Eeze Old School House Ltd

The Old School House

Inspection report

Old School House
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Tel: 01952580629

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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
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.

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 did not always have the opportunity to gain new skills or experience new things.

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.

People were limited with the choices they made, some areas had improved including how meals were planned however this was one aspect of people's care and for other areas this had not been considered.

Improvements had been made to the environment to ensure it was safe, however further improvements were needed to create a homely environment for people to live in.

Right care
Staff did not understand, and people were not protected from abuse. Staff had training on how to recognise and report abuse, however, we could not be assured this was effective.

People were at risk of not receiving their medicines when needed and recording systems were not always in place or guidance for as required medicines.

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.

People were limited in pursuing their interests as we saw people mainly only accessed the local shop and community instead of experiencing wider environments. There was no evidence of how people were involved with their care or the people that were important to them.

The care people received was not always person centred, care plans we reviewed were not always individual to the persons needs and not presented in a format they could understand.

Staff protected and respected people's privacy and dignity.

Right culture
People were not 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.

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. The service was inspected on 17 and 22 December 2021. (Published 14 March 2022) There were breaches of regulations.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

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 included checking the provider was meeting COVID-19 vaccination requirements.

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 12, Safe care and treatment, regulation 13, safeguarding service users from abuse and improper treatment and regulation 17, Good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is

added to reports after any representations and appeals have been concluded.

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 overall rating for this service is 'Inadequate' and the service remains 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below

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 two inspectors.

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.

Notice of inspection
The inspection was announced. We telephoned the provider on the morning of the inspection to find out the COVID-19 status in the home and discuss the infection, prevention and control measures in place.

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 other chose not to speak with us. During our inspection we spoke with the home manager, the deputy manager, three care staff and one agency staff. 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 four relatives. We also spoke with social workers of people living in the home and shared feedback with the local authority.

Inadequate

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 remained inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure medicines were consistently administered. The provider was unable to demonstrate medicines competency assessments were carried out by a skilled, competent person. We also found Inappropriate infection, prevention and control practices placed people at risk of avoidable infections and the spread of Covid19. The provider had also failed to ensure people had received safe care and treatment.

This was a breach of regulation 12 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 12.

Assessing risk, safety monitoring and management

- After our last inspection where we raised concerns with weight loss, we were told by the provider monthly weights were being completed.
- At this inspection we reviewed care plans which stated people should be weighed monthly. There were no records in place to confirm this was being completed. The home manager confirmed that people were not currently being weighed and this would be introduced shortly. This placed people at an increased risk of losing weight as this was not being monitored.
- When incidents and accidents occurred within the home, there was no evidence reviews were taking place. Care plans and risks assessments had not been updated to reflect these incidents or action taken to reduce the risk of these further occurring. For some of the incidents the home manager offered us a verbal explanation of what action had been taken.
- When people had displayed periods of emotional distress, we saw these incidents were documented. It was unclear what action had been taken following these incidents as there was no further information recorded. No one was able to tell us the action taken.
- People received various levels of support to keep them safe. One person received funding so they could safely access the community with two staff. We saw this person frequently accessed the community with the support of one staff. There was no risk assessment in place for this, placing the person at an increased risk of harm, during these times.

Using medicines safely

- We found one person was prescribed 'as required' medicines. There was no medicines administration record (MAR) for these in place despite them being administered. Furthermore, it was documented in this person's care file that they did not receive any medicines.

● When people were prescribed 'as required medicines' there was no guidance in place for staff to follow. This placed people at risk of not receiving these medicines when needed.
● Since the last inspection staff had completed medicines competency training and all staff administering medicines had now been deemed competent.
● The records we reviewed confirmed people were receiving their medicines as prescribed.

Preventing and controlling infection
● We were not assured that the provider was preventing visitors from catching and spreading infections. We were not asked to show we had completed a lateral flow test before entering the building, in line with current guidance.
● Relatives we spoke with also stated on their last visit they had not been asked to provide proof of a test.
● We could not be assured PPE was being effectively used. On one occasion we had to ask a staff member to put on a mask. We saw on other occasions staff adjust their mask when we entered the room.
● Individual Covid19 risk assessment were not available in the home for us to review. After the inspection they were sent to us. However, they were not individual and did not have the most up to date guidance in them.
● 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.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from abuse as procedures were not in place to manage people's finances. An incident had occurred in the home which is currently under police investigation.
● After the incident occurred, we were told by the home manager procedures were now in place to monitor people's finances. These were sent to us after the inspection, we found they were not always robust enough to ensure people were protected from financial abuse.
● A relative we spoke with was not aware of these procedures.
● A serious incident had occurred in the home which had resulted in harm to an individual. This had not been raised with the safeguarding team. The social worker confirmed this had been raised with them.

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

● Staff had received safeguarding training since the last inspection and could demonstrate an

understanding of what this meant for people.
● Safeguarding procedures were displayed and in an accessible format for people living in the home.

At our last inspection the provider had failed to ensure the environment was safe for people to access.

This was a breach of regulation 15 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 15.

● Since our last inspection the provider had taken some action to improve the environment. For example, we saw where carpet was damaged hazard tape had been applied to reduce the risk. We saw COSSH was now securely stored in a locked cupboard.
● The home manager told us, and we saw that maintenance checks were completed so that any new concerns could be identified and actioned.
● There were also checks on the current environment, for example, all water temperatures were recorded, to ensure it was safe for people to use.
● The provider was also in the process of employing a domestic assistant to ensure the home was kept clean.
● People's individual personal evacuation plans (PEEPs) had been completed since the last inspection, and staff were aware what action to take in an emergency.

At our last inspection the provider had failed to ensure there were enough staff on duty to meet people's assessed needs.

This was a breach of regulation 18 (1) 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 18 (1).

Staffing and recruitment
● We saw there were enough staff to support people in a safe way, staff we spoke with confirmed this to us. One staff said, "Yes we always have enough now".
● On the day of the inspection all people had been assessed as needing one to one support and this was provided for them.
● Although the relatives we spoke with felt there were enough staff they raised concerns about the limited activities and opportunities their relations had.
● All people either went to the local shop or for a walk during our inspection.
● Staff told us, and we saw they had received the relevant pre employment checks before they could start working in the home.

Learning lessons when things go wrong
● There were some evidence lessons had been learnt when things went wrong. For example, the provider had introduced an action plan on the environmental risks and was working towards completing this.
● However, other areas had not been considered or any action taken, for example in relation to The Mental Capacity Act. (MCA). (Reported upon under effective) There was also no evidence reviews were being

completed after incident occurred, to reduce the risk of further occurrence.

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 inadequate. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection 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.

This was a breach of regulation 11 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 11.

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.

- There was a DoLS matrix completed however from this it was unclear if anyone had a DoLS in place or if these had just been applied for. We found a further DoLS matrix that stated all five people had an authorised DoLS in place. However, this was inaccurate as one person had been assessed and this rejected due to them having capacity. During our inspection we did not see any copies of DoLS authorisations.
- The home manager or staff could not confirm if these had been applied for, or approved. This was of concern as people received constant supervision and were unable to freely leave the home.
- Where the home manager thought an application had been submitted, they were unable to tell us what these were for, as were the staff we asked. The home manager or staff were unable to tell us how people were being support in line with the MCA.

● It was often unclear where people had capacity or not. For one person we saw recorded in their care plan, they lacked capacity to manage their finances. There was no capacity assessment in place for this or best interest decisions.
● We found consent forms which had been signed by people's relatives. This is not in line with the MCA.
● During our inspection we did not see any capacity or best interest decisions in place for anyone living in the home, despite being told by the home manager three of the five people did not have capacity to make certain decisions themselves. Staff and the home manager did not demonstrate an understanding around all of these areas.

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.

At our last inspection the provider had failed to ensure there were sufficient, skilled and experienced staff available to support people

This was a breach of regulation 18 (2) 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 18 (2).

Staff support: induction, training, skills and experience
● Since our last inspection staff had completed a variety of training and introduced competency checks in some areas for staff. They felt the training had improved.
● Staff were also observed by the home manager and deputy completing their day to day role to ensure they were working in a safe way.
● Further work was needed to ensure staff fully understood all areas such as safeguarding and MCA.
● We did not find anything during our inspection that suggested staff had not responded to people's needs as they did not have the skills to do so.
● New staff had been employed and there was an induction process in place for them when they commenced.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care plans had been updated since the last inspection, it was unclear how people had been involved with this.
● It was unclear how people were receiving the right support as no one was able to tell us what people's assessed hours were for.

At our last inspection the provider had failed to ensure people had been supported to eat and drink sufficient amounts.

This was a breach of regulation 14 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 14.

Supporting people to eat and drink enough to maintain a balanced diet
● There were now systems in place to monitor what people ate and drank in the home. These charts had been reviewed and there were no indications people were not eating or drinking.
● People now had the opportunity to have snacks throughout the day.
● People were now involved with their meal planning and this was completed each week as a group task, one person went out into the community to complete the shopping for people.
● Where people were reluctant to eat staff told us how they had introduced new foods for them and supported them with this.

At our last inspection the environment was worn, tired and in need of essential decorating and repairs to ensure people live in a safe and stimulating environment.

This was a breach of regulation 15 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 15.

Adapting service, design, decoration to meet people's needs
● Although improvements had been made to ensure the environment was safer, further improvements were needed as the environment remained tired.
● There were plans in place to further improve the home for example, new carpets were due to be fitted and a new television had been purchased which was waiting to be fitted.
● Some areas had been improved for example; we saw butterflies had been put on the walls in the dining area to make it more homely. Signs had been put on doors to show whose bedroom it was with a picture of something that was important to them.
● The garden was accessible however it still required further improvements. The home manager told us there were arrangement for a gardener to work on this. It was unclear why people living in the home could not do this.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care
● We found more professionals were involved with people's care.
● People had or were in the process of having annual reviews with the GP and social workers to discuss their current needs.
● When people needed referring for example for support with mental health needs, we saw this had been completed.
● Relatives we spoke with did not always feel they were kept up to date. One relative spoke with us about a GP appointment they had requested. They were unaware if this had taken place and what the outcome was. We sought reassurances from the provider about this, after our inspection.
● People's oral health care was assessed to ensure people received the support they needed.

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.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate.

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.

- After our last inspection the provider sent us an action plan. We reviewed that action plan as part of this inspection. Where we raised concerns around capacity, consent and DoLS the action plan stated, 'The Home Manager will discuss about DOLS review and their conditions with staff through handovers. All staff will be made aware about the DOLS status and their conditions on handovers and this will be included in the service users Care Plan document.'
- During and after our inspection, both the home manager and provider were unable to assure us they understood MCA and what these means for the people they support. We found similar concerns throughout the action plan in other areas.
- This meant the home manager or provider did not demonstrate the knowledge or skills to make the necessary improvements.
- We reviewed the action plan where it told us action had been taken. For example, the action plan stated, 'Old School House has implemented frequent screening of nutritional requirements of the service users with the use of tools such as MUST (Malnutrition Universal Screening Tool) and weight matrix. Service User's weight will be recorded monthly and MUST score will be calculated for Nutritional support evaluation'.
- We found on this inspection monthly weight and MUST scores were not being completed. This meant we could not be assured the provider had taken the action they had told us they had taken to keep people safe.

Continuous learning and improving care

- A medicines audit had been introduced and was being completed by the home manager. However, this was not effective as it had not identified that a MAR chart was not in place for one person or that 'as required' medicine protocols were not in place.
- The audit completed on the incidents and accidents had not identified that reviews were not being completed after each incident. Or that care plans and risks assessment did not reflect these.

● The audits completed had not identified people were not being weighed or identified the concerns we found during our inspection in relation to IPC.
● We were told and we saw, that the provider now completed a review and audit of the home monthly. The audits they had completed did not identify any of the concerns we raised. This meant these audits were not effective in identifying areas of improvements.
● There was still no clear oversight of understanding people's needs. For example, no one was able to tell us what people's assessed hours were for. We asked for copies of people's social work assessments to be sent to us after the inspection. Instead we were sent a list of hours they received.
●There remained no clear leadership in the home, there was no acknowledgment about the serious concerns and shortfalls we raised during our inspection

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.
● 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.

● Some of the relatives we spoke with did not feel involved or updated.
● Satisfaction surveys had been introduced, however only one person had completed this.

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
● There had been a significant incident at the home. There had been a delay of 18 days before the provider notified us of this event.
● The registered manager was currently not working in the home. The local authority had notified us of this. We have not received formal notification of this from the provider in line with their legal requirements.
● We had not been notified about an event in the home where a person was harmed.
● We could not be assured duty of candour was understood and followed.
● Relatives were not always aware of incidents that had occurred in the home or the action taken. They did not feel involved.
● When incidents had occurred there were no reviews of these, we were therefore unable to see if these could have been avoided.

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.

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

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 11 HSCA RA Regulations 2014 Need for consent The principles of MCA were not followed.

The enforcement action we took:

We have issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed in a safe way, increasing the risk of people not receiving these when needed. There were insufficient systems in place to ensure safe practise in relation to infection, prevention and control. (IPC) Risks relating to the welfare of people were not monitored or mitigated.

The enforcement action we took:

We have issued a Warning Notice.

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 protected from financial abuse.

The enforcement action we took:

We have issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place had failed to effectively monitor and make improvements to the quality and safety of care to people.

The enforcement action we took:

We have issued a warning notice.