Care Quality Commission

The Old School House Limited

The Old School House and Courtyard Nursing Home

Inspection report

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Brough
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Old School House and Courtyard Nursing Home is a residential care home which was providing personal care and support to 30 people aged 65 and over at the time of the inspection. The service can support up to 42 people.

People's experience of using this service and what we found
The provider had failed to ensure fire safety risks were resolved in a timely manner. Risks to people's safety and wellbeing were not always identified, managed and effectively monitored. These shortfalls placed people at risk of harm.

Robust quality assurance systems were not always in place or effectively operated. Shortfalls had not been identified or promptly addressed which placed people at risk of receiving a poor-quality service. The management team was inconsistent and there was a lack of oversight from the provider.

Regular changes in the management team had led to low staff morale. Staff were kind and caring and had a positive attitude when supporting people. Relevant professionals were contacted to ensure people's healthcare needs were met.

Staff ensured people lived in a clean and tidy environment. Infection prevention and control measures followed government guidance. However, on one occasion isolation processes were not fully followed.

People's medicines were administered safely. Staff were trained in safeguarding adults and concerns had been appropriately reported. Action was taken following accidents and incidents to reduce the risk of them happening again. There were enough staff to meet people's needs safely and in a timely manner.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection
The last rating for this service was good (published 19 February 2020).

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We found there was a concern with governance systems, so we widened the scope of the inspection to become a focused inspection, which included the key questions of Safe and Well-led. No areas of concern were identified in the other key questions, therefore we did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the Safe 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.

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.

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.

We have identified breaches in relation to risk monitoring, record keeping and addressing quality shortfalls at this inspection. 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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

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The Old School House and Courtyard Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was completed by one inspector on both days.

Service and service type
The Old School House and Courtyard Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, by the time of the inspection they had left the service and submitted their application to de-register. A new manager was in post but left their position during the inspection process.

Notice of inspection
We gave a short period of notice of the inspection because of the COVID-19 pandemic. We had to arrange safe working procedures for our inspection. We told the manager we would be returning on the second day.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with nine members of staff including two managers, the deputy manager, senior care staff, care staff, activities co-ordinator and the maintenance person. We observed staff interactions with people using the service and spoke with four relatives.

We looked around the home to review the facilities available for people and the infection prevention and control procedures in place. We also looked at a range of documentation including care files for four people and medication administration records for three people. We looked at two staff recruitment files and reviewed documentation relating to the management and running of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at a variety of records relating to the management of the service including training, staff rotas, safety certificates, risk assessments and meeting minutes.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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; Learning lessons when things go wrong; Staffing and recruitment

• Safety issues had not been addressed in a timely manner. For example, some fire exit doors required magnetic locks. However, the provider had not ensured work to address the issue was completed promptly.
• Not all risks to people's wellbeing had been assessed or appropriately managed. One person's test result showed they were dehydrated. However, a risk assessment had not been completed and there was no guidance for staff to follow to ensure the person drank enough each day. Fluid monitoring charts were in place, though, they were not closely monitored.
• Following accidents and incidents, action had been taken to maintain people's safety. However, monitoring systems were not in place before September 2020. After systems were implemented, robust analysis had not always been completed which made it difficult for lessons to be learnt and placed people at risk of accidents and incidents happening again.
• The provider's recruitment systems promoted safe recruitment of staff which included appropriate checks. However, some staff worked at the service before all checks had been finished. Risk assessments to ensure the potential risks this posed had not been completed.

The failure to ensure the safety of the service and appropriately assess and manage risks placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. The manager assured us safety issues had been addressed and risk assessments had been put in place.

• There were enough staff on duty to meet people's needs. Agency staff were used when necessary. Processes were in place to ensure agency staff only worked at the service to reduce the risk of cross contamination from other services.

Using medicines safely

• Most medicines were appropriately stored. However excess medicines were not stored in locked cupboards. We raised this with the manager who advised locks on cupboard doors would be put in place immediately.
• People's medicines were administered as prescribed.
• People were supported with their medicines in a calm and caring manner. Staff sought people's consent and respected their right to refuse. Staff were knowledgeable about how people liked to take their

medicines.

Preventing and controlling infection
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were somewhat assured that the provider was admitting people safely to the service. Processes were in place to isolate people new to the service and people returning from hospital stays. However, we found one person had not fully completed their isolation period.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse
• Staff followed the provider's processes and appropriately reported safeguarding concerns to the local authority.
• Staff were trained in safeguarding to ensure they had the relevant skills and knowledge.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• Complete and comprehensive records of governance systems were not in place. For example, systems to monitor and analyse accidents and incidents were not in place before September 2020 and appropriate analysis had not always been completed.
• The provider had identified shortfalls in their quality assurance system and had made changes to promote improvements. However, where changes had been implemented, they had not been monitored to ensure they were effective. This had resulted in shortfalls continuing.
• There was a lack of oversight by the provider to ensure shortfalls were addressed. Senior management had requested quotes be obtained to address fire safety issues. However, they had not ensured this was completed or that issues were resolved in a timely manner.
• There was a lack of consistent management. Relatives told us they were concerned by regular changes in the management team, as the service had been managed by four different managers since the last inspection. As a result, staff did not receive consistent support.
• There was a lack of engagement with people and their relatives about how to improve the service.

The provider had failed to ensure systems were established and effectively operated to seek feedback and improve the safety and quality of the service, which placed people at risk of receiving a poor-quality service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

• Staff felt undervalued and morale was low. A staff member told us, "Staff morale is understandably low at the minute. On top of COVId-19 and losing some of the residents we have loved and looked after for years has been heart-breaking, we have now had a few different managers come in and it's been difficult for the staff to adapt to different ways of working in a short space of time with everything else going on."
• Communication with staff was not always effective and important information was not always known by all staff. A staff member told us, "Communication from management to staff remains a problem and always has been."
• Staff were passionate about their roles and wanted the best for the people they supported. Staff had raised

money and organised the building of a visitor's pod in the home to enable people to be visited by their relatives.
• The management team engaged with and sought advice from healthcare professionals about people's needs to promote good outcomes.

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 manager understood their legal responsibility to notify the CQC about incidents that affected people's safety and welfare.
• The manager was aware of their responsibilities in relation to the duty of candour.

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 registered provider had failed to assess and manage risks to people's safety and ensure the safety of the service and equipment. Regulation 12 (2)(a)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure effective systems were established to ensure compliance with regulations. The registered provider had not ensured records were in place or sought feedback from relevant persons to support with evaluating and improving the service. Regulation 17 (1)(2)(d)(ii)(e)