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:
17 September 2018
21 September 2018
26 September 2018

Date of publication:
24 April 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 17, 21 and 26 September 2018 and was unannounced on the first day. The Old School House is registered to provide accommodation for up to 36 people who require personal care, most people live with some degree of dementia. Some people require nursing support and this is provided by the local district nurses. At the time we visited, 26 people were living at the home.

There was a registered manager employed at the home. 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 and associated Regulations about how the service is run.

The last inspection in September 2017 rated the service as Good overall, and across all key questions. This inspection was brought forward because of a high number of safeguarding concerns being raised and being investigated by the local authority, which had resulted in the service becoming part of an organisational safeguarding process. This meant the local authority safeguarding team, commissioners, CQC inspectors, police and other professionals had met to discuss the safety and well-being of the people living at the service. The provider, their operations team and the registered manager had been part of these discussions. The findings of our inspection have also been shared with the local authority, so that it can form part of the safeguarding process.

At this inspection in September 2018 we found there were failings across all key questions. People were not safe at The Old School House. There were not enough staff to ensure people's needs were met in a timely way or by staff who had the information they needed to meet people's needs. Many people at The Old School House were living with some degree of dementia with complex needs, requiring support and supervision to keep them safe. The staffing levels did not ensure they received the care they needed.

The organisation and leadership of the service was poor. This meant the registered manager and provider had not recognised that the staffing levels did not reflect people's individual needs. The service was based on completing tasks for people with a routine focussing on staff rather than people's needs. The provider and managers had not listened to staff, who said they had raised the issue of inadequate staffing levels many times but had been told the numbers of people at the home was low so staffing levels had been reduced. This meant that although staff were caring and worked hard to meet people's basic needs, they were physically unable to ensure people received person centred care in a timely way. This had led to very low staff morale.

The lack of effective staff deployment meant three people were not able to get up and go to bed when they wanted or have their needs met in a person centred or timely way. Staff said personal care support continued into late morning on a regular basis as during our inspection on the first day, based on how much time staff had. Many people required one or two care staff for personal care and mobility support, and most people needed prompting or assistance with eating and drinking. All the people living at the home required

their food and fluid intake to be monitored, to help ensure adequate nutrition and hydration. There was not enough time for staff to meet these needs effectively or keep people safe. Staff had recorded people's weights and food and fluid input was recorded but they had not recognised that in reality people may not be receiving adequate nutrition, including those people identified as being at high risk. This meant people remained at risk of losing weight and not receiving enough food and fluids throughout the day and night.

Falls risk assessments showed that most people at The Old School House were at high risk of falls which was increased due to lack of staff supervision, especially in the lounge and during the night. Continence management was also poor, there was a lack of regular assistance with maintaining continence which further put people at risk of skin damage and lack of dignity.

Although people were supported by kind, caring and compassionate staff who tried to promote people's independence and treat them with dignity and respect, they were unable to ensure that people's dignity was maintained at all times. The atmosphere was chaotic, rushed and task orientated. People had poor personal care and there were call bells ringing constantly.

People's health needs were not always managed well, such as short term health problems and skin care. The provider and registered manager did not ensure staff had the information they needed to meet people's needs. Staff relied on verbal communication or none at all. The agency care workers told us they had not received any handover on the first day. On the second day staff were using handover summary sheets which we had asked the registered manager to complete to help promote people's safety.

Staff did not all know how to use the electronic care plans and told us they did not use the care plans to inform people's delivery of care. This included senior staff managing a shift. Training and supervision was not up to date or comprehensive, ensuring staff had the knowledge they needed to meet people's needs.

Records were not always comprehensive or completed meaning that health risks were not always identified, consistently recorded or managed to completion. This put people at risk of not having their health needs met effectively or identified. On the first day of our inspection, we contacted the provider and asked for reassurances that there would be enough staff to meet people's needs going forward and they showed us a new rota with some additional staff.

Medicine management was poor and put people at risk.

On the second day of our inspection there were some improvements due to the additional staff. The service appeared calmer and cleaner, people were not so late in getting up or having to wait as long for assistance but the organisation of the shift pattern, staff deployment, lack of adequate communication, training and person centred care remained a concern.

Although there were some quality assurance systems in place to monitor all aspects of the home to identify areas or improvement, the provider had failed to identify the urgency of our concerns or identified the experience for people living at the home in reality.

We found that people's day to day life in the home was not always a positive experience. There was no activity co-ordinator or designated staff member to ensure people's social and leisure needs were met. This was despite some instructions in the brief care plans showing how people's needs should be met.

Arrangements were not effective or responsive and did not ensure each person had regular opportunity for stimulation and engagement. People were not facilitated to maintain regular social stimulation in a person

centred way to maintain wellbeing. During our inspection many individuals were left for long periods alone, despite care plans identified specific need for engagement, such as depression, behaviours which could be challenging for staff and anxiety. Staff did not have time to spend with people, chat or to have input into activities and social stimulation. This meant that people had little contact with staff other than for tasks.

Some people with more complex needs such as living with dementia or other mental health needs were not consistently supported. Staff were unable to be pro-active in ensuring care was based on people's preferences and interests, join in and seek out activities in the wider community and consistently help people live a fulfilled life, individually and in groups.

People, relatives and staff did not have confidence in the registered manager and provider. Staff were visibly upset about the lack of time to provide a good service to people they cared about. They told us how they sometimes cared for people in their own time or visited them in hospital. They did not feel valued, listened to or part of a team with no regular team meetings or supervision sessions. Staff had not received an appropriate induction and suitable training, and did not have the knowledge to meet people's needs.

The home was not always clean and free from offensive odours. Staff did not have time to do cleaning. Equipment such as commodes, hoists and wheelchairs were not clean and there was no system to check the ongoing cleanliness of the service. There was no cleaner employed on the first day of our inspection so we asked that this be addressed as a priority.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. The provider has voluntarily agreed as part of the safeguarding process not to admit any new people to the home at present.

We found 9 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, safe care and treatment, premises and equipment, person centred care, dignity and respect and good governance.

Following the inspection, we imposed a condition on the registered provider's registration requiring them to undertaken internal audits of all areas identified as requiring improvement and to provide CQC with a monthly report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough skilled and experienced staff to ensure people remained safe and received individualised care in a timely way.

Risks were not well managed to ensure that people were safe.

People were at risk of not receiving adequate nutrition and hydration to maintain their health and wellbeing.

Medicines management was not safe.

Systems were not in place to protect people from the risk of abuse.

Is the service effective?

Inadequate

The service was not effective in ensuring people's needs were met.

Staff had received some training but most staff were not up to date with their training.

Staff did not have information about how to meet people's needs and/or have time to be able to meet them.

Staff did not understand their legal obligations or know who or how to support people who could not consent to their own care and treatment, and did not always have time to ensure people's rights were protected.

Is the service caring?

Inadequate

The service was not caring.

Although the staff were kind when supporting people, people's dignity and respect were not always maintained.

People received an uncaring service because staff were rushed and had insufficient time to provide support in a manner that

respected people's privacy and dignity.

The provider had failed to ensure people received a personalised service from staff who were kind, caring and compassionate at all times.

People and their relatives, where required, were not always involved in making decisions about their care and their concerns were not always acted upon.

Is the service responsive?

Inadequate

The service was not responsive.

People's social needs had not been assessed, and people were not supported to lead interesting or fulfilling lives.

People did not receive a service that was responsive to their changing health and wellbeing needs.

Staff were not able to provide individualised care to people to maintain their quality of life and wellbeing due to the lack of knowledgeable staff.

People's individual care needs and preferences had been assessed and basic care and support needs were being met, but not to a good standard. and staff did not have the time or information to provide stimulation and engagement to meet people's social and leisure needs.

People could not be confident complaints and concerns were taken seriously and dealt with to help promote improvement of the service.

End of life care planning was lacking and did not ensure people's needs were known and met.

Is the service well-led?

Inadequate

The service was not well-led.

People and staff did not benefit from an open, inclusive culture within the home and there was a high turnover of staff.

Good leadership, openness, support and visibility were not demonstrated by the provider and registered manager to ensure staff felt supported and valued.

The provider's oversight and quality assurance systems failed to

ensure people received a good quality service driven by responsive improvement in a timely way.

The Old School House

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 was planned to check 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 brought forward this comprehensive inspection due to numerous concerns raised from various sources which included, people receiving support, relatives and staff. In addition, there was a local authority safeguarding process taking place, to help ensure people's ongoing safety. Concerns included repeated medicine errors resulting in hospital treatment, falls and lack of supervision, cleanliness, lack of adequate staffing levels and support from the management team.

This inspection took place on 17, 21 and 26 September 2018 and was unannounced on the first day. The inspection team consisted of one adult social care inspector and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day there was one adult social care inspector, an adult social care manager and a pharmacy inspector. On the third day there were two adult social care inspectors.

Before the inspection, we reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us. We also looked at all the safeguarding information which formed the basis of the on-going safeguarding process, this also included information from ex-staff, people who had recently stayed at the service and relatives.

During the inspection, we spent time with all 26 people living at The Old School House. We spoke individually with 20 people and as some people could not tell us about their experiences directly due to medical conditions, we spent time with people observing their care in the communal areas. We spoke with five visiting relatives, the registered manager, the provider, head senior, acting deputy manager, two cooks, three agency care workers, eight care workers and a visiting health professional.

The records we looked at included all 26 care records, six in detail, all 26 people's medicine records, health care records and other records relating to people's care. We looked at four staff recruitment files and staff training and supervision records. We also observed a medicine round. We also looked at records relating to how the provider monitored the quality of the service such as complaints, audits and quality assurance surveys.

Inadequate

Is the service safe?

Our findings

People were not receiving safe care.

There were not enough staff to deliver effective, safe or person centred care that met people's needs. People and relatives all told us there were not enough staff. People and relatives told us, "There are not enough staff, we have to wait", "Calls bells go morning, noon and night", "I just see the staff for meals, good job I'm ok on my own" and "In the last six to 12 months this place has gone downhill – staff are run ragged", another said, "When I visit in the evening and weekends I wait ages at the front door to be let in" and another said, "All you hear is the call bells – ringing and ringing and not being answered".

All staff we spoke to told us there were not enough staff commenting, "Sometimes there are only two staff on the floor" and "We need more staff". One staff member said, "We need staff in the lounge especially, we have asked the manager and provider but nothing happens." One agency care worker who arrived in the afternoon said, "I haven't had any handover, it seems hectic", which was the same for the care worker from the provider's other service who had come to assist.

On the first day of the inspection we had to wait some time to be let in, this was also voiced by some relatives and in recent complaints received by us. During our inspection, staff on duty were not visible around the home and appeared sweaty and rushed. They were caring for people in a three-storey building with an average of eight people in the ground floor lounge and the other 18 people in their rooms.

Staffing rotas showed, at times there had been only two or three staff assisting people in the morning. On the first day of our inspection, staffing was chaotic. There was the registered manager, the acting manager (who had come in after a night shift due to the inspection), two seniors and two care workers. One care worker had gone off sick. The registered manager was trying to book agency staff. They said they were recruiting staff but it was hard to find any. The seniors spent the morning administering medicine and dealing with health professionals, which left two care workers to assist people to get up and have breakfast. There was also a laundry person and cook. There was no activity co-ordinator or allocated staff member to deliver social stimulation and engagement consistently and/or on a regular basis.

There was no system to link people's dependencies with staffing levels to ensure people's needs were met in a timely way. Care staff also had additional tasks such as the medicines round, morning and afternoon drinks trolley, delivering breakfast to all 26 people, including 20 in their bedrooms at breakfast time, retrieving crockery and were responsible for meeting people had their leisure and social needs met.

We discussed people's needs with staff and looked at people's care plans and concluded, that there was a high level of care and support needs within the service. 17 people required pro-active support with maintaining their continence and were at high risk of skin damage, five of the 17 people living with dementia required supervision due to them independently mobilising and being at risk of falling, three people used a hoist for all transfers, requiring two staff, seven people required two staff at all times for support and three people needed assistance with eating and drinking. Call bells were ringing often throughout our inspection.

Complaints received also mentioned this was the case.

During our inspection, the lounge was left unattended for long periods, with an average of eight people spending time in the lounge throughout our inspection. One person told us, "Sometimes we can go for hours without seeing anyone." Most people in the lounge were living with dementia. People were shouting out and at one point two people became agitated and frustrated with each other so we needed to call staff for assistance to make sure they were safe. Most people in the lounge were also at risk of falls, some were noted as trying to be independent and so needed assistance. There were two night staff on duty at night. Therefore, if they were in rooms supporting people, there were no staff available around the home, despite a high risk of people getting up and walking around the service, at night due to living with dementia. One person was funded for one to one care during the night due to living with dementia. This was not in place during the day for that person.

People did not receive care in a timely way. Three people were still receiving assistance to get up after 11:45am on the first day, not due to their choice, although if people wanted a lie in this was accommodated. They were still in bed with the curtains closed. Breakfast was then taken near to lunch time and people were not able to enjoy any social or leisure time in the mornings. One person, told us that this was often the case. Three people were in the lounge at 10.00am with their night clothes on. The person sat next to them was able to tell us staff were busy and people were waiting for assistance. One person was found to be bent over their chair arm in their bedroom and remained like this for at least half an hour, so we asked staff to assist them to a more comfortable position.

On the first day of our inspection, we contacted the provider and asked for reassurances that there would be enough staff to meet people's needs going forward and they showed us a new rota with some additional staff.

Staff were not effectively deployed or in sufficient numbers to ensure people's needs were met safely and in line with their wishes and preferences. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection there were some improvements due to the additional staff. The service appeared calmer and cleaner, people were not so late in getting up or having to wait as long for assistance but the organisation of the shift pattern, staff deployment, lack of adequate communication, training and person centred care remained a concern.

People's risk of pressure area skin damage was not well managed. Paper records showed care workers were managing to ensure three people were turned and had their position moved regularly in bed, although some people did not have regular position changes if they were in their chairs rather than the bed. Care plans did not always state what pressure relieving equipment people required. Staff said they were worried about some people's skin especially if they were in their chairs. Re-positioning records did not mention the condition of people's skin. For example, one person's care plan stated, "No skin problems but at risk of developing them. Skin is fragile and paper like. Ensure checking skin on a regular basis." Their risk assessment said, "very high risk". The daily records included a line saying, "Has sore bottom", but there was no further mention to show what this was like and/ or what action was being taken. They were also at risk of self neglect so the care plan said one staff member to ensure the person was washing each day, but there were no further details about this or any monitoring going on.

Records showed the person was re-positioned in bed two hourly but not moved in the day, or it stated 'pad changed' but no mention of skin condition. Some people's night records had no turn records saying

"sleeping no concerns" during the whole night for that person. The registered manager said there were no pressure sores, however one complainant in the month before the inspection said a person had a sore which was not being managed. Therefore, we reviewed the associated documents for this person, and spoke to staff. A staff member told us this person did have a moisture lesion and staff had decided to keep the person in bed as they were more likely to get turned. However, it was not clear from the person's records whether they had a sore area or not, nor had a body map been put into place to help identify any vulnerable areas to help ensure preventable action was taken.

Some people had pressure relieving mattresses in place. However, these did not have information for staff about what settings their mattress should be set at and this was not in the care plans. One persons was on a setting of 30kg, which did not reflect their weight, which was above 30kg.

Topical creams to help minimise risk of skin damage were poorly managed. There were no records for staff about what cream to use and where. There were lots of creams in people's rooms but these had no opening dates on them. One pot said, "Do not exceed 28 days once opened". By the end of our inspection some records had been put into people's bedrooms. However, people's daily notes stated, "applied correctly" but there was no information about what had been applied and where. "Cream not required" with no further details of condition of skin or where and "Very sore bottom and vagina, washed and creamed". A later risk assessment showed "requires immediate action see Waterlow guidance" but there were no details for staff in this guidance to instruct them how to deliver care. When we asked for a handover sheet to be devised this said the person had a particular cream all over. However, we saw no monitoring of the person's skin condition to show monitoring and progress or what pressure relieving equipment they required. One person said they had a sore bust and sometimes staff used some cream but this was not in their care plan.

People were not protected from the risk of choking despite some risk assessments showing they were at risk. For example, two people were observed having their breakfast lying flat. The handover sheet said, "At risk of choking due to eating in bed". In addition, there was also no care plan about how this risk was to be managed. Staff told us, they did not have time to find another care worker to assist, to help sit people up. Five people were noted to be at risk of choking on the handover sheet, however care plans did not always reflect this risk of choking or how to manage it.

One person had been referred to the speech and language therapist and was on a specialist diet. Staff serving people's drinks were not sure who had a prescribed thickener, for example to help minimise choking. We asked the service on the first day to ensure handover sheets were devised so that staff knew who was at risk. On the third day, staff had been given a list by the manager, of people's drink preferences, however staff still had no clear guidance about those who were at risk of choking, because they did not access people's care plans.

One person's care plan said they were at risk of choking and needed their food cut up, however despite the handover sheet being put into place, there was still no information about what food the person could safely eat. During our inspection, we saw this person eating biscuits.

Continence management was lacking. This resulted in people sitting in their own urine, whilst in their bed or in their chair before care workers could get to them. We saw at least five people with bulging continence aids during our inspection. On the first day staff said at 2.30pm that they had not yet had time to assist people to the toilet so people were using their pads.. In addition, many people could not use their call bell independently due to living with dementia or physical restrictions, however there were no care plans in place to help support people's continence needs, to ensure their needs were met. This also increased the risk of people trying to access the toilet by themselves and so increase the risk of them falling. People had

been assessed for continence aids. However, there were none in people's rooms. Staff said they had to ask for them as they were locked away but no-one had had time to replenish the boxes in people's rooms. Staff said they sometimes did not have enough continence aids for people, who were often wet. There were no systems to ensure all 17 people who required assistance with continence had these needs met. We saw few people being assisted to the toilet.

Staff felt de-moralised and said they did not feel they had done a good job when they went home. Care staff were given a list of tasks which failed to recognise people as individuals, or refer to people in a respectful and dignified manner. Staff were allocated room numbers and tasks each day. Daily notes were brief and mainly stated food and fluid or care accepted with no further detail or link to care planning needs. Staff said they did not have time to write up their notes and often stayed on after their shift to complete records, meaning records were not always up to date during the shift. Staff said they simply did not have time to complete what was required each day, and during our inspection we saw this was the case.

People were at risk of falling because despite their care plans saying people required monitoring due to high risk of falling, the lounge was often not supervised meaning people were not monitored. Most people living at The Old School House were assessed as being at high risk of falling. However, care plans were not clear about what people's current mobility status was and/or how staff were to support people. For example, one care plan included, "Physio assessed, managed to move a very short distance with two carers but sank to knees, decided by physio should use a wheelchair for moving around the building. We did not see this happening in practice, and saw records in the person's daily notes saying, "8/9 "Found walking with frame from bedroom to lounge", "14/9 "Now getting out of bed". The handover sheet said the person, "Tranfers with two carers with a frame."

During our inspection we saw at least eight people left unsupervised for long periods in the lounge throughout the inspection. There was no means for them to call for staff, by use of a call bell and most people, because of their complex needs, would have been unable to use it. Sometimes people were calling out or attempting to mobilise unaided, with their care plans stating that they should be monitored when mobilising. This put people at high risk of falls. Four people were at risk of falling from their chairs. Daily records showed this had been occurring, but alternative chairs had not been sourced. For example, one care plan said, "Slid out of chair, pain in back." There was no further action recorded and the person was using the same chair. Staff said one person had remained in bed for three weeks because their chair had not been suitable. A new chair had still not been sourced and the person looked uncomfortable in bed, with their leg retracting. One person had sustained a large arm bruise due to getting it stuck down an armchair. This chair had also not been changed for a more suitable one. We asked the provider to make appropriate referrals for appropriate equipment as a matter of priority.

At least four people were at risk of falling but independently mobile. We saw them throughout the inspection mobilising around the home, going up and down stairs, sometimes with hot tea unsupervised. We found one person in another person's room cleaning their teeth with the person's toothbrush. There was no signage on most people's bedroom doors so this was difficult for people living with dementia to navigate. We asked the registered manager to rectify this as a matter of priority, which they did by the end of the inspection. Another person had recently fallen down the stairs requiring hospital treatment. They were still living in a room on the top floor and we saw them at all times of the inspection, mobilising unsupervised around the home. Their care plan stated, "If unsteady on feet I would benefit having staff with me when I am walking around". This was not happening and the person had fallen twice since. Another person living with dementia was constantly walking unaided around the home. Their care plan said, "Staff to monitor and be aware when is walking up and down the stairs". This person fell down the stairs again requiring hospital treatment during the first and second days of our inspection. They were still living on the top floor

unmonitored on the third day. We asked the acting manager to ensure this person was safe as a matter of priority.

One person had been able to recently leave the premises without staff being aware. They were therefore known to be at risk of wanting to go outside but, there was no care plan showing how this person was to be kept safe. They were constantly on the move. One note in their daily record said, "To monitor every half an hour" but we saw no monitoring being done. We were told by staff and witnessed during the inspection that this person was regularly urinating around the home. Staff said they were not always aware when this had happened and could not always get to clean this up in good time if they were busy elsewhere. We found them about to urinate in a corridor with their trousers down and had to guide them to the toilet. On the first day we saw all around a hand basin was wet and on the third day we saw fresh urine all around an upstairs toilet which we asked staff to clean up.

Risk assessments relating to the environment, and to people's health and wellbeing had been completed but were not monitored or communicated to staff to ensure actions were taken. Accidents and incidents were recorded individually with action plans in place to help reduce re- occurrences, but the actions were not always taken from findings, which continued to put people at risk. For example, if someone had fallen, an action would be to monitor and we did not see any meaningful or effective 'monitoring' in practice. One person had fallen unwitnessed six times since 28 August 2018 but no plans or actions had been taken to keep them safe.

Risks associated with people's care were not assessed, identified or managed effectively to ensure they were supported safely, especially in relation to continence, falls, pressure area care and choking. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not safeguarded. The person who had sustained a bruise due to their chair had not had this reported to the local authority safeguarding team, and/or had their chair assessed. Another person required a safeguarding alert to be made relating to possible external financial abuse. We asked that this was done as a matter of priority. Not all staff had had safeguarding training, 13 of 26 staff had not. One staff member's training had been signed for but they told us they had never seen the safeguarding DVD as there had not been time. One staff member said they knew how to alert and had rung the local safeguarding team to report an old bruise for one person. They said, "The bruise was old. There's no body maps and staff aren't seeing or know what to do."

Another person told us someone else living at the home had hurt their arm, showing us a lump on their wrist. They told us a man came into their room. The acting manager knew there had been an altercation but there were no care plans or risk assessments in place to help provide guidance to staff, as to how to manage and help prevent further problems. The person's sore arm had not been detailed in their care plan. Another person's daily records included, "17/9 three bruises on left arm" and "19/9 bruising cleared" with no record of how this may have happened and/or what actions were taken.

People were not kept safe from other people entering their rooms, including at night. This was despite this risk being identified in people's care plans. We saw these people moving constantly around the home unsupervised despite them being at risk of aggressive behaviours if they became anxious or frustrated. One care plan for a male noted, "Took pad off in [room number] and started to put person's [female][clothes on", "Wandering around", "Found in dining room urinating on carpet", "Going into rooms disturbing residents moving furniture around", "Rang GP for advice as peeing and faeceing on floor" (outcome was a decline in their dementia), "Wandering around corridors", "Wandering around very restless. For half hour checks". We saw no evidence of these checks. The notes went on to say, "Escaped from another person's

bedroom door", "Wandering around corridors moving furniture around" and "Wandering around, opened bowels in [room number] chair and floor." This had mostly been during the night when there were only two staff on duty. Records showed that during one night shift the person entered another person's room and put on the light. The person was so distressed an extra member of staff had to be called. Another person told us people often came into their room. This again showed there were not enough staff on duty at all times to keep people safe.

People were not safeguarded from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection, we looked at the systems in place for managing medicines. We spoke to staff involved in the oversight of the administration of medicines, observed medicine administration and looked at 26 medicines administration records (MARs). Staff managed medicines in a way that did not always keep people safe.

Staff signed MARs when people had medicines administered or recorded a code if a medicine was not given. However, MARs were not accurate. MARs had been signed when people's medicines had not been given. MARs contained gaps where it was not possible to tell if a medicine had been given or not. Some MARs were handwritten, which meant they did not contain sufficient information to ensure that people received the right dose and were kept safe. Staff assisted one person to administer a subcutaneous injection. The MAR did not record the dose of medicine to be given, yet staff were adjusting the dose of the injection pen before the person administered. When asked how they knew what dose to give, staff said they remembered the dose from previous records.

Staff did not always administer medicines as prescribed. Three people were prescribed medicines that were prescribed to be given once a week. MARs showed that these were not always given. The time of administration of one medicine for two people was changed from lunchtime to teatime without consulting their GP. A nasal spray prescribed to be given twice a day, was only being given once a day in the morning.

Staff did not ensure that people always had access to their medicines. We saw that several people had run out of medicines before a new supply had been received in the home. One person had been without a critical, high risk medicine for at least 14 days. Staff had not told the person's GP.

Staff did not have any information or guidance to help them decide when to give a medicine prescribed to be taken when required. We saw that people received when required medicines regularly or not at all. Not all people in the care home could request their own medicines or make a judgement about their levels of pain. So, the routine in the service was that iIf the person did not respond, when asked, then no medicine was given even though the person was demonstrating possible symptoms of pain. When we asked staff, how they decided whether to administer a when required medicine, one staff member said, "You learn people's preferences and patterns". Staff did not record the outcome of giving 'when required' medicines, so could not always be sure that they were effective.

There was no guidance for staff to support people who felt anxious or agitated. Half the people living in the home were prescribed medicines to calm behaviour when required for anxiety or agitation. However, we saw that these medicines were being given regularly without addressing the underlying cause. MARs showed that people sometimes received these medicines more frequently than prescribed.

Medicines in use were stored safely and securely. However, medicines waiting to be disposed of were not stored securely and could be accessed by non-medicines trained staff.

Medicines were not well managed which put people at risk. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not kept clean and tidy or free from offensive odours to promote a pleasant living space. Two relatives mentioned that the home had an unpleasant odour. One said, "It never used to be whiffy here" and another said, "[Person's name]'s bin isn't always emptied". Two relatives showed us unemptied bins, dirty carpets and bedrails. We saw some people eating their meal off dirty tables.

There was no attention to detail and staff and complaints we received also stated that the home was not always clean. On the first unannounced day of our inspection the premises were very dirty and there was no domestic cleaner working. The provider said a domestic cleaner was being recruited. Staff said they did not have time to address cleaning. All the bins were full in people's rooms, containing soiled gloves and wipes. The bins were all broken and the foot pedals did not work, meaning staff had to use their hands to open them. Floors, especially in people's en-suites were dirty. One had fresh urine all over the floor with no signage. A relative in a recent complaint to us said, "The toilet blocked and wet towels were left on the floor over the sewage water for over a week, there was no signage and we had to bring in our own cleaning products". High rise seat raisers were dirty with dried faeces and all commode buckets were dirty.

We were told there was no sluice, and as cleaning products could not be stored openly due to safety, staff just swilled these out with water. There were some cleaning products but these were on the ground floor only. Therefore, there was an underlying odour of urine throughout the home. One empty room had a bin with dried vomit in. We asked the provider to rectify this as a priority. Carpets needed cleaning and people's rooms were untidy with sticky side tables and dirty crockery. One person had a soiled bed rail which their relative pointed out. After meals, food was left on the floor for most of the afternoon. The communal laminate floors were sticky and unclean. We spoke to a domestic cleaner who said they did not always clean because they were asked to do other tasks such as pick up prescriptions. There had not been a cleaner for some weeks. One staff member said they had never seen a cleaner clean a toilet, hoist, commode or wheelchair and there was no system for checking these were clean and suitable for use.

Staff said there was one working shower room for 26 people and we saw in daily records that people were not regularly enabled to have a shower. There was also no shower chair so people had to sit on a commode chair. Staff said if people could not walk they could not have a shower and there was no bath facility.

One review on a national care home review website stated in June 2018, "It was wonderful to see such a clean and bright environment. The staff were knowledgeable and very person-centred. The food looked lovely and the home gave a very good impression" and another in June 2018 said, "Over this month, The Old School House has improved significantly. Concerns have started to be addressed, new furniture and some painting (further required). Hopefully, this will continue." However, we found that this progress had not continued. There were gloves and aprons available and staff used these at times but not always when handling food or going between rooms assisting people. Staff said they did not have time to go looking for gloves and aprons if a box had run out, for example. There were some improvements in cleanliness after the first day because we asked the provider to rectify the situation as a matter of priority.

People's environment was not clean and free from offensive odour. Infection control procedures were not well managed which put people at risk. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff files showed that relevant checks had not always taken place before a staff member commenced their employment. This included disclosure and barring service (DBS) checks, gaps in employment history and

two references. We looked at four recruitment files. There were no interview notes and one DBS had been accepted from another employer but this was dated 2015, with the care worker recruited at The Old School House two months ago. There were gaps in employment history which did not make it clear what the potential employee had been doing during this time. One employee had not had previous care role employment contracts extended, however there was no recorded discussion about the reasons for this. This did not make sure potential new staff were safe to work with vulnerable people.

Recruitment procedures did not ensure that potential staff were safe to work with vulnerable people which put them at risk. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The service was not providing effective care, so therefore put people at risk.

Although people had care plans detailing some of their care and support needs, we did not see any care workers referring to them. They told us they did not use the care plans and they were difficult to access on the electronic tablet. We tried using the tablet but the screens kept changing and freezing. There were a lot of pages to click on to, to ensure care workers had all the information they needed about people. Four staff members, including two senior staff, told us they had never seen a care plan so relied on their knowledge of people or verbal handovers. However, they said often they did not get a full handover as they were required 'on the floor' because of staffing shortages.

People's care records did not give sufficient information to enable care workers to meet people's needs, putting them at risk. This was the case on the first day when we asked the registered manager to devise a handover sheet with people's basic needs so that staff had some information to work with. They did not know how to access the care plan and said they had never been shown. One newer staff member said no-one had ever gone through each person's needs despite them working for some weeks.

The daily records were brief and not related to needs shown in the care plans. Short term health needs were poorly recorded and did not ensure they were met to completion. Input was mainly task related, food and fluids or personal care accepted or declined. Any issues were not reflected in the care plan but within the daily records. Therefore, although the registered manager said any health issues were able to be flagged up at the front of the daily record to enable it to be discussed at handover, there were no records as to whether appropriate actions had been taken. At times people were described as possibly being constipated, for example with no follow up. People who were at risk of constipation or who could not communication their toileting needs verbally, for example due to living with dementia, could not be confident their needs would be met safely with many people prescribed medication for bowel management.

There were no body maps or care plans for specific health needs. For example, in some people's daily records it had detailed sore bottom, cut finger, bubbly chest, black vomit or need for a urine test to determine a possible urine infection. However, there was no clear follow up or care plan detailing what staff were to do. One care plan for a person known to have a history of ankle pain had recorded, "?ankle hurting" with no follow up of any actions taken. This person lived with dementia and may not be able to tell staff if they were in pain.

One person who had fallen and broken a bone had no care plan or pain relief instructions for staff. The person had dementia and we saw they were clearly in pain, grimacing and moving their arm with their other arm. We asked staff to assess and ensure this person had adequate pain relief and monitoring. None of these issues could be followed up within the records so we could not be sure they had been addressed or what the progress was. One person was insulin dependent diabetic, there was no care plan showing how this was managed. Staff said they 'just knew' what dose of insulin the person had and gave them their meals after the insulin. Blood sugar readings were taken with no analysis or instructions for staff about the

findings.

People's behavioural needs were not monitored or addressed despite being identified. Some people were living with depression and anxiety and on medicines, but there were no care plans showing information about how staff were to support these people. One care plan said, "Anxious service user who requires constant verbal support. Constantly shouts for help", "Physical health can become worse when anxious. Support her by talking to her until the feeling has passed", "Support her by explaining why she is at the home and this normally settles her." We did not see staff supporting this person other than for tasks. They were seen throughout the inspection looking highly anxious without staff support. Another care plan said, "Presents challenging behaviour that follows an unpredictable pattern" with no further details. The person was living with advanced dementia. Their daily notes included little information about the person's behaviour but included, "[Medication] given", "Sat in lounge appears a little confused but nothing out of character", "Very confused shouting for help, thinks someone is coming into her room", (this could have been true), "Very restless did not want to sleep tried to reassure her", "Confused state unlike herself", "?urine infection 21.00pm. Please obtain urine sample", "Agitated, asking to go to the toilet", "Very agitated", "Very unsettled today shouting all afternoon". There were no records of actions taken or whether a urine sample had been taken. Lack of assistance with supporting continence appeared to be a factor in people's behaviours. The daily notes for the person who was known to urinate in inappropriate places stated on 9 September 2018, "Wife recommended toilet every few hours as she did this at home to stop him weeing around the house". We did not see this happening at all and this behaviour was continuing which we witnessed.

One person's care plan stated in the daily records, "Please can we document behaviours and activities on a daily basis". There were then 14 incidents recorded from 6 September 2018 to 23 September but no action plan or care plan in place to show staff how to manage this. Incidents included, "Agitated and wants to go home, relaxes for 15 minutes then agitated again", "Restless set fire alarm off, vocal and requiring a great deal of time to reassure", "Angry, vocal and shouting 30 mins chat", "[Set off] fire alarm and punched staff in nose".

One person was walking around and sat in the lounge with bare feet. Their feet were described in their care plan as "Requires minimal attention." Another record said, "Big toe appears to have an infection, recommended antibiotics", there was no further information about progress or dates. The person had bare, swollen, dry and cold feet during our inspection. The care plan said, "Feet and legs can become very dry" and to "Check and document". The person was on diuretics (water tablets) and their skin was very tight. Staff had not sought adequate footwear. Staff said the person's feet should be elevated but we did not see them with their feet up. Staff said they needed more stools, which we asked the provider to source. We put the person's feet on a stool and the person was happy to keep them there. Staff said they sometimes used cream but there was no detail of what or how. The later handover sheet said a particular cream all over. Daily notes said "cream applied correctly" but no detail of where. The floor was dirty and there was a risk of another person urinating at the bottom of the stairs where this person walked.

People did not receive effective, safe care and treatment to ensure their needs were met. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives commented that staff had not received adequate training and did not always know what to do to meet people's needs. Comments included, "The staff they have are young and extremely inexperienced, some having never worked in care before", "Staff are good, but a lot of new ones" and "Lots of new faces and new things which doesn't help you know who is who". One relative commented that "sometimes there are no seniors on but very young staff or agency staff". We found staff did not read care

plans and on the first day of our inspection had no information other than a verbal handover about people's needs. One senior care worker had not worked in care since 2000. They had moved into the health and social care sector recently as they said they had felt people were being neglected. They had never seen a care plan and did not have the experience to be a senior.

Staff training and induction were not all up to date and not always put into practice. Staff did not undergo a comprehensive induction process. One senior member of staff told us they had had to ask for an induction despite working at the home for some weeks. Their records said the electronic care record system may require further attention but this had not happened, resulting in them never being shown how to access care plans.

The training matrix, a spreadsheet used to centrally record staff training, was sent to us by the registered manager. It showed some evidence of training in a range of subjects such as manual handling, health and safety, food hygiene, infection control and fire safety. However, we spoke to a new member of staff who was signed as saying had had training. They said their induction had taken 'minutes', they had never seen any of the DVDs as there had not been time, and they had immediately started working with people. Their training record stated they had undertaken training, however this and other staff training was recorded all on one day. This did not assure us that staff had received adequate training to be able to meet people's needs. The staff member said they did not feel confident to carry out personal care or medicine rounds as they did not know people.

During our inspection, a staff member had to be stopped giving a person the wrong medicine. They later told us they had told managers they did not want to do the medicine round but had been told to. A senior told us young staff were not supported or taught how to deliver personal care in the right way. For example, they did not know how to shave someone or to wash people when changing a continence aid. Some staff had completed a dementia care workbook in three modules. However, these were all completed on one day and we did not see any learning put into practice. 16 staff had not completed fire safety training, 11 had not completed infection control training, 13 had not completed safeguarding training and there was no evidence of any training relating to pressure area care despite most people being at risk.

There had been concerns about manual handling techniques by care workers raised in the recent safeguarding process. We found that of the 26 staff, only four had had practical manual handling training. Two staff told us, they did not know how to use the hoists and they had never been shown. One recent complainant stated, "The registered manager said newer staff would work with a care worker who had had practical training but this was not the case. For example, on night shifts there were often only two staff working, and both had not had practical manual handling training. Three people required a hoist for all transfers and two hourly re-position changing. There was only one hoist on the first day of our inspection with people requiring the hoist on different floors. Staff were frustrated by having to look for another care worker, then the hoist and then take it upstairs in the lift. We asked the provider to source adequate equipment which they did. However, on the third day care workers did not know there was a second hoist and were still using one. This did not ensure that people were moved safely in the way they had been assessed as requiring.

One recent complaint included an incident where a person had slipped from a hoist. The registered manager said four staff were about to have practical manual handling training following our inspection. The provider's care report March/April 2018' report stated, "Training matrix reviewed and all up to date." A staff member told us that the week before, they had had to stop two newer care workers trying to lift a person from the floor without a hoist, which is not good practice. Staff said some chairs were not suitable, so people kept sliding out and there were no always staff around to notice. We asked the provider to make appropriate

referrals to the occupational therapist as a matter of priority for some people. Staff said another person was difficult to assist get out of bed as they only had a divan mattress which was low so staff were at risk of hurting their backs. People had to use a commode chair in the shower as there was no shower chair. There was no bath facility.

Staff were not trained sufficiently to enable them to meet people's needs effectively which put people at risk. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at a high risk of losing weight and not receiving sufficient nutrition. The registered manager said everyone was being monitored using a food and fluid chart within the electronic records. Many people were at risk of losing weight or required support with prompting due to living with dementia. Three people required full assistance with eating and drinking. We looked at six care plans and daily records in detail. We found although fluids and food was monitored in daily records, there was no analysis or overview of people's individual daily intake. This was despite the March/April 2018 providers report noting a lack of recording. A complainant had noted that staff often took away people's food and drinks uneaten. We saw this happening during our inspection with staff not returning or checking to see if people wanted to eat later on. There was a stock of named food supplements but we did not see these being used or referred to within people's care plans. Some people had high calorie drinks prescribed and cartons stated, "Could have up to three between meals" but we saw no record of what type of fluids were offered or had.

One person's care plan showed the person had been on a food monitoring chart since August 2017. Their weight graph showed consistent weight loss since February 2018. There were no records of people's optimum fluid intake requirements or comment on low totals. No in-between meal snacks were offered for people at high risk of weight loss, due to living with dementia, such as snack boxes or finger food. Two people were noted as needing encouragement, the handover sheet stated, "a lot of encouragement to eat" but we saw them left alone with their meals. One person's daily records showed 22 times the person had "not eaten" their offered meal over 13 days. There was no information as to what action had been taken. There was also a risk some people may refuse meals because they had only recently eaten and were not ready for their next meal. For example, having their breakfast at 11.45am having had nothing since the night before and then lunch at 1.30pm.

Fluids were also poorly monitored to ensure people were receiving adequate hydration. People were left alone for long periods and they did not always have accessible drinks near them. We saw some hot drinks taken away almost full, when cold, where people had left them. Daily records showed people's intake but there was no daily overview, so we could not be sure people's intake was accurate and met with their individual needs. People had amounts recorded, some days showed adequate fluids although generally under 1000ml in 24 hours, whilst other days showed either no record or as little as 150ml. This included people at risk of urine infections which could result in detrimental behaviour which could be challenging for staff and distressing for people. For example, one person was noted to be "Poorly and to push fluids". However, there were no records of fluids offered from 19.39 until 15.00 the next day. Following a collapse of one person, their care plan stated, "22/9 Very sleepy refusing food and fluids. Paramedics "Keep a close eye on her". There was then no record of how this was done and what happened. There was no guidance for staff showing people's optimum fluid target or what action they should take if they were concerned about how much a person was drinking. The provider and registered manager had not audited these food and fluid records or spent time 'on the floor' to ensure people were receiving sufficient nutrition or fluids in reality.

The two cooks were new in post. We saw well presented plates of food were offered. They had a list of

people's likes and dislikes. They made individual main meals and handed them to each care worker to give to people. However, until the handover sheet was in place, staff could not be sure of people's needs. One care worker asked the senior, "How do we ask people what they would like" and the reply was "just ask them." Food looked appetising but people did not know what meal was coming, because the menu board on two days did not reflect the meal being provided. Staff asked people living with dementia what they wanted to eat, but people did not always know what the staff member was saying. There were no other ways to ensure people had meaningful choice such as photos or showing people a plated meal to choose from. There were no condiments and people told us food came in 'dribs and drabs' and sometimes was brought to them cold.

Failure to monitor whether people were having sufficient food and drinks of their choice at regular times throughout the day placed people at risk of malnutrition, dehydration, weight loss and other health related illnesses. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA). The 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 Act 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 MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Staff did not understand the importance of seeking people's consent and offering them choice about the care they received. Two people were being 'put to bed' so that they would relieve pressure on their skin as staff were not confident their positions would be changed if they were in their chair. One person was not being allowed to go to bed because they may soil themselves, and staff did not have time to support them. One person had particular habits. There was no care plan about these which staff said made the person aggressive because staff were arguing with them not doing what they wanted. We were told by staff that people were "not allowed" to go out, as there were not enough staff to take people out. Two people were recorded as being at the door wanting to go out/home on occasions and one person had left the building unnoticed twice. There were no plans as to how their needs were to be addressed or how they could be enabled to go out. One person was given excessive sedative medicine in response to their behaviour which could be seen as challenging for staff.

Where people lacked capacity to make some decisions, the staff were not always clear about their responsibilities to follow the principles of the MCA when making decisions for people in their best interests. This was because they did not always know people's needs or capacity. A recent complaint from an ambulance service stated staff described a person as having capacity when they did not. Some staff thought people had capacity and treated them as such. For example, asking people living with dementia questions that they could not answer clearly such as if they were in pain, and did they need certain medicines.

People were not able to get up or go to bed when they wanted due to lack of adequate staffing. People were given simple choices such as what they would like to drink or what clothes to wear or where to sit. Therefore, although staff understood about enabling people's choice and providing care in people's best interests, they could not meet people's preferences due to lack of adequate staffing levels.

Records showed that people's ability to consent to certain decisions had been assessed in their care plans

and best interest decisions made such as use of bed rails and pressure mats but these did not show relatives and health professionals had been included in the decision making process. One person had injured themselves on their bed rail but there was no further discussion about how to manage this in the future or discuss the appropriateness of the bedrails to restrict that person. Another person was constantly asking to go to bed throughout the first two days of our inspection. Staff did not assist them, despite their door being open so they could see the person trying to move from chair to bed. Staff later said they did not put the person into bed because they would soil and then need further assistance from two staff and they were too busy.

There was no clear information to give staff guidance on how they needed to support people to make a number of different decisions about their daily lives and staff did not read care plan information.

People were not enabled to make choices or consent as staff did not understand how to meet their needs or maintain their legal obligations. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises were large over three floors providing large spaces and communal areas. Although no-one was facilitated to use the garden unless with a visitor, this was a secure, large area with seating areas.

Inadequate

Is the service caring?

Our findings

The service was not caring.

The provider's service brochure stated, "[We] pride ourselves on offering a highly professional care service for the elderly with a personal touch." However, we did not find this to be the case. Although care staff were kind and chatted to people during tasks, people did not experience person centred, caring support. People and relatives said staff were lovely when they saw them but had to wait a lot or were left alone for long periods. One relative said, "Individual carers were lovely and caring, but their hands were very much tied by the system they were forced to work with." Two relatives were also positive about the carers saying, "All the carers are friendly, smiling and caring". Two relatives mentioned that whilst most staff were caring, their job was made difficult because of the low staff numbers. One commented, "The staff are lovely and good at what they do but there is just not enough of them". We saw that whilst staff frequently said hello to people, they were too busy to engage with them. One person said "Staff don't have the time to talk to you because there's not enough of them" and another said, "It's sad that nobody helps the people who are shouting out all the time".

Staff spoke of and recorded about people in terms of 'numbers', 'doubles', feeds', 'room' and 'turns'. There was almost constant noise from call bells ringing or people shouting out. Care staff said they felt stressed as they were usually in the middle of assisting someone so they just turned off the call bell and said they would be back later. We witnessed this a number of times over the three days.

People had to wait long periods for any support depending on the routine of the home and where staff were up to with their daily tasks. For example, people waited a long time for assistance with continence management, which meant their continence was not managed at all and/or people had to used their continence aids. One person was never offered the use of a toilet, and used their continence aid instead. Some staff said they did not know why the person did not use the toilet, with other staff saying the toilet and commode were not safe for the person to use. We asked that a referral to an occupational therapist be considered to support them effectively to promote their dignity.

There was no way for people to alert or contact staff if they required support in the lounge as most people were unable to use a call bell due to living with dementia. People who could have used a call bell in the lounge did not have one, they told us they would shout for help. If a person declined assistance when asked, they could not rely on care staff to assist them later.

People's daily records showed when people had declined personal care but did not show that staff had returned to offer further assistance. This was the same for meals, we saw full drinks and meals taken away uneaten. Where people were assessed as being self-caring, staff had not ensured they were offered assistance to check their skin and health was satisfactory. Staff said some people had been wearing the same clothes for some days. We saw some people sitting in bulging, wet pads on all days of the inspection as staff had not been able to offer assistance with continence.

People felt rushed or had to wait until staff were ready to help them. Person centred care was poor, staff had no details of how people liked to be assisted and they would not find this information in the care plans. On the first day of our inspection, three people were having their breakfast at 11.45am. One person was able to tell us this often happened despite them getting up at 07.00am or earlier as they wished.

This person was assisted to wash whilst sitting on their bed but told us they used to have a bowl but now they were given a damp flannel. Staff said there was not always enough equipment to wash people properly. The laundry person worked until 2.30pm. After this staff could not access the basement where the laundry room was as it meant leaving the floor. Therefore, sometimes they said there were not enough towels and flannels in the afternoon. Staff and one person was able to tell us staff sometimes used the end of a damp towel to wash them finishing with the other dry end. Two recent complaints received prior to the inspection from a relative and another person said, "There are no flannels and the ends of towels are being used to wash people." They went on to say that their relative had days not having a wash at all, saying "[Person's name] frequently waited hours for care or a bedpan or had to wait after being given a bed pan to be 'finished off'. Complaints received said staff did not wash people following a 'pad change'. Staff were seen to spend little time in people's rooms when assisting them. Some towels and flannels were of a poor quality and thin and ragged. Some people had no covers on their pillows or sheets and pillows were stained. Some staff said newer staff did not know that which flannel was for people's faces, or for their intimate areas, having not worked in care before.

People visibly had poor personal care. After meals, people's clothes were sometimes soiled but not changed. One person on the third day of inspection had vomit on their top for over an hour until we asked staff to assist them. People's hair had not always been brushed, although a hairdresser did visit to do some people's hair.

People had poor oral hygiene and on the first day all toothbrushes were dry and dentures still in pots. The registered manager said one person refused oral care assistance. They had a very dirty mouth. However, the care plan did not show if care had been offered or how staff were to manage this, such as returning later of giving the person their toothbrush. One staff member told us they had taken out a person's dentures recently and there had been mould on them. The manager's 'director of care' report for March/April 2018 stated, "Observed care and resident's appearance over the last few days, no concerns at present." There had not been a report since.

People had poor nail care, despite some people having their nails painted. Numerous people had visibly dirty nails, including a person who had complex continence issues. The registered manager said they had raised oral and nail care in a team meeting, however despite this, no actions had been taken to ensure this was being addressed.

On all three days we heard people who did not want to/could not use the call bell, calling out for assistance. One recent complaint received by us stated, "We could frequently hear frustrated bed ridden people banging loudly and shouting for assistance for long periods, bells rang constantly and relentlessly and the carers would come in and turn them off." Care plans did not instruct staff as to how to check and manage these people's needs.

People in their rooms were left alone, sometimes just sitting in their room for long periods. Two people lay in bed with little engagement other than for meals or assistance with changing position throughout our inspection. There were no details in care plans about people's life history or interests and background. One person said, "It's a good job I'm used to being on my own." The three people in bed at 11.45am on the first day still had the previous evenings meal crockery in their room and their curtains still pulled. Crockery was

seen around the home throughout the inspection. Staff said they did not have time to take it to the kitchen.

On the first day one person was crying as they had pain. They said there was no point ringing the call bell as staff did not have time. This person was later being assisted to use the commode with the door open. A relative told us in a complaint that one person had been wandering around the home with no clothes on their lower half. We saw four people living with dementia mobilising unsupervised around the home going into other people's rooms. Most staff did not have a name badge so people did not know who to call for or who was on duty.

People's likes and dislikes were not always respected. For example, care staff served morning and afternoon drinks to people. However, there was no list on the tea trolley for staff to know what drinks people liked. We asked for a drink for one person, we were given milky tea when the drinks list in the kitchen stated they liked black tea.

People were not assisted to communicate effectively. Care plans did not show in a person-centred way how their dementia affected them and/or what they could do for themselves. Although people's care plans said they required glasses for example, those people were not wearing them. Care plans said for example, "Has impaired vision, staff need to encourage to wear glasses at all times as they will often forget to wear them". We found people were not wearing their glasses throughout our inspection.

People's rooms were dirty and untidy. There were some improvements after the first day because we asked the provider to rectify the situation as a matter of priority. However, throughout the inspection, there were dead flowers in some rooms and one room had a broken lampshade. One person told us that the light in their toilet hadn't worked for three months. We tried to turn on the light, however it was still not working. There were no tongs so staff were picking up afternoon tea cake with their hands. There was mouldy fruit in the fruit bowl on the trolley.

People were not treated with dignity and respect and they were not cared for in a person- centred way. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

The service was not responsive. People did not receive a responsive service or receive care in a timely or person-centred way. The routine each day was based on staff and tasks. Staff said if anything different happened such as someone needing additional assistance or displaying behaviour which could be challenging, this put the routine back and so they were always playing 'catch up'. We did not see staff spending any social time with people other than for caring out essential care and support tasks, except for a care worker doing a jigsaw with a person for a short period on the third day. Staff said they did not have time to sit or chat with people and clearly, they found this upsetting as they spoke to us. They told us, "I can't sit and chat to anyone, there is too much to do. We hardly have time to write in the daily records."

There were various communal areas in the home, one large lounge upstairs with a lovely view, but only the lounge/ dining room was used and people's bedrooms. Some people were able to choose to stay in their rooms but they said there was no reason to go to the lounge as there was nothing to do, and they couldn't reach a call bell in the lounge. We saw the lounge was unsupervised for long periods unless staff were delivering meals, supporting people, administering medication or using the tea trolley.

Due to the inadequate staffing levels and poor daily organisation people were not able to enjoy regular social and leisure time. There was no activity co-ordinator and care staff did not have time to engage with people. They tried to offer some colouring or put a game on a table but otherwise we saw the television on, with no subtitles and people sitting in the same chair all day. One person had loud pop music playing in their room all day, we asked if the person liked this music but staff did not know. The person laid on the bed all day with their eyes shut with no engagement other than for meals. Another person had their head in their hands for much of the day with no engagement. Some people due to living with dementia were shouting out regularly. Staff were not in attendance to reassure people and one person was able to tell us, "It's horrible, relentless." One person told us, "Sometimes you can go for hours and see no-one."

There were no records showing people's life history, backgrounds or interests all of which can help in the design and delivery of personalised, social stimulation for people. During our inspection we saw an external singer in the lounge but this was for seven people and staff did not engage with people during the entertainment, although some people appeared to be enjoying the singing. The television was otherwise on all the time. People said they were not watching it and the atmosphere was noisy.

Records were not kept individually of activities people took part in and of the activities offered. For example, one person's records stated, "29/8 Singer, 6/9 Singer, 7/9 Singer, 9/9 Nails TV, 14/9 Singer, 15/9 Nails Friend came". Another person's said, "29/8 Singer, 6/9 singer, 7/9 singer, 14/9 singer, 15/9 nails." People stayed alone in their rooms all day or went from their room to the lounge and back again, with very little engagement or meaningful stimulation. The manager's 'director of care' report for March/April 2018 identified there was a lack of evidence regarding activities for people who spent most of the time in their bedrooms. It stated a new audit and monitoring tool was being developed but this had not happened. At the last inspection in September 2017 we noted that the registered manager was introducing individualised care records and more social opportunities for people, but this had not happened.

People said they had not been outside for a very long time despite the nice weather in the summer. Staff said they had never seen anyone going out or use the garden other than with families and there were no links to the community. The team meeting in July 2018 noted one staff member would like to do 'memory days', however this had not happened. Recent complaints received by us stated, "There have been no day trips for at least a year and no stimulation or activities", and this is what we found at our inspection.

Where there were comments in people's care plans about social and leisure needs these were not used or addressed. For example, "Physical health can become worse when anxious. Support her by talking to her until the feeling has passed". "Staff to encourage with activities. Likes newspaper and knitting", we did not see this person engaging with staff and they had a high level of behaviour which could be challenging. "Can communicate well (This person had Alzheimer's and was unable to understand the world around them), "Give time and patience", this person had a recent bereavement and was constantly looking for their late spouse. There was no care plan about how staff were to support the person. "Enjoys daily paper and the daily entertainment", this person was not engaging with staff in a meaningful way and did not have their paper. One care plan said, "Can communicate" but did not mention they were living with dementia, later stating, "Struggles with remembering short term." Another plan said, "Loves to reminisce about growing up and her family, keen gardener". This information was not used to inform person centred care. The person sat in the same chair all day throughout our inspection and had no meaningful engagement with staff. "Can be agitated but is able to be calmed if staff sit and talk with her" and "Likes to talk about owls, dogs, Harry Potter and London. Likes staff to sit and have a cup of tea" There was a notice in kitchen about this but staff did not know about this when spoken to and this was not happening because staff did not have time. This person moved around the home on their own during our inspection.

People's care files did not show how each person could communicate and how staff could effectively support individuals. Staff were unable to demonstrate that they knew how people communicated to encouraged choice whenever possible in their everyday lives. There was no evidence to show staff were looking at how the Accessible Information Standard (AIS) would benefit the service and the people who lived in it. The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. For example, there was minimal information for staff about how people communicated although staff did not access the care plans. The handover sheet did not include communication needs or whether people were living with dementia, therefore staff did not know how to communicate effectively with people. Agency staff said they did not know people so did not know how to talk to them or whether they had any sensory or sight issues that could be a barrier to communication.

There were some signs on toilets and the lounge but other than that there were no communication aids of information sharing such as large print, photos to aid choice or visual prompts.

People did not have their emotional, leisure and social needs met or assessed. People's care records did not always record how their needs should be met, and did not always detail people's wishes and preferences or encourage staff to use this information in practice. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No-one was receiving end of life care during our inspection. However, the only details in people's care plans about their end of life care, preferences and wishes was the treatment escalation plan (TEP), which showed if people were to be resuscitated or not. Therefore, staff would not know people's end of life wishes.

People could not be sure their end of life needs would be met as there were no instructions for staff and they had not received training in end of life care. This is a breach of Regulation 9 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

The registered manager said that formal complaints were low and there was a policy to follow. However, relatives and staff said they had raised issues verbally about staffing levels and cleanliness but nothing had happened. We had asked the provider to look into some complaints recently and received assurances that issues had been dealt with such as medicine management, training and staffing levels. However, during the inspection we found these issues had not been addressed. People who were able to tell us did not know how to make a complaint. We asked for a summary of complaints and actions taken but we did not receive one.

We recommend that systems are in place to ensure robust management of complaints and concerns.

Inadequate

Is the service well-led?

Our findings

The service was not well led.

We found significant failings across all key questions during our inspection and that the provider had failed to ensure people were safe and their needs were met in a person-centred way.

The provider's brochure stated that The Old School House was a 'Family run business providing the highest standards of care in a safe, warm, friendly environment and our team of dedicated, well trained and motivated staff will provide 24 hour care that is personalised to the individual." We did not find this to be the case during our inspection.

The managers were not visible and the office was at the end of a corridor on the first floor. Most people didn't know who the registered manager was. One person said "I don't know who the manager is or how to raise any concerns", another said, "Not seen the manager", and another person said, "Don't know the manager, the staff change a lot". Two relatives knew who the managers were and a third didn't. Two relatives indicated that whilst they felt the managers were approachable and caring, they were slow in making changes or moving things forward. One relative commented "It feels like empty promises because they don't always follow through". The registered manager had worked at the home for some years and at the last inspection in September 2017 we had rated the service as Good overall. Since then the registered manager had been dividing their time with the provider's newly purchased second service.

Staff we spoke to were not happy working at the home. They did not feel well supported or listened to by the registered manager or provider. They felt they were told they were not doing a good job but no--one had listened when they said there were not enough staff and support was poor. Staff said they did not feel valued or part of a team. They said they were not thanked and we did not see this during our inspection. One staff member had put a thank you on the wall of the staff room and said, "I thought I would put it up as no-one else will thank us". They said they did not get full breaks despite long shifts or were told to go and work when on their break.

There was a high level of staff sickness. This was being managed using the company policy with return to work interviews. However, we heard from staff who told us they felt they could not keep on working at the service much longer as they did not feel cared for. Staff comments included, "We have said about the need for more staff but no-one listens. I want to leave but I don't want to leave the people living here, they won't get looked after" and "People are being neglected so I stay to look after them."

We asked for evidence of regular one to one or group supervision sessions for staff. These are so that staff can discuss their training, any issues and look at competency for example. We did not receive any information and did not see evidence of supervisions happening in the four staff files we looked at. Two newer staff told they had not had a supervision session despite working at the service for some weeks.

Most people hadn't been asked for feedback on the service they received or been given an opportunity to

make suggestions on the running of the service. One person said, "I'm not asked for my views; I do what I have to". Three relatives mentioned that they hadn't been asked for their views on the service. We asked for the latest satisfaction survey but we did not receive one. There were no residents/relatives meetings.

The provider and registered manager told us the values of the organisation were – "Independence, choice, fulfilment, rights, caring, privacy and dignity." When asked how they ensured staff knew these and how they monitored them, we were told, the values formed part of the induction and team meetings. However, the induction was minimal or not at all for some staff with one staff member telling us they had had to ask for an induction after working for some weeks. During the inspection we did not always find people were fulfilled or had their needs met safely or effectively. They had little social stimulation and we found people's privacy and dignity was not always respected.

The provider and registered manager said their statement of purpose was also clear what the values of the service were and it also included information about everyone being welcome to the home no matter what their differences or needs were. They said they had looked after people who had protected characteristics of the Equality Act in the past and were confident in meeting the needs of people who might have differences. However, the registered manager said their initial assessment stage may need reviewing to ensure appropriate questions around people's individual needs are comfortably raised.

The provider told us he had no formal quality monitoring system or governance arrangements. He told us he relied on the registered manager. However, he added he was in the home most days and would pick up on any issues he observed and he was kept up to date through meetings with the registered manager. The issues we found during the inspection had not been noted or addressed.

The registered manager had a level 5 manager national vocational qualification (NVQ). A new manager who had been appointed to be the manager of The Old School House had recently left. However, the lack of good oversight arrangements by the provider and registered manager have contributed to the many failings found during this inspection. For example, the manager's 'director of care' report for March/April 2018 identified there was a lack of evidence regarding activities for people who spent most of the time in their bedrooms. It stated a new audit and monitoring tool was being developed but this had not happened. When asked how they ensured people felt part of the local community they told us they held an annual garden barbeque and invited the local community. They also said they used to be involved with the local schools and church visiting but this was no longer the case. People told us there was nothing to do day to day apart from a singer and there were no links with the community.

The registered manager told us they normally carried out a monthly care managers' report which included analysing audits on most aspects of running the home, for example, medicines, care plans, risk assessments, the environment, accident, incidents, staff training and supervision. However, we found these were not effective at consistently improving care practices. For example, we found care plans out of date and not being used, risk assessments were poor putting people at risk. There was limited, effective monitoring of people's daily care needs including food and fluids, unsafe medicine practices, limited social stimulation and lack of person centred information and care. There was poor oversight of staff recruitment, induction, training and staffing levels and poor oversight of the environment which resulted in the home being dirty on the first day of the inspection.

We asked the registered manager to provide us with the last four care managers reports. We received the last one dated March/April 2018. Although it covered a wide range of topics such as care planning, falls, staff ratio, activities, food and fluids and records it did not show actions taken to address any of the issues we found. Some areas had identified improvements were needed such as monitoring of activities, falls and

recording, these had not been addressed to keep people safe and fulfilled.

The registered manager told us they kept up to date by reading professional care magazines and attending the local authority's care forum. However, the registered manager had not been to any of these recently and the provider did not normally attend. We did not see any learning put into practice.

The registered manager told us they gather views of the service from people through annual questionnaires and talking with people during reviews. They also used happy / sad cards to enable people with limited verbal communication to express concerns. There was no record of this. They held staff meetings to keep staff up to date on issues, however we only saw one set of minutes and some staff said there had not been meetings for a while. The meeting in July 2018 by the previous manager had discussed that internal audits and observations had taken place raising issues around documentation, turns, personal care and fluid intake. All of which we found issues with. For example, the minutes said a person should be having at least up to two litres of fluid. Average intake for the six people we looked at was recorded as under 500ml. These issues had not been addressed since then and people's needs and staffing levels had not been analysed.

There was a lack of effective governance arrangements to ensure people received effective, safe and good quality care. In addition, the provider did not have effective systems in place to help monitor the culture of the service, in line with their own vision and values. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have their emotional, leisure and social needs met or assessed. People's care records did not always record how their needs should be met, and did not always detail people's wishes and preferences or encourage staff to use this information in practice. People could not be sure their end of life needs would be met.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect and they were not cared for in a person- centred way.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not enabled to make choices or consent as staff did not understand how to meet their needs or maintain their legal obligations.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 12 HSCA RA Regulations 2014 Safe care

personal care	and treatment Risks associated with people's care were not assessed, identified or managed effectively to ensure they were supported safely. People did not receive effective, safe care and treatment to ensure their needs were met. Medicines were not well managed which put people at risk. The home failed to monitor whether people were having sufficient food and drink to maintain their health.

The enforcement action we took:

we imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from abuse and improper treatment.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The environment was not clean and free from offensive odour. Infection control procedures were not well managed.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance arrangements were ineffective and did not ensure people received effective, safe and good quality care.

	The provider did not have effective systems in place to help monitor the culture of the service.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures did not ensure that potential staff were safe to work with vulnerable people.

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not effectively deployed or in sufficient numbers to ensure people's needs were met safely and in line with their wishes and preferences. Staff were not trained sufficiently to enable them to meet people's needs.

The enforcement action we took:

We imposed a condition on the provider's registration.