Eeze Old School House Ltd

The Old School House

Inspection report

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

Tel: 01952580629

Date of inspection visit:
19 October 2023
23 October 2023

Date of publication:
21 December 2023

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?	**Inadequate**
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 3 people at the time of the inspection. The service can support up to 7 people. People living in the home have their own bedrooms and there are shared communal spaces, including lounges, a kitchen and a garden area. At the time of this inspection 3 people were receiving a regulated activity.

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.

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. The provider did not promote independence or the development of social or vocational skills.

People were not supported by staff to have the maximum possible choice, control and independence. The completion of mental capacity assessments was inconsistent and did not follow best practice. There was a lack of understanding and application of the mental capacity act or the decision-making process when people were unable to make decisions for themselves.

Although people were supported by enough staff there was little direction on how to effectively engage and stimulate people. There was limited information on people's individual communication skills or how to identify and promote individuals' goals and aspirations.

People were not involved in the development of their care and support plans and the plans in place did not accurately reflect their current needs and wishes. Care plan reviews were ineffective and did not involve the person or those close to them.

Right care
People did not receive appropriate care and support as staff did not have the right information, guidance or assessments. People were at the risk of abuse as the management could not evidence they had effectively monitored incidents or situations or pass on information of concern to others when needed.

People's individual care and support plans did not reflect their needs, wants and wishes.

The principles of STOMP (stop over medicating people with learning difficulties) had been considered and referenced when people were prescribed 'as required' medicines. However, when people received medicines disguised in food there were no care and support plans to support this safely or in accordance with the person's wishes.

The management team failed to promote equality and diversity as this was not recorded in people's care and support plans. People did not receive privacy as the introduction of CCTV had not evidenced people's involvement, consent or best interests.

Right culture
People did not receive effective or responsive care and support which met their individual needs. People were not empowered by a staff team to live a fulfilled life that included taking positive risks. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible or in their best interests; the policies and systems in the service did not support good practice. 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 requires improvement (published 4 May 2022) and there were breaches of regulations regarding consent, person centered care and how the service was managed. 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 and we found additional concerns and breaches including safety and protecting people from the risk of abuse.

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 following 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 the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to inadequate 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 have identified breaches in relation to people's individual care and support, consent, keeping safe, protecting from abuse and how the service is managed.

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.

The overall rating for this service is 'Inadequate' and the service is 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 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.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive 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
This inspection was completed by 1 inspector.

Service and service type
The Old School House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Old School House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. However, a new manager had recently commenced their employment at The Old School House and was going through the registration process with the CQC.

Notice of inspection

The inspection was announced. We gave the service 24 hours' notice of the inspection. This was because the service is small, and people are often out, and we wanted to be sure there would be people at home to speak with us.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We asked the local authority and Healthwatch for any information they had which would aid our inspection. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring it's quality. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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 1 person and 3 relatives. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with the home manager, the deputy manager and 2 care staff.

We reviewed a range of records. These included care plans and records of medicines administration for 3 people. We looked at a variety of documents relating to the management of the service, including quality monitoring checks. We confirmed the safe recruitment of 2 staff members.

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 requires improvement. The rating for this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were not safe from the risks of avoidable harm. There were exposed hot water pipes which put people at the risk of burns. There was open access to the electricity consumer unit and electrical wires were in contact with exposed hot water pipes. This put people at the risk of electrocution. Not all wardrobes were secured to a fixed-point putting people at the risk of crushing. Not all windows had restrictors in place putting people at the risk of harm from a fall from height.
- Known risks to people were not assessed or effectively managed. There was a lack of available risk assessments for asthma and epilepsy, consuming inappropriate substances, mobility or impaired skin integrity. This lack of assessment put people at the risk of harm from ineffective support.
- There was a lack of appropriate signs in some places to effectively direct people in the event of an emergency. This put people at the risk of harm in the event of an emergency.
- When there were changes to people's health or needs these were not reviewed. Risk assessments were not completed to account for changes meaning staff did not receive consistent information on how to safely support people. This put people at the risk of harm from receiving inconsistent support with their changing needs.

Using medicines safely

- We could not be assured people received their medicines safely or in accordance with their wishes. When people could not manage their medicines or make decisions regarding receiving medicines there was no process to indicate this was in their best interests. When medicines were hidden or disguised in food there was no covert medicines procedure in place to safeguard the individual.
- Staff monitored the temperatures of the medicines room and fridges but there was no trigger for action or direction on what to do if the temperature exceeded safe storage ranges.
- There was a protocol on when to administer PRN medicine but there was a lack of supporting guidelines on how to support someone prior to the administration of such medication.

Learning lessons when things go wrong

- The provider did not effectively review all incidents, accidents or near misses to see what could be done differently to minimise the risk of reoccurrence. For example, there were 3 occasions whereby 1 person's actions could have resulted in harm. One incident resulted in hospital investigation. We asked the manager about these and they stated they did not know about them. They had failed to review incidents or accidents. They failed to review care and support plans. They failed to complete a risk assessment based on the known risks to this person. They failed to ensure items which could potentially cause harm to the person were removed and safely stored. The manager stated, "Staff should have told me." However, this information was clearly available in the person's records but had not been reviewed by the management team.

Preventing and controlling infection

● People were not always protected from the risk of infection as the management team were not consistently following safe infection prevention and control practices.

● Staff kept a record of fridge temperatures for the storage of food items. However, the management team had not identified the safe temperature range and there was no trigger for action should the temperatures exceed the safe storage range. There were multiple occasions where staff had recorded temperatures outside of the safe range. This put people at the risk of harm from potentially harmful bacteria growth on food.

We found no evidence people had been harmed. However, systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. These issues constitute a breach of Regulation 12 (Safe Care and Treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection site visit we raised our concerns with the funding local authorities for each individual for their attention and action.

Following our inspection site visit we have received assurances that actions are underway to address the more serious of our concerns.

Systems and processes to safeguard people from the risk of abuse

● People were not safeguarded from the risks of abuse or potential mistreatment. We saw 1 incident whereby it was believed by staff a person had been assaulted. There was a lack of available record or investigation completed by the provider. There was no safeguarding alert at the time of the suspected incident or risk assessment to safeguard the individual whilst concerns were being investigated. The manager could not demonstrate the incident had been effectively and robustly reviewed and any learning passed to staff.

● Although staff members had received training on how to safeguard people this learning had not been effectively applied at The Old School House. We explored a concern which had been raised which was an allegation of potential abuse with staff. Staff failed to understand the action described was abusive. This lack of knowledge put people at the risk of harm from abuse and ill-treatment.

● We saw an incident whereby a staff member received injuries as a result of an altercation. The management team had failed to see the potential abusive actions contained within this report and had failed to take any safeguarding action. This lack of awareness and analytical review put people at the risk of harm from abuse and ill-treatment.

The provider failed to identify, assess, mitigate or investigate potential risks of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, we raised our concerns with the local authorities adult safeguarding team and the commissioners responsible for the placement of people at The Old School House.

● There was information available to people and visitors on how to raise concerns.

Staffing and recruitment

● People were supported by enough staff to respond to them in a timely way. One person told us, "Staff are OK, and I can go get someone." However, there was a lack of managerial guidance or direction informing

staff on how to effectively engage with people. For example, there was no information available on how to support people with activities within their home to avoid times of boredom or reduced stimulation.
● Staff said there were enough to support people and if they were short the management team allocated agency staff to ensure there were enough to assist people.
● The provider followed safe recruitment checks. This included checks with the Disclosure and Barring Service (DBS). Disclosure and Barring Service (DBS) checks and provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The provider had systems in place to address any unsafe staff behaviour including disciplinary processes and re-training if needed.

Visiting in care homes
● There were no restriction placed on visiting and visitors could access the home freely. One relative told us they could visit whenever they wanted.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.

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.

● People did not have individual capacity assessments which reflected their current abilities. We saw conflicting information in assessments and the beliefs of staff and relatives. One capacity assessment for the use of CCTV stated the person did not have capacity to make a decision. A later capacity assessment then concluded the person had consented to the use of CCTV whilst family and staff stated the person didn't have the ability to make such a decision. We could not be assured the management team had the right skills or awareness of capacity or the MCA to complete such assessments.
● There was a generic capacity assessments for people, which were not specific to the decisions being made. There were no best interest decision documents in place for these people. When people lacked the ability to make decisions for themselves the provider failed to evidence they consistently followed the best

interest processes.
● We found that relatives continued to consent to care on behalf of people without the legal powers to do so. For 1 person the consent forms had been completed since our last inspection. This meant the principles of the MCA were not being followed in this instance.
● Staff were making decisions for people, for instance how much to drink, without the authority to limit such activities. There was no capacity assessment available, or a best interest decision evidenced for restricting drinks. The management team failed to provide guidance or information to support the person who's choices were being limited.

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.

We passed our concerns to the local authorities responsible for commissioning individuals' placements for those living at The Old School House.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law. Supporting people to eat and drink enough to maintain a balanced diet. Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care
● People did not have individually completed assessments of needs or choices which used recognised best practice. There was a lack of specific assessments regarding the risk of falls, impaired skin integrity, mobility or choices. Assessments were not available to staff at the time of the inspection and when asked staff were unsure why they were doing specific interventions for people. We asked 1 staff about offering choice to someone and they stated "They don't really know so we just do what we think is best for them."
● There was limited information available on how people were involved in their individual assessments. We could not be assured people were actively engaged in their assessments. We asked 1 person about the care they received. They said, "I don't know. They (Staff) just do it."
● People had their weights monitored. However, the management team failed to provide guidance or explanations for monitoring this. One staff member told us, "It is so we can see if there is any change." One record highlighted a weight change of 2 stones over a 2-month period. We asked staff and management about this and no one had identified the weight fluctuation or taken any action. This put people at the risk of harm through poor assessment and monitoring of their personal circumstances.
● We saw 1 person's fluids were monitored with a total amount for each day calculated. We asked staff for the reasons for this. No one knew. The management team did not know why they were completing such monitoring. The management team had failed to identify safe ranges for weight fluctuation, healthy drinking amounts or food intake. They had not completed assessments which were in line with recognised best practice and they had failed to effectively monitor any changes to people's individual circumstances. This put people at the risk of harm as systems in place to monitor changes to their health and welfare were not effective.
● At the time of the inspection there was no record available of people's individual characteristics including, ethnicity, disability, gender, religion or sexuality. This put people at the risk of losing their personal identities and the characteristics of what makes them who they were.
● When medical changes were highlighted these were not acted on by the management team. We saw a change in one person's skin condition. The management team had failed to pick up on this or complete care and support plans to assist the individual. We saw changes to one person's mobility but again the management team failed to identify this or make arrangements for the person's safe and consistent support.

These concerns were a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We passed our concerns to the local authorities responsible for commissioning individuals' placements for those living at The Old School House.

Adapting service, design, decoration to meet people's needs

● The physical environment of The Old School House had recently been redecorated. However, 1 person told us they had not been involved in the decoration or the decisions. Relatives we spoke with told us it is nice to see the improvements, but they had not been consulted

● The garden, although accessible, was not welcoming for people. We saw 1 person liked to go into the garden but had to sit on a low brick wall as there was no furniture available for them. Used item of equipment and empty paint tins were in this area. The manager told us someone must have taken them out of the skip but had not recognised or planned for a more welcoming area. The manager told us they were hoping to complete a wall painting but there was no evidence available on how people had been involved in this decision or what their personal preferences were.

Staff support: induction, training, skills and experience

● Although staff had received training there was little direction by the management team on the correct application of training and the impact on those they supported. One staff member told us they had received training in adult safeguarding but failed to see an abusive act could be perpetrated by a family member.

● Staff had received training in the safe administration but did not know what the requirements for safely storing medicines in hot weather were. Staff had received food hygiene training but did not have the awareness to highlight potentially unsafe food storage temperatures of consumable items.

● There was little management review of staff members practice to ensure the training they had received was being effectively applied to The Old School House or those who were being supported.

● 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.

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 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
● People were not actively engaged in decisions where they could. There were some day to day decisions made regarding activities but one person told us, "They (Staff) do this all the time for us and tell us what is happening." Relatives told us they were not encouraged to be actively involved and the only real time they were asked for their opinions was when social workers were involved. We saw one person actively had their choice removed from them by indicating they wanted a drink. Staff stated they couldn't have one at that time as they had one recently. This did not promote the persons choice or offer an explanation as to why staff were restricting them in their decision making.
● The management team did not routinely engage people or those close to them in decision making about their care or support. One relative told us, "I don't get involved in anything and it is only when I call that I am told anything. I get it that [relatives name] is an adult but we are still heavily involved, and we are just pushed to one side." The management team could not demonstrate or evidence how people or relatives were involved in the development of the care and support plans.

Respecting and promoting people's privacy, dignity and independence Ensuring people are well treated and supported; respecting equality and diversity
● People were not encouraged to be independent. There were no instructions or guidelines on how people could improve their skills to become independent. We asked staff about this, and they told us some of those living at The Old School House could do so much more but there is nothing in place to support or guide them. The management team told us they recognised this and would look to introduce some skill building but had yet to do so. A relative told us they felt staff were bored as they were just there keeping an eye on things rather than actively engaging with people. The management team did not make available information on equality characteristics for people or how staff could actively support people with their diversity. During our inspection we did not see any skill building activities and there were no functional

interactions to encourage people's independence.
● People's privacy and dignity was not respected by the management team. The provider had introduced CCTV in communal areas. None of the staff or the management team could tell us who is able to actively watch the CCTV or in what circumstances this is monitored. The manager said, "I don't even know which camera's have sound so it is not known who is able to listen into conversations." The manager told us no one had been provided with a privacy statement outlining the use of CCTV. Relatives we spoke with did not know if their conversations with those close to them were being monitored or recorded.
● Although staff could tell us what mattered to people on a day to day basis, like food choices or drinks and leisure activities, there was little understanding of goals or aspirations for people as this had not been recorded or made available by the management team.

People were not actively treated partners in their care provision, they were not actively or routinely engaged in the decisions effecting their care and the provider was enforcing decisions without the legal authority to do so. These issues were a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We passed our concerns to the local authorities responsible for commissioning individuals' placements for those living at The Old School House.

● People and relatives felt the staff were kind and approachable. One relative said, "The staff themselves as individuals are great. They are kind and approachable and I know they want the best for [person's name]. I think they treat them with dignity and they do respect them as an individual" Another relative told us, "Taking staff as individuals they are sound. They are kind and want to do activities and get out and about, but I think the management is lacking. I don't believe anyone would intentionally mistreat [person's name] or act in a way which would deliberately harm them."

Inadequate

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 changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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 did not contain information on how to safely support people or to meet their needs or preferences. For example, there were missing guidelines on specific health conditions, changes in mobility, behaviours which could cause harm or individuals ability to make decisions. This put people at the risk of not receiving care and support which met their needs.
- People were not actively engaged in the development of their care plans. One person told us they had never seen their plan and they don't know what is in it. Relatives told us the management team never asked for their opinions and they were not involved.
- People were not involved in reviews of existing care and support plans. A recent monthly support plan review completed by the management team was the same form completed for all those at The Old School House. The form contained the same statement for everyone and in one instance initials had been scribbled out with a different person's initials added. People were not involved in this review and relatives did not know it had occurred. The review failed to highlight the information missing and despite the form prompting the reviewer about risk assessments, goals, aspirations and outcomes these were not included or commented on. They were not individual or functional reviews and did not include the person they related too.

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. Information contained in the care and support plans was significantly omitted and there was little information on how to

effectively engage with people or how to present information in an accessible way to encourage the person's understanding. We did see some information presented in an easy read format but there was not a consistent approach to identifying and promoting people's personal communication preferences or how staff could encourage and develop these.

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

● Activities were limited and did not encourage skills or independence. One relative told us the management team had failed to apply for a bus pass in time and so specific activities have had to stop for about 6 weeks until they got it sorted. Other activities included going for a ride in the car. These were not functional activities which encouraged or promoted engagement in people's local community or what was culturally relevant to them.

● We saw 1 person had not left their room for two days. We asked staff about this, and they said it was the person's personal choice, but they could not tell us what they were doing to encourage this person or how they were engaging with them in their room. The management team had failed to identify if the person was at risk of social isolation or what they were doing to effectively meet this person's changing needs to maintain their emotional well-being.

● Another person like to spend time in the garden. We asked staff what they do to support this person when they are outside. They told us they didn't really do anything whilst they are outside apart from "Keep an eye on them." There were no plans in place to actively engage this person in activities whilst in the garden apart from sitting on a brick wall.

End of life care and support

● End of life care and support plans were not person to the individual. The plans did not contain information which was important to the person, their preferences or how they liked to be cared for. We asked 1 staff member what would happen if this person moved to another location suddenly and they told us "I guess they (new provider) will have to find this out if they went to them." This was not an effective, personal plan of care which took account of their individual preferences and put the person at risk of receiving care which failed to meet their needs.

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.

We passed our concerns to the local authorities responsible for commissioning individuals' placements for those living at The Old School House.

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. The complaints policy was available for people in an easy read format with a written record of the most recent complains which had been addressed with a written explanation and outcome provided.

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 requires improvement. The rating for this key question has changed to 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.

At our last inspection the provider had failed to ensure quality monitoring systems were effective in highlighting the shortfalls identified 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

- The management team did not have effective quality monitoring systems in place. They had failed to identify or correct deficits in people's risk assessments including mobility, eating and skin integrity. They failed to identify and rectify deficits in people's care planning like choices or independence and they failed to identify and address deficits in diversity and equality characteristics for people. This put people at the risk of receiving care that was not in accordance with their individual needs and wishes.
- The management team and the provider failed to complete effective checks to ensure people received positive outcomes regarding choice and decision making. The application of the MCA was not in accordance with the best practice guidelines and the management team did not promote people's inclusion when making decisions about them. This put people at the risk of having their individual rights abused.
- The management team and the provider's quality checks failed to identify and correct issues with the physical environment which put people at the risk of avoidable harm, including but not limited to, exposed hot water pipes, unrestricted window openings and open access to electrical systems. This put people at the risk of harm from avoidable incidents.
- The provider had a poor history of meeting regulation. This is the fourth inspection since March 2022 where the provider has been in breach of regulations including regulation 17 governance. The provider failed to drive improvements at The Old School House. When they have completed spot checks or quality checks, they have failed to ensure improvements are then driven by the management team. For example, following a recent spot check/audit the provider identified the management team were failing to keep a log of incidents/accidents, there were contradictions in the application of the MCA, there were no residents' meetings and the previous head office audit/report had not been actioned. However, the provider failed to ensure these issues had been addressed by the management team to drive improvements in people's experiences. This failure to drive improvements put people at the continued risk of receiving poor care and

support which did not meet their individual needs.

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

● Good and positive outcomes for people were still not being promoted by the provider or the management team. There was a lack of information regarding goals for people and there was a lack of involvement in people regarding the development of their personal plans. The management team failed to engage people in meaningful discussions and failed to empower staff to support people in their care plans. We could not be assured the management team understood how to support and promote people's individual protected characteristics as these were not recorded or encouraged.

● Neither the management team nor the provider prompted the inclusion of people in the running of where they lived or in decisions about their care or accommodation. The management team failed to identify or prompt positive outcomes for people including skill building or independence. The management team failed to motivate or empower staff to explore and promote new and different experiences to enrich people's lives.

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. Relatives told us they were not engaged by the management team and in 1 instance they had not been informed there had been a change of manager. The management team had not officially introduced themselves to those involved in people's lives. No one could tell us the last time they had been asked for their opinion and there was no user feedback questionnaire. One relative told us, "The only time they [the management team] contact me is when something goes wrong. Even then it is several days later and its as if we are an afterthought."

Working in partnership with others

● Although other health care professionals had ongoing involvement in people's care and support the management team failed to review and adapt care and support plans to identify and reflect advice and guidance. For example, 1 person had been identified with a potential breakdown in skin condition. The manager stated, "No one told me about this." However, it had been recorded by staff but not reviewed by the manager who had therefore failed to amend the care plans. Partnership working was not effectively promoted by the management team putting people at the risk of having changes to their medical needs being unaddressed.

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

● The provider and management team failed to demonstrate they had kept themselves up to date with best practice in adult social care. Neither the provider nor the management team could demonstrate they understood or effectively and lawfully applied the Mental Capacity Act at The Old School House.

● Staff told us they had now started to have staff meetings but these were more about being told what was happening and not asked for their opinions. One staff member said, "We still don't have all the information we need to support people. We are the ones who know people, yet we are still not being asked to get involved in care plans. We do what we can when we can but its all a little up in the air at the moment."

The quality monitoring systems were ineffective in identifying concerns and driving improvements at The Old School House. This was a continued breach of regulation 17 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014

We passed our concerns to the local authorities responsible for commissioning individuals' placements for those living at The Old School House.

Following our inspection site visit we have received assurances that actions are underway to address the more serious of our concerns.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure the care and support plans for people were individual and reflected their personal needs.

The enforcement action we took:

We have issued the provider with a warning notice giving them 14 days to make the necessary improvements and to be compliant with the law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to demonstrate they had applied the principles of the mental capacity act when making decisions for people.

The enforcement action we took:

We have issued the provider with a warning notice giving them 14 days to make the necessary improvements and to be compliant with the law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to complete risk assessment regarding known conditions and had failed to ensure the physical environment was safe for people to live in.

The enforcement action we took:

We have issued the provider with a warning notice giving them 14 days to make the necessary improvements and to be compliant with the law.

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 The provider failed to demonstrate they had

	reviewed all incidents of concern to promote safety and safeguarding of those receiving support.

The enforcement action we took:

We have issued the provider with a warning notice giving them 14 days to make the necessary improvements and to be compliant with the law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure there were effective quality monitoring systems in place to identify and drive improvements in the care people received.

The enforcement action we took:

We have issued the provider with a warning notice giving them 14 days to make the necessary improvements and to be compliant with the law.