Eeze Old School House Ltd

The Old School House

Inspection report

Old School House
17 Church Street, Madeley
Telford
TF7 5BN

Tel: 01952580629

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

About the service
The Old School House is a care home providing personal care to five people at the time of the inspection. The service can support up to seven people. People living in the home have their own bedrooms and there are shared communal spaces, including lounges, a kitchen and a garden area. The building is over two floors.

People's experience of using this service and what we found
The service could not show how they met some of the principles of right support, right care, right culture

Right Support
Although The Old School House is a smaller building, part of a local community, people still did not always have the opportunity to gain new skills or experience new things. People were going out more and there were plans in place to further develop this in the future.

People were not supported by staff to have the maximum possible choice, control and independence, as people's capacity had not been considered or best interests decisions made. There was a lack of understanding around this and staff provided us with inconstant views of how people should be supported.

People were supported by enough staff, further improvements were needed to ensure staff fully understood the needs, wishes and aspirations of the people they supported. When people chose not to verbally communicate, more development and understanding was needed to ensure they were involved in the home equally as the other people who lived there.

People were supported to make day to day choices however they needed to be empowered to ensure they were involved with making bigger decisions. Improvements were needed to ensure people were involved with their care and reviews and to ensure information was presented to them in a format they understood.

The home environment had improved it was homely and clean.

Right care
Staff did not always have the relevant skills or experience to ensure they received
the appropriate care. Although training had increased since our last inspection, we could not always see how staff had implemented this and how this had impacted on people.

Staff received training and an induction that helped them support people. Competency was checked in some area's improvements were needed to ensure this covered all keys areas, including capacity and consent.

Improvements had been made and people were protected from harm, procedures in place supported this and staff were able to demonstrate an understanding to us.

Care plans had been updated to identify when people may be at risk and when incidents had occurred these were reviewed. The governance of the home had improved, and audits were identifying areas of improvement. These needed to be more robust to ensure the identified all concerns.

The principles of STOMP (stop over medicating people with learning difficulties) had been considered and referenced when people were prescribed 'as required' medicines.

Staff enabled people to access specialist health and social care support in the community. Staff promoted equality and diversity in their support for people. People received kind and compassionate care.

Staff protected and respected people's privacy and dignity.

Right culture
People continued to not always be always supported by a management team and staff who fully understood the holistic needs of supporting people with learning disability and autism. People were not empowered by a staff team to live a fulfilled life that included taking positive risks. The culture of the home restricted people as the ethos, values and attitudes of the management team and staff were not empowering. There was a lack of understanding around how people should be involved with the service delivery.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 4 May 2022) and there were breaches of regulations.

At this inspection we found the provider remained in breach of regulations. The provider had not complied with the warning notice for Regulation 11 and this remains.

This service has been in Special Measures since 11 March 2022. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

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

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture and to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

This inspection was carried out to follow up on action we told the provider to take at the last inspection You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from inadequate to requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Old School House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to Regulation 11, Need for consent, Regulation 9 Person Centred Care and Regulation 17, Good governance.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.
Details are in our safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.
Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.
Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.
Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.
Details are in our well-led findings below.

Requires Improvement

The Old School House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection team consisted of one inspector and an Expert by Experience.
An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by experience made telephone calls to people's relatives.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager is not currently working in the home. There is a new manager who has recently started working in the home.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We gathered feedback

from the local authority and other professionals who have visited the home since our last inspection.

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

During the inspection
We spent time observing care and support in the communal areas and how staff interacted with people living in the home. Some of the people living in the home were unable to verbally communicate to us and others chose not to speak with us. During our inspection we spoke with the home manager, the deputy manager and three care staff. We also spoke with four relatives. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for five people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including audits carried out within the home.

After the inspection
We continued to seek clarification from the home manager and provider to validate evidence found. We also spoke with the provider on the telephone.

Requires Improvement

Is the service safe?

Our findings

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

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

At our last inspection the provider had failed to ensure medicines were always managed in a safe way. There were insufficient systems in place to ensure safe practice in relation to infection control. We also found risks relating to welfare of people were not mitigated or monitored.

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

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12.

Assessing risk, safety monitoring and management

- When incidents or accidents had occurred care plans and risk assessments were in place highlighting this and action taken to mitigate the risk. Further improvements were needed to ensure this was always completed in a timely manner as some incidents were reviewed as part of the planned monthly review and not after the event. This meant there could be a delay in ensuring that risks were mitigated, however no one had been harmed because of this.
- People's individual risks were assessed and monitored; this included any health needs. When people did have individual risks such as, weight loss or epilepsy, people had care plans and risk assessments identifying this. We saw people were supported in line with this guidance and staff were aware of their needs. One relative commented, "[Person] has lost a lot of weight in the past, but they are really on top of it now. I asked what their weight was when I was visiting last time, and the staff were able to go and get the information quickly to show me".
- When people had displayed periods of emotional distress, these incidents were documented. Care plans were reviewed and updated to ensure all incidents were reflected.
- Relatives we spoke with raised no concerns with safety. One relative we spoke with said, "I feel absolutely sure [person] is safe living there".

Using medicines safely

- Records we reviewed confirmed people were receiving their medicines as prescribed. All people now had medicines administration records (MAR) in place.
- When people were prescribed 'as required' medicines there were protocols for these. The information in this guidance was clear and detailed to ensure staff had the information to administer these medicines when people needed them.
- Staff administering medicines had completed training and a competency check to ensure they were safe

to administer these.
● Further improvements were needed to ensure individual medicine care plans were updated to reflect their current prescribed medicines.

Preventing and controlling infection
● We could not be fully assured PPE was always being effectively used. On one occasion when we entered a communal area, two of the three staff in there were not wearing their masks correctly and adjusted them when we entered.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

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

Visiting in care homes
● There were no restriction placed on visiting and visitors could access the home freely.

At our last inspection the provider had failed to ensure people were protected from financial abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 13.

Systems and processes to safeguard people from the risk of abuse
● When needed incidents had been reported to the safeguarding team. However, improvements were needed to ensure all incidents were reported appropriately. We saw documented a person had an unexplained bruise, an internal investigation had been completed, the outcome was inconclusive, it had not been considered this therefore may need reporting to the safeguarding team for further investigation.
● Records confirmed and staff told us they had received safeguarding training. One staff member told us, "It is making sure no harm comes to the residents. We would report if something happened to them or if there were any changes."
● Safeguarding procedures were displayed and in an accessible format for people living in the home.
● There were now systems in place to manage people's finances, to ensure people were protected from financial abuse.

Staffing and recruitment
● Some people needed one to one support, although this was available for them, it was unclear what this was always for and how people received additional support for personal care. The manager told us they had raised these concerns with people's social workers, and this was under review.
● There were enough staff available to support people and they did not have to wait for support.

● Staff told us, and they had received the relevant pre employment checks before they could start working in the home.

Learning lessons when things go wrong

● There were examples of how lessons were learned when things went wrong. A lesson learned sheet had been introduced, this had reflected on incidents that had occurred within the home. For example, when people had displayed emotional distress.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
At our last inspection people were being deprived of their liberties and the principles of the MCA were not always followed.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also issued a warning notice this remains in place as this warning notice has not been fully complied with.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Since our last inspection, we found some improvements had been made. However further improvements were needed, to ensure the service was fully working in accordance with the MCA.
- People did not have individual capacity assessments or best interest decisions when needed. We found when people lacked capacity to make decision for themselves, this was recorded in their care plan. There was a generic capacity assessment for these people and this was not specific to the decisions being made. There were no best interest decision documents in place for these people.
- One person had a DoLS authorisations and for other people applications had been made. However, these applications did not always cover all restrictions placed upon people. For example, where people were not

free to leave the building, could not consent to medicines or finances or when they received constant supervision. Furthermore, there were no care plans or risk assessments identifying how people were supported in the least restrictive way whilst applications were considered. Staff we spoke with gave inconsistent accounts of how they would support people. This placed people at an increased risk of being unlawfully restricted.

● We found that relatives continued to consent to care on behalf of people without the legal powers to do so. For one person the consent forms had been completed since our last inspection. This meant the principles of the MCA were not always followed.

● CCTV was in use in the home, when people could consent to this they had, when people were unable to consent there were no mental capacity assessments or best interest decisions in place.

● There remained a lack of understanding around capacity from the management team, despite them telling us they had received training in this area. They told us they were not aware capacity assessments needed to be decision specific and had not completed best interest decisions for people as they were awaiting the social worker.

The principles of MCA were not understood or followed within the home. This placed people at risk of harm. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the provider sent us an action plan identifying how they were going to address the concerns we found during our inspection. We also met with the provider to discuss these concerns and action they have taken.

Staff support: induction, training, skills and experience

● Although staff told us they received online training in relation to the people they were supporting; for example, people with learning disabilities and autism, it was felt staff would benefit from more enhanced training to fully understand the needs of the people they supported. For example, when people did not verbally communicate there was a lack of understanding around how they could be involved with the delivery of the service.

● Staff continued to receive other training since our last inspection. They felt the training was of a good quality. The manager acknowledged further improvements were needed to ensure staff competency was checked in all areas, for example MCA.

● When new staff had started working in the home, they told us they had completed an induction, this involved training and the opportunity to shadow more experienced staff so they could get to know people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People received care that was in line with their assessed needs. This considered people's characteristics and their cultural and religious needs. It remained unclear how people were involved with this process.

● People's social needs were also assessed and considered.

Supporting people to eat and drink enough to maintain a balanced diet

● People enjoyed the food they were eating. One person told us, "I liked my eggs".

● People's dietary needs had been assessed. Staff recorded what people ate and drank so this could be monitored. When people required specialist diets or were at risk of malnutrition, there was guidance for staff to follow. We saw this was followed during our inspection.

● Further work was needed to ensure people were fully involved with planning their meals and to ensure this and choices were presented to them in a format they could understand. For example, the menu for the day was written on a chalk board, this was not the preferred communication method for most of the people

living in the home.

Adapting service, design, decoration to meet people's needs
● Improvements had been made to the environment. New carpet was being fitted and pictures and decorations had been put around to make it more homely. A relative said, "The house looks lovely now, so homely. Big murals in the social area, bright colours, new carpets and curtains."
● The garden was pleasant, and people accessed this.
● There were signs around the home guiding people to key areas, such as the dining room or kitchen.
● It again remained unclear how people had been involved with this and if they had been involved in choosing the new furnishings.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care
● Staff worked with other agencies and health professionals to ensure people's needs were met. When there were concerns with people, they had shared this information with the relevant health professionals.
● People had access to GP and records confirmed they attended appointments. One relative told us their relations medical condition had improved since our last inspection.
● People's oral health care was assessed to ensure people received the support they needed.

Requires Improvement

Is the service caring?

Our findings

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

At our last comprehensive inspection, we rated this key question requires improvement. At this inspection the rating has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

At our last comprehensive inspection people were not always involved with their decision making and the care they received.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9.

Supporting people to express their views and be involved in making decisions about their care
● Although people were involved in making some day to day decision, they were not consistently involved. For example, we were told how one person would choose their meals by visually looking at the items. On one occasion they did this, however on the second occasion they were provided with a meal and not offered a choice.
● People were not consistently involved with decision making. Three of the people living in the home had very little control of their lives as information wasn't always presented to them in a way they could understand. It was unclear what involvement they had with making decisions about their lives and futures.
● There was no evidence how these people had been involved with their care planning and their reviews. Other people had agreed with their care plans after it had been written for them.

Respecting and promoting people's privacy, dignity and independence
● There was a culture of staff doing things for people instead of encouraging them to be independent. For example, we saw staff ask people if they would like a drink and then go into the kitchen without the person and make it for them.
● The manager told us they had introduced tasks for people so they could learn new skills. For example, one person had been encouraged to butter their own bread. Further improvements were needed as we did not see the person doing this during our inspection. It was also not documented when they completed this or part of their care plans. Staff confirmed they did not regularly complete this as part of their routines.
● Records we reviewed reflected the levels of support people needed. However further improvements were needed to ensure it was documented what people could do for themselves and the importance of maintaining this, and what they would need support with.

People were not actively involved in their decision making. This was a continued breach of Regulation 9 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's privacy and dignity was encouraged and promoted. Staff were able to provide examples of this and we observed people were supported in a dignified way.

Ensuring people are well treated and supported; respecting equality and diversity
● Relatives were happy with the care and support people received. One relative said, "The staff are very kind and patient. They take time to explain things to [person]. They are very welcoming when we visit. The feeling in the house is calm and relaxed. All the tenseness in the residents and staff has gone. [Person] is treated with respect".
● People were supported in a kind and caring way by staff. People responded to staff well. Some people smiled when they were around staff and approached them for support when needed.
● Staff were able to talk to us about people and knew them well, including their likes and dislikes and what was important to them. One relative told us, "The original staff know [person] very well. The new staff are supported to get to know them".

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last comprehensive inspection, we rated this key question requires improvement. At this inspection the rating has remained the same. This meant people's needs were not always met.

At our last inspection people were not always supported with care in a person-centred way or have information presented to them in a way they understood.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans had been updated and contained more information, including likes and dislikes. However further improvements were needed to ensure people always received person centred care. Care plans were in place, when needed, however lacked the individual detail about people. For example, the generic capacity assessment that had been completed was the same for all people and one person's care plan referred to 'she' instead of 'he'.
- People did not always have control over their lives as people were not always encouraged to express opinions. For example, there was no evidence of how all the people living in the home contributed to meetings.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information was not always available for people in a format they could understand. Staff did not always know how to communicate with people to support them to make important decisions and choices in their lives. One staff member told us, "It's hard to involve [person] as they don't understand and doesn't communicate that well." This meant staff needed further support to understand the people they were supporting and how they chose to communicate.
- The manager was aware of the assessable information standards and people had care plans stating how they communicated. Staff were aware of this and were able to give good examples of how people would make day to day choices, such as what clothes to wear.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them
● Although people were going out more since our last inspection, people had limited opportunities to try new experiences. People mainly accessed the local community and shop.
● We saw documented that one person throughout June had been out on two occasions. There were only a variety of three other activities that they had participated in throughout the month. Meeting minutes we reviewed had recorded there were plans to extend this further in the future, for example supporting people with holidays. One relative told us, "The staff are more motivated and want to do more with [person]. They like to go out in the garden. They also like to be quiet and will take themselves off to their room. They listen to music and watches the TV."
● People's religious and cultural needs were considered. However further work was needed to ensure people were fully supported with this. For example, one person had religious preferences. Staff told us they played music to this person to support with this, however it was unclear what the relevance of this was. There was no clear documentation offering staff guidance as to how they may wish to be supported.

People were not actively involved in their decision making. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had the opportunity to visit their relatives and they could visit the home when they wanted to. People were encouraged to develop these relationships and relatives felt more involved since our last inspection. People had been allocated keyworkers since our last inspection and they ensured they made regular contact with families.

Improving care quality in response to complaints or concerns
● People and relatives knew and felt able to complain. One relative said, "I know how to complain and would feel able to if necessary."
● There was a complaints policy in place and the manager assured us this would be followed if needed. The complaints policy was available for people in a format they could understand.
● No recent complaints had been made.

End of life care and support
● There was no one currently receiving end of life.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to ensure quality monitoring systems were effective in highlighting the shortfalls identified of which placed people at risk of receiving an inadequate service.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care

- Despite there being an action plan, the provider has not met the warning notice in relation to Regulation 11 and this remains in place. We were still not assured the management team understood MCA and what these meant for the people they supported. This meant we could still not be assured they had the knowledge or skills to make the necessary improvements.
- Improvements had been made since the last inspection; however further improvements were needed to ensure the systems introduced were robust in identifying all areas of improvements. For example, financial procedures had been introduced. However, for one person this had been added up incorrectly, an audit had been completed prior to our inspection that had not identified this.

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

- There was still not a culture of care in which staff truly valued and promoted people's individuality protected their rights and enabled them to develop and flourish. We were not assured the management team had the understanding or knowledge to support people with learning disabilities or autism.
- Staff were still not dynamic in empowering people to pursue new experiences and to achieve good outcomes.

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

- There was no evidence as to how people were involved with their care and the management of the service.

There was a lack of understanding around how people with nonverbal communication should be involved with this.

● Satisfaction surveys included mealtime experiences. Again, this was not always presented to people in a format they could understand. Only one person had completed these. There was no evidence how this had been used to make improvements.

The quality monitoring systems in place remained ineffective in identifying concerns and driving improvement within the home. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care

● Additional audit processes included medicines and incidents and accidents which had identified the need for improvement and action had been taken.

● Staff and relatives, we spoke with felt the home was improving. One staff member said, "It's one thousand times better now, staff morale is better." Comments from relatives included, "The home seems a really happy place now. They have had a few summer fayres to fundraise for a minibus for the house. Communication is good, they are thinking of having a newsletter". "I think it is well managed and the attitude of the staff has changed. There was a high turnover of staff, but it seems more settled now. Some of the staff who were unhappy before and left, have now returned".

● The previous rating was displayed in the home in line with our requirements.

Working in partnership with others

● There was some evidence that more health professionals were involved with people's care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always supported with care in a person-centred way or have information presented to them in a way they understood. People were not actively involved in their decision making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of MCA were not understood or followed within the home. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Further improvements were needed to ensure the systems in place were robust in identifying areas of improvements.