Eeze Old School House Ltd

The Old School House

Inspection report

Old School House
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22 December 2021

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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'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
People were not supported by staff to have the maximum possible choice, control and independence. People did not have the opportunity to gain new experiences or learn new skills. People were not always supported by staff to pursue their interests. Staff did not support everyone to take part in activities within their local community. People were not supported to play an active role in maintaining their own health and wellbeing.

Right Care
People were supported by staff who did not have the relevant skills or experience to ensure they received the appropriate care. Staff did not always understand or respond to people's individual needs. Staff did not understand how to protect people from poor care and abuse. Staff had training on how to recognise and report abuse but did not apply this understanding. People did not always have the opportunity to take part in activities and pursue interests that were tailored to them. The provider did not have enough appropriately skilled staff to meet people's needs or to keep them safe. Staff protected and respected people's privacy and dignity.

Right Culture
People did not have an inclusive or empowered life because of the ethos, values, attitudes and behaviours of the management and staff. People were not supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and autistic people may have. This meant people did not always receive compassionate or empowering care. The care and support people received was not always person-centred. We could not be assured that people and those important to them were involved in planning their care. Not all people's quality of life was enhanced by the service's culture.

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
This service was registered with us on 2 July 2020 and this is the first inspection.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of right support right care right culture.

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.

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 9, Person-centred care, regulation 11, Need for consent, regulation 12, Safe care and treatment, regulation 14, Meeting nutritional and hydration needs, regulation 15, Premises and equipment, regulation 17, Good governance and regulation 18, Staffing at this inspection.

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 re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

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

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 (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
One inspector carried out the inspection.

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.

Notice of inspection
This inspection was unannounced. We telephoned the provider from outside the home to find out the COVID-19 status in the home and discuss the infection, prevention and control measures in place.

What we did before inspection
We reviewed information we had received about the service since the provider's new registration. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the

judgements in this report.

During the inspection
We spoke with two people who used the service, three relatives and four staff members. We also spoke with the registered manager and had contact with the registered provider. Three other people who used the service were unable to verbally communicate with us. However, we observed staff interaction with them.

We reviewed a range of records. This included two people's care records and medicines administration records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the registered manager and the provider to validate evidence found. We looked at training data. We requested details of people's relatives to enable us to find out their views in relation to the care and support provided. However, we were only provided with two details. We requested clarification with regards to the current Covid19 vaccination status.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
•People did not live safely and free from unwarranted restrictions because the service did not assess, monitor or manage safety well.
•The environment was unsafe, placing people at risk of potential injury. We observed frayed carpet on the stairs that posed a tripping hazard. We observed a radiator located in a bedroom was not fitted with a guard to provide protection from the hot surface.
•Large furnishings were not secured to the wall to mitigate the risk of injuries. We observed control of substances hazardous to health (COSHH) materials were not securely stored. If ingested this could cause serious harm to the individual. Water from one shower was hot to the touch and accessible to people who lived in the home. We asked for records of water temperature monitoring. However, the records provided to us did not identify this shower. This meant people were at potential risk of scalds.
•On the first day of our inspection we identified combustible materials stored under the stairs. In the event of a fire this would impede the fire escape route. On the second day of inspection no action had been taken to remove these materials. We saw a personal emergency evacuation plan in place for one person. However, information contained in the plan related to another person. This meant in the event of an emergency they may not be provided with the appropriate support to evacuate the premises.
•We observed a fire door wedged open; this would compromise fire safety in the event of a fire.
•An area where electric switches were located was not secured and if tampered with could cause serious injury.
•Discussions with the registered manager identified prompt action had not been taken to ensure the safety of the environment where needed.

This is a breach of regulation 15, Premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Since our inspection visit, we have received an action plan from the provider which, shows action has been taken to mitigate the risk to people. This will be reviewed at our next inspection visit.

Using medicines safely
•There was no light in the treatment room where medicines were stored. A staff member told us they used a torch when administering medicines. This increased the risk of mistakes due to poor visibility.
•One person's medicines administration record showed they had not consistently received their prescribed treatment for a number of weeks. Staff told us the person frequently refused their medicines. At the time of our inspection this information had not been shared with the GP.
•On the second day of our inspection visit the registered manager told us they had received instructions

from the GP about what actions needed to be taken if the person refused their medicines. However, they confirmed this information had not been shared with the staff team. This placed the person at continued risk because staff were unaware of what to do.
•Two members of staff responsible for the management of medicines and the registered manager had different views on how to safely manage one person's medicines. This demonstrated the person would not be adequately supported to take their prescribed medicines, which could compromise their health.
•Staff told us they had received medicines online training. However, the registered manager was unable to demonstrate competency assessments were carried out by a skilled, competent person to ensure medicine practices were safe.

Preventing and controlling infection
•The service did not use effective infection, prevention and control measures to keep people safe. The service did not have good arrangements for keeping the premises clean and hygienic.
•Systems and practices did not ensure people would be protected from the risk of avoidable infections. We observed that not all staff used personal protective equipment (PPE) appropriately to mitigate the spread of Covid19 and other infections. One staff was seen wearing their face mask hanging from their ear and only adjusted this when the inspector entered the room.
•Appropriate systems were not in place for the disposal of PPE. The inspector was told to dispose of their PPE in the bin located in the kitchen.
•There were no systems in place to prevent the cross contamination of laundry.
•Staff told us they had received online infection, prevention and control training. However, there were no systems in place to ensure skills learnt were put into practice. After our inspection visit, we contacted the registered manager on 13 January 2022, who informed us of an outbreak of Covid19 in the home.
•We observed not all handwash areas had soap to promote good hand washing. Sanitary bins were not available in all toilet areas to ensure the suitable disposal of sanitary wear. We observed one bedroom was extremely unclean with food debris covering the floor. Holes were present in the wall in the kitchen which would compromise cleaning, resulting in the growth of bacteria.

This is a breach of regulation 12, Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Since our inspection visit, we have received an action plan from the provider which, shows action has been taken to mitigate the risk to people. This will be reviewed at our next inspection visit.

Systems and processes to safeguard people from the risk of abuse
•People were not safeguarded from potential abuse, as systems in place to share concerns about abuse were not in a format everyone could understand.
•We found prompt action had not been taken to obtain medical intervention for one person using the service, placing them at risk of harm.
•Staff demonstrated a good understanding about different forms of abuse. However, they did not recognise or, had not shared concerns about the shortfalls we found during our inspection visit that had an impact on people's wellbeing.

Staffing and recruitment
•There were insufficient staffing levels to ensure people's assessed needs would be met. The registered manager told us there was a shortfall of 208 care hours which was covered by existing and agency staff. On the day of our inspection we observed there were insufficient staff to provide one person with one to one support they had been assessed and funded for.
•A staff member told us the shortage of staff meant people were not always able to partake in things they

like to do.

This is a breach of regulation 18, Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•The registered manager told us they were recruiting additional staff and were awaiting safety checks before staff commenced employment. The provider's recruitment procedure was safe to ensure suitable people were being employed.
•The provider ensured vaccination of COVID-19 was a condition of employment.
•Since our inspection visit, we have been informed by the registered manager, staff numbers have increased, leaving six care hours vacancy.

Learning lessons when things go wrong
•People did not receive safe care because there were inadequate systems in place to ensure staff had the appropriate knowledge and skills.
•The registered manager did not recognise the deficiency in the service which had an impact on people. For example, where people required support with their behaviour, professional support and guidance had not been obtained. This meant people may not be adequately supported with their behaviours.

Inadequate

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet
•People did not consistently receive support to eat and drink enough to maintain a balanced diet.
•Staff told us one person frequently refused their meals and drinks. However, at the time of our inspection, no action had been taken to seek medical intervention. Records showed this person had lost two stone in weight within a short period.
•We saw food and drink charts for the same person had not been completed consistently to show the accurate amounts taken.
•Staff told us people were involved in the preparation of their meals. However, during the course of the inspection we did not observe this and people who used the service were unable to tell us.

This is a breach of regulation 14, Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
•People's care and support was not provided in a safe, clean, well equipped, well-furnished and well-maintained environment which met people's sensory and physical needs.
•The environment was sparse, worn, tired and hazardous in some areas. The registered manager had made an effort to paint some areas of the home themselves, to provide a more homely environment.
•We observed a washing machine in a person's en-suite. Although, the person was not in residence, we observed this washing machine in use. This meant their bedroom was used for communal use. We observed a vacant bedroom which, was not fit for purpose, furnishings were worn and broken.
•Outside areas were unkept and did not provide a pleasant area for people in warmer months.

This is a breach of regulation 15, Premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•The premise was situated on ground and first floor levels, accessible via stairs. All bedrooms were single occupancy and wash areas were near to all communal areas.

Staff support: induction, training, skills and experience
•The service did not check staff's competency to ensure they understood and applied training and best practice.
•Staff told us they had access to online training, although they would benefit more from face to face training. We were provided with one staff's training record which showed they had received various training.

However, there were no systems in place to ensure skills learnt were put into practice and people could not be confident they would receive an adequate service.
•We found staff who had been left in charge of the home did not have sufficient experience or skills. However, the registered manager felt staff's previous roles that were not relevant to adult social care was sufficient to manage the service in their absence.
•On the first day of the inspection, it was not recognised that one person needed to be seen by a GP promptly, or administrating medicines in the dark using a torch was inappropriate. This demonstrated that staff did not have the necessary skills to manage the service safely in the absence of the registered manager.

This is a breach of regulation 18, Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Staff told us, and records showed they had been provided with an induction into their role. Two staff members told us they did not have any previous experience working in adult social care and they found their induction very useful.

Supporting people to live healthier lives, access healthcare services and support
•People were not referred to health care professionals to support their wellbeing and help them to live healthy lives. For example, prompt action had not been taken to obtained medical intervention for a person who had a very poor diet and fluid intake. This resulted in a significant loss of weight.
•Another person required support with their behaviours. However, at the time of our inspection, no action had been taken to obtain professional support for them.
•The registered manager told us about some people's anxiety and behaviours when leaving the home. However, professional support had not been obtained for these individuals.

This is a breach of regulation 12, Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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.
•Staff did not demonstrate best practice around assessing mental capacity, supporting decision-making and best interest decision-making.
•The registered manager was unaware if anyone had a DoLS in place. This was of concern as staff had informed us some people had been assessed for one to one support which, meant they required constant supervision. The registered manager told us people would be denied the right to leave the premises if they wished, for their safety. This meant at the time of our inspection the registered manager was unaware if it was lawful to deprive people of their liberty.

•After our inspection visit, we were informed everyone living in the home had DoLS in place. However, we were not confident these were being reviewed to ensure these restrictions continue to be appropriate.
•A staff member told us one person was receiving their prescribed medicines covertly. This is where medicines are hidden in food. However, they were unaware if a best interest decision was in place. The registered manager told us the person was not receiving their medicines covertly, but they had been identified by the GP to crush the medicines. This meant actions taken by staff were unlawful.
•Staff and the registered manager demonstrated a good understanding of DoLS and MCA. However, their understanding had not been put into practice.

This is a breach of regulation 11, Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•Two out of five people were involved in their assessment. Systems had not been developed to enable others to be actively involved. This meant some people may not always receive care and treatment the way they like. The registered manager told us they had pictorial cards in place to assist one person with communication and they would be looking at developing this further to enable them to be more involved.
•Care plans were in place which, provided staff with information relating to the individual's support needs.

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.

This is the first comprehensive inspection for this service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
•We found shortfalls regarding the safety of people, lack of support in assisting them to access healthcare services when needed, all of which compromised the treatment and support people received. However, two people we spoke with told us they were happy living in the home.
•We looked at two care plans which did not contain any evidence that areas around equality and diversity had been considered to ensure people's care and support preferences were met. The registered manager told us more work was needed to provide a person-centred approach.

Supporting people to express their views and be involved in making decisions about their care
•People were not consistently enabled to make choices for themselves and they were not always provided with information they needed.
•We spoke with staff and the registered manager about people's involvement in making decisions for themselves. However, they focused on two out of the five people living in the home. There was no evidence efforts had been made to support the remaining three people to be involved in decisions about their care.
•Staff did not accommodate people's preferences or wishes, including those relevant to protected characteristics under the Equality Act, as care plans, we looked at did not make reference to this.

Respecting and promoting people's privacy, dignity and independence
•People did not have the opportunity to try new experiences, develop new skills and gain independence.
•We observed staff carrying out domestic tasks in the home, but we did not see people being supported to carry out these tasks themselves.
•Staff told us people were supported to clean their home. However, we observed one bedroom was unclean, and a staff member acknowledged the person had not been supported to clean their room.
•The registered manager told us systems and practices needed to be more person-centred. However, at the time of the inspection we did not observe this approach.

This is a breach of regulation 9, Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) 2014.

•The registered manager told us they were in the process of reviewing all care plans to ensure they were more person-centred.
•Staff had a good understanding of the importance of respecting people's right to privacy and this was observed throughout the inspection.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first comprehensive inspection for this service. This key question has been rated requires improvement. This meant people's needs were not always met.

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.

•Staff did not ensure people had access to information in formats they could understand
•The registered manager and staff were unaware of AIS.
•The registered manager told us one person used Makaton, this is a form of sign language. The registered manager told us they had received Makaton training, but staff had not. This meant staff may not be able to communicate with the person effectively. The registered manager told us pictorial cards were used to assist with communication with this person.
•Consideration had not been given to explore other methods or equipment to promote communication. The registered manager said, "We need to be more person-centred to help people to understand." We observed hospital passports were in place which provided relevant information to assist medical staff.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
•Staff did not offer choices tailored to individual people using a communication method appropriate to that person.
•Information obtained from staff and the registered manager identified systems were not in place to ensure everyone had the opportunity to have a say about their care preferences due to the lack of communication systems in place.
•The registered manager acknowledged the need to introduce more systems to assist people to have more choice and control of their life and to express their preferences.
•Care plans were detailed to show people's assessed needs and how to support them. Two out of five people were actively involved in planning their care.

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
•People did not have the opportunity to try new experiences or develop new skills to promote their independence. For example, two people had a plan schedule throughout the week for activities outside of the home. However, because these services had closed for the holidays, we did not observe staff offering them any alternative activities. This meant people had limited access to activities outside of the home.
•Staff told us about a person's specific faith which they said was very important to the individual. However,

we found staff had very little knowledge of the person's faith and culture. This meant people could not be assured they would be assisted to maintain their faith or culture.

This is a breach of regulation 9, Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Improving care quality in response to complaints or concerns
•People did not have access to information about how and who to share concerns with, in a format they would understand.
•The registered manager told us they had not received any recent complaints. They told us any complaints received would be acknowledged, investigated and responded to in writing.

End of life care and support
•At the time of the inspection no one was receiving end of life care. We did not see any evidence this had been discussed with people.

Inadequate

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.

This is the first comprehensive inspection for this service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
•The registered manager had not instilled a culture of care in which staff truly valued and promoted people's individuality, protected their rights and enabled them to develop and flourish.
•The registered manager had been in post since September 2020, they told us they had inherited a culture that was not person-centred. We found this culture continued.
•We observed staff were not dynamic in empowering people to pursue new experiences and to achieve good outcomes. The environment was unstimulating and posed many hazards.
•Insufficient management meant staff were not provided with the appropriate training or assessed by persons who were skilled or competent. They lacked clear direction in providing a safe and effective service. This meant people did not receive a good service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
•The registered manager did not have the skills, knowledge and experience to perform their role, they did not have a clear understanding of people's needs or oversight of the services they managed.
•We found there was no clear leadership within the home. The registered manager acknowledged all the shortfalls identified during the inspection. However, they had not taken prompt action to address them to ensure the safety of people using the service.
•The registered manager told us the culture within the home was not person-centred. However, they did not provide us with a clear direction of how improvements would be made.
•Quality audits carried out did not identify shortfalls with regards to the safety of the environment, the lack of prompt action to obtain medical intervention for one person and to promote people's right to independence and choice.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•People, and those important to them, were not supported to work with managers and staff to develop and improve the service.
•Discussions with staff and the registered manager identified that not all people living in the home were involved in the management of the service. We found very limited evidence of people having the opportunities to be actively involved in their local community.

Continuous learning and improving care
•The provider did not have a clear vision for the direction of the service which demonstrated ambition and a desire for people to achieve the best outcomes possible.
•At the time of our inspection there was very little evidence of clear leadership. However, the registered manager acknowledged improvements were required to provide an effective service.

Working in partnership with others
•At the time of our inspection the registered manager did not work with relevant professional agencies to ensure people received a safe and effective service.

This is a breach of 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
•The registered manager was aware of the duty of candour and recognised the service needed to be improved to ensure people had positive experiences. Since our inspection visit, they developed an action plan with the involvement of other agencies to make changes within a specific timescale.
•Staff we spoke with were open and honest with regards to the service but did not demonstrate an awareness of the poor culture within the home.
•Since our inspection visit we have been made aware by the local authority of their involvement in working with the registered manager to improve service delivery. The provider told us action has been taken to ensure people have positive experiences and are provided with the necessary support to learn new skills. We will review improvements and sustainability at our next inspection visit.
•The registered manager told us all staff have received further training. This should ensure all staff have the relevant skills to make sure people receive a service specific to their needs.

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 could not be assured they would receive care and support that met their specific needs, as practices and systems in place were not person-centred. There were no systems in place to ensure everyone had access to information in a format they could understand, or to enable them to be involved in decisions about their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were being deprived of their liberties without staff's knowledge of whether it was lawful to do so. The lack of knowledge of who had a Deprivation of Liberty Safeguards in place did not provide assurance these had been reviewed to ensure they were still appropriate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Inappropriate infection, prevention and control practices placed people at risk of avoidable infections and the spread of Covid19. The absence of sanitary bins in all toilets, meant these materials were not always being disposed of appropriately and action is required to address this. People were not always supported to access

essential medical professionals to ensure their health needs are met in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs One person had not been supported to eat and drink sufficient amounts and this had a significant impact on their health. Action should be taken to ensure medical intervention is obtained for the individual.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Appropriate monitoring and action had not been taken to ensure the environment was safe for people accessing the home. Action is required to ensure all hazards identified in this report are addressed to ensure the safety of people accessing the home. The environment was worn, tired and in need of essential decorating and repairs to ensure people live in a safe and stimulating environment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality monitoring systems were ineffective to highlight the shortfalls identified of which placed people at risk of receiving an inadequate service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff on duty to meet people's assessed needs. The absence of

sufficient, skilled and experienced staff left in charge of the home, placed people at risk of their assessed needs not being met safely.