this created a calm and restful lunchtime experience. People in The Courtyard unit required assistance to eat their meals and we observed that staff encouraged people to eat and were patient, offering assistance at the person's preferred pace.

People were provided with drinks throughout the day and encouraged to drink. However, one person said to us, "I don't know why they leave a full jug of juice every day – it is a waste." She said that she was given two glasses a day, which she drank. She needed the assistance from staff, as she could not lift the jug. No-one had explained to her that it was important for her to drink regularly. One visitor told us that a family member visited the home every day to assist their relative to eat their lunch. They said they felt staff "Did not have time to spend the hour it takes" but also felt that this was an opportunity for them to "Do something for their relative."

People's assessments and care plans were reviewed on a regular basis to ensure that there was an up to date record of the current health care needs. We saw that care plans were amended following these reviews as needed. One person's care plan review recorded, "Now requires a soft diet." In addition to in-house reviews, the local authority had carried out care plan reviews when they had commissioned the service for the person.

There was a record of any contact people had with health care professionals, for example, GP's and dieticians. This included the date, the reason for the visit / contact and the outcome. We saw advice received from health care professionals had been incorporated into care plans. Details of hospital appointments and the outcome of tests / examinations were retained with people's care records. One person told us that, when she needed to be taken to the GP or hospital, it was arranged.

Accidents that had occurred were recorded in a person's care plan. Staff told us that one person was confined to bed and had some 'redness' on their back. This was been treated by the district nurse. We noted that this person was being repositioned every three hours and was laid on a pressure care mattress; this meant that staff were taking appropriate action to reduce the risk of people developing pressure sores.

The staff who we spoke with told us that communication between the staff team was effective. They said that information was passed from shift to shift to keep staff informed of each person's current well-being and care needs.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions with them when they are not able to

Good

Is the service effective?

verbally communicate their needs to hospital staff. They include details of the person's physical and emotional health care needs. This meant that hospital staff would have access to information about the person's individual needs.

Good

Is the service caring?

Our findings

All of the people we spoke with told us that staff were "Kind and caring." One person said, "They are very kind and good, considering the long hours they work" and another person told us, "the girls that look after us are good and very friendly" although they did add "But a lot of the good ones have left." They all said that staff worked very hard. People told us they had confidence in the staff and felt that they understood their needs. We overheard one person who lived at the home say to another, "She is a beautiful carer, that one" about a particular care worker. A relative told us that she and her family were '"Quite satisfied" with the care their relative received and another visitor told us that the care staff were good and really cared about their relative.

We observed that staff displayed kindness and empathy. We saw one care worker kindly encouraging someone to keep their glasses on and assisting people with eating and drinking. We saw another care worker asking someone if they would like a rug over their knees and then 'tucking her in' and caressing her hands, and another who checked on people who were in bed. We observed that they were reassuring and told them that they would be back later to check on them again. One person told us that staff helped them to put on their socks and shoes whenever they needed help. They said, "I prefer to stay in my own room and they let me do so. They also let me go out with my wife when she comes, sometimes for a meal."

A visitor told us that care workers had ensured their relative's pressure care needs had been met and we saw that pressure care mattress had been provided for one person who spent most of their time in bed. This had ensured that they had not developed pressure sores. One relative told us that their relative needed regular re-positioning to prevent the development of pressure sores. They said, "I am impressed that they turn them every three hours and keep clear notes in their bedroom." However, we saw that one person's care plan stated that they required a pressure care cushion and they had not been provided with one on the day of our visit. This was rectified during our visit to the home.

We observed that staff were aware of people's individual needs and were able to recognise changes in the person's behaviour that indicated they were not well. Staff were aware that people needed different levels of support on different days or at different times of the day, due to their fluctuating health needs or capacity for decision making. One care plan that we saw described how the person's behaviour could be managed by staff. We overheard a care worker say, "(The resident) likes her back to be stroked." We noted that this, along with other information about how to reduce this person's behaviours, was recorded in their care plan. This meant that all staff had information about strategies that would reduce the person's anxieties and ensure they received appropriate support.

There was a key worker system in place and we saw that records had been made of the time key workers spent with people who lived at the home. This included activities such as cleaning glasses and mobility equipment, and time spent chatting with the person on a one to one basis.

None of the people we spoke with were aware of their care plan or whether their needs were reviewed, although they all said that they were happy with their care. We saw in care plans that people's needs were regularly reviewed and that care plans were updated accordingly.

Staff told us that everyone who lived at the home occupied a single room; this meant that there were no issues in respect of privacy and dignity in shared rooms. We also observed that staff respected a person's privacy and dignity in the way they approached them. One care worker who we spoke with said, "We ask discreetly if people wish to use the toilet. We close toilet doors and curtains. We involve as few staff as possible with mobilising and personal care." This showed us that staff had a good understanding of how to promote dignity within the home.

Staff told us that they encouraged people to be as independent as possible. They acknowledged that sometimes it took a long time for people to see to their own personal care and to mobilise, but understood that it was important for people to retain the abilities they had. They said that they were confident all staff were patient and allowed time for people to help themselves.

There was a lack of evidence to confirm that people had been assessed to determine which hoist and sling was suitable for their individual needs. This meant that there was a risk that the correct equipment might not have been used. However, we observed staff when they were assisting people with mobilising and saw this was done safely. Two staff assisted when this was an identified need and they used mobility equipment when required.

Good

Is the service caring?

Information about advocacy services was displayed in the entrance hall; advocacy services are available to provide independent advice to people about a variety of care issues. There was no information available about whether people had asked staff about advocacy services, if staff had told people about available advocacy services or who had accessed these services.

Good

Is the service responsive?

Our findings

We saw a care worker filing and polishing one person's nails and it was clear that this person enjoyed the one to one attention. People told us that there were occasional visits from the church choir and that the hairdresser visited the home each Thursday. We saw people having their hair done on the day of the inspection and people told us that they appreciated this service. However, there was no weekly activities schedule and people told us there were no regular activities. They said this was because an activities coordinator was no longer employed.

A relative told us that their relative enjoyed singing when entertainers visited the home but this did not happen very often. They said that they also enjoyed playing bingo and whist but these activities no longer took place.

When we spoke with staff it was clear that they would have liked to spend more time with people but they told us that the current staffing levels did not allow for this.

We saw that staff supported people to maintain relationships with family and friends. They made visitors welcome and they were flexible about visiting times. They helped people to get ready to go out with their relatives. One person told us, "My family is welcome and can take me out for a meal or to the garden centre." They said that their family were "Happy she was safe and well looked after."

We saw that care plans included information about a person's previous lifestyle, their hobbies and interests and their family relationships. We overheard conversations between people who lived at the home, relatives and staff and it was clear that staff knew people well, including their likes and dislikes and their individual preferences for care. They knew when relatives had visited and when they were due to visit again.

None of the people we spoke with were aware of their care plan or whether their needs were reviewed, although they all said that they were happy with their care. We saw in care plans that people's needs had been assessed when they were first admitted to the home, that care plans had been developed to record people's individual needs and that care plans were regularly reviewed and updated accordingly.

Assessment tools had been used to identify the person's level of risk. These included those for pressure care, tissue viability and nutrition. Where risks had been identified, risk assessments had been completed that recorded how the risk could be managed or alleviated. Assessments and risk assessments had also been reviewed on a regular basis.

We asked people if they knew how to express concerns or make a complaint. All of the people we spoke with told us that they did not know who they should raise a concern or complaint with. One person said, "If I raise a concern with the girls they said they can't do anything as they don't have the authority." Another person told us that they were not convinced they would be listened to if they raised a concern. However, staff told us that they would support people to make a complaint if they were reluctant to do so themselves. They also said that they thought people's concerns and complaints were listened to by staff and the acting managers.

One relative told us that they were very unhappy with the care provided at the home. This had been investigated by the local authority and a further meeting was taking place on the day of the inspection to discuss whether the person's needs were being met or would be better met elsewhere.

The complaints procedure was displayed in the home although we noted that the contact details for CQC needed to be updated. We checked the complaints log and saw that there were four complaints recorded during the period July to October 2014. Three complaints had been resolved and one had not been resolved; this was about families finding it confusing that staff wore different coloured uniforms but they did not seem to signify their level of seniority or their role. A senior staff member explained to us how this was being addressed. We saw that people had been sent an apology when the home identified that their care had fallen below the expected standard. The complaints had been analysed by an acting manager to identify areas for improvement.

Requires Improvement

Is the service well-led?

Our findings

At a previous inspection we had been concerned that staff from the home had been supporting people who lived in the community, and that they were not correctly registered to carry out this activity. The acting managers told us that care workers no longer left the premises to assist people who lived in the community.

The registered provider had informed us that, in the absence of a registered manager, two acting managers were assisting to manage the home and one of them was at the home each day. However, staff told us that the acting managers were not at the home every day. On the day of the inspection both managers were attending a training course. When they were informed of our arrival, they left the training venue and attended the home. The acting managers told us that the post of registered manager had been advertised and that they hoped to be in a position to offer one applicant the position.

One person who lived at the home told us that they were unsettled following the recent changes. She said, “I am uncertain about the future and don’t want to leave the locality.” Another person said, “There has been a lot of problems but those (referring to the managers) here now are making it more comfortable.” Other people told us, “I am very unsure of the new people as I have no contact with them (referring to the managers)” and “I don’t know who the manager is, never see anyone.” However, one relative told us that the acting managers were “Better than the previous one – I never saw her” and someone who lived at the home told us, “The new managers seem to be trying hard.”

Staff told us that the lack of leadership and low staffing levels were affecting the service and that some staff had left the service as a result. They said that some staff were tired and ‘moaning’ all of the time and that “Everything seems rushed.” Another member of staff described the care they provided as “A conveyor belt.” Staff felt that the lack of an activities coordinator had impacted on people and were concerned that they did not have enough time to provide frequent activities.

One member of staff told us, “I used to enjoy working here” but did not elaborate. A person who lived at the home said, “Staff don’t agree with management.” Again, they did not elaborate but this indicated to us that staffing issues were impacting on the atmosphere of the home.

We received information prior to the inspection from a health care professional. They told us that people who lived at the home used to have links with the local community and that this was no longer the case. They told us, “It is very sad for us to see what was once a good home with great local staff and a very village community feel now turned into a place with stressed staff and residents and unhappy relatives, and it has lost its local feel altogether.” On the day of the inspection we saw that there was little effort made to include people in events within the local community. Staff told us that they wanted to do more to make sure people were involved but that they did not have the time due to the current staffing levels.

One person told us that there appeared to be some ‘cost cutting’ going on. She said, “They used to bring me a clean towel and flannel every morning but now they ask if I want one.” Another person said that the home “Was not as good as it used to be.”

People who lived at the home told us that there was no ‘residents’ meetings with staff or managers to enable them to discuss whether they were satisfied with the service they received or to ask if they had any suggestions about how the care could improve. We asked if there had been a satisfaction survey for people who lived at the home and staff confirmed that there had not been a recent survey and that there had not been a resident’s meeting. This meant that there was no regular process for obtaining resident’s views.

Relatives also told us that they had not been asked for their views or completed a survey in the last year. However, we saw that a family and friends survey had been completed in May 2014. We looked at the responses and noted that one relative had commented, “The place seems deserted.”

We saw the minutes of a staff meeting that had taken place on 15 Sept 2014. Topics discussed included safeguarding, job description / roles, training, contracts and the management structure. One member of staff told us that the first meeting with the acting managers had been quite positive but that, by the time of the meeting in September 2014, “Nothing had really changed.”

Is the service well-led?

Care staff told us that they did not have one to one meetings with a manager to give them the opportunity to discuss their training needs or any concerns they may have had about people who lived at the home. However, following the inspection the acting managers forwarded to the Commission evidence of supervision meetings that had taken place with four staff in September 2014. The acting managers told us that they also had reflective practice meetings with staff after they had attended training courses and they sent us an example of one of these meetings following the inspection. One member of staff told us that they had not had a supervision meeting with a manager since the time the service was registered as a nursing home. It seemed that staff did not recognise these meetings as supervision and we discussed with the acting managers that this needed to be addressed. Staff also told us that they had not received satisfaction surveys and this was confirmed by the acting managers. This meant that there were insufficient opportunities for staff to meet with a manager to discuss their concerns.

We asked the acting managers if there was a suggestion box. They told us that one had recently been placed in the staff room and one had been obtained for visitors to the home; they were waiting for this to be fixed to the wall. It was too early to assess whether this provision would result in suggestions being made and improvements being made to the service as a result.

Although we did not look at the suitability of premises or infection control on this occasion, we noted that there was an unpleasant odour in some areas of The Old School House unit, including corridors and unoccupied bedrooms. The 'damp' odour appeared to be coming from the drains. We also noted that there might be some subsidence. We saw that an infection control audit had been carried out in September 2014. This identified that toiletries were found in communal areas of the home, that mattress checks were not being carried out and that bed rails were not been cleaned; the form recorded that audits of bed rails would be introduced in October 2014 but they had not commenced by the date of this inspection.

We saw that accidents were recorded in people's care plans and in an accident book. A falls analysis had been carried out in September 2014 and this recorded the number of falls during the month and any identified trends. Action taken following falls had been recorded, such as, "Changes made to (the person's) care plan following a fall and injury." One member of staff was able to tell us about when incidents had to learning and safer care for the person concerned.

In addition to this, we saw that there was a general risk assessment about unobserved accidents and falls. This recorded that there should be a member of staff in both lounges at all times. The review for September 2014 recorded, "No falls reported in lounge this month". However, we saw that it was not possible for people to be observed constantly in lounge areas with the current staffing levels and people's dependency levels. This meant that there continued to be a risk that people could have unobserved falls and accidents.

We did not see any audits of the medication system on the day of the inspection. However, after the inspection the registered person told us that medication audits had been carried out in May 2014 and September 2014. In addition to this, the home's pharmacy supplier had also carried out a medication audit. We did not see audits in respect of pressure area care, nutrition, the content of care plans and recording. This meant that there were insufficient checks in place to monitor that people received care that was safe and met their needs.

We saw that equipment had been well maintained. Bath and mobility hoists had been serviced in April 2014. There was a current gas safety certificate in place and a six monthly fire safety test had been carried out on 1 October 2014. There was a fire risk assessment in place and an environmental risk assessment that covered areas such as hot water, scalds and slips and trips.

The acting managers told us that they kept their practice up to date by attending meetings with other professionals and by checking the CQC and other websites. However, there was no evidence of robust communication systems that ensured good practice guidance had been shared with staff.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing In order to safeguard the health, safety and welfare of service users, the registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified skilled and experienced persons employed for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had not protected service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of the Regulations; and the registered person had not regularly sought the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service users.