Options for Care Limited

Orchard House

Inspection report

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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 caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

We carried out this inspection because we had concerns shared with us about the provider. The provider has two other locations registered with CQC. They had recently been inspected and a number of concerns were identified. We brought forward our planned inspection of this service.

Orchard House is registered to provide accommodation for six people with Learning Disabilities. There were three people living there when we inspected. The service was registered in June 2013. This is our first Inspection of this service.

A registered manager is required to manage this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A registered manager was not in post.

People were not protected from the risk of abuse because the provider did not have had systems in place to minimise the risk of abuse. Staff were not trained to identify the possibility of abuse occurring. Risks associated with people's care was not always identified and planned for and this put people at risk of harm.

Arrangements in place did not ensure that there were sufficient numbers of staff available to meet people's

Summary of findings

identified needs. Recruitment procedures had not always been followed to ensure staff were suitably recruited and received the necessary training to meet the care and support needs of people.

People had been supported to attend some health care appointments. However, arrangements in place did not ensure that people's health care needs were well managed and monitored.

People were comfortable and relaxed around staff. Staff did not always ensure that they protected people's privacy and dignity. Staff did not always ensure that they sought people's consent before providing care.

People were supported to access some community based activities which they enjoyed.

There were no systems in place to seek people's views about their care and to listen to people's concerns and complaints.

Systems in place to assess and monitor the quality of the service provided were not effective. We found multiple breaches of the regulations. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

People were not protected from the risk of avoidable harm as the systems in place were not robust.

Risks relating to people's needs were not assessed and managed appropriately.

People were not protected from the risk of unsuitable staff being employed. Arrangements for recruiting staff were not robust.

Inadequate

Is the service effective?
The service was not effective.

People did not always receive care that meets their needs because staff did not have sufficient training.

People's health care needs were not always met.

People were provided with food and drink that met their needs.

Requires improvement

Is the service caring?
The service was not caring.

People told us that staff were kind and caring.

Staff were occupied carrying out domestic and cooking tasks and not so involved and motivated about the care they provided.

People's privacy and dignity was not always protected.

Requires improvement

Is the service responsive?
The service was not responsive.

People did not have their care and support reviewed.

Staff were not always responsive to people's needs. Some activities took place to meet people's individual needs.

Systems were not in place that would ensure that people and their relatives would be listened to and any concerns would be acted on.

Requires improvement

Is the service well-led?
The service was not well led.

The service had not been well managed. There was no registered manager in place.

Inadequate

Summary of findings

There were some systems in place to monitor the quality of the service however these had not been effective and did not ensure the wellbeing and safety of people.

Orchard House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 and 27 August 2015. The inspection was unannounced. One inspector carried out this inspection. We had received concerning information about the providers two other services so we brought forward the inspection of Orchard House.

We looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We contacted the local authorities that purchase the care on behalf of people, to see what information they held about the service and we used this information to inform our inspection.

We met and spoke with the three people that lived there, the acting manager, Operations Director, three care staff members and an agency staff member. We met one relative. Some people were unable to tell us about their views about their experiences of care, so we also spent time observing interactions between staff and the people that lived there.

We looked at records in relation to three people's care. We also looked at six staff recruitment and training records. We also looked at records relating to the management of the service and a selection of policies and procedures.

Inadequate

Is the service safe?

Our findings

One person told us, "Yes I do feel safe, this is my home". We observed long periods of time when all three people were in the lounge and no staff were present to observe people or respond to people's requests for help. We observed that two of the people often shouted out at each other and this got louder when staff were not present. One person stamped their foot and looked unhappy when these interactions took place. We asked two staff about the relationships and friendships between the people that lived in the home. They told us that the interactions that we had observed were not uncommon.

We saw in people's care records that staff had described an incident between two people living in the home and one person had threatened another person. This incident had not been reported to the local authority or to CQC as required under safeguarding procedures. We saw recorded in people's care records that some people had bruises to their body. We asked staff about this and one staff members told us, "That's what they do" and "They do it to themselves". Staff had not recognised or considered that these injuries may be an indication of abuse or avoidable harm and had not taken any steps to protect people including notifying the local authority or CQC.

We spoke with three care staff and asked them what they would do if they had any concerns about people's safety or wellbeing. They told us that they would escalate any concerns that they had to the manager. Staff told us they had no concerns about the safety and wellbeing of people. However, the acting manager told us about an incident that had been reported to them by a staff member. The staff member had become concerned about the wellbeing of people when a particular agency staff member had worked in the home. The staff member had delayed in reporting their concerns to the acting manager, and the acting manager told us that there was a lack of clarity around the time and date and no further action had taken place.

Staff that we asked were unsure when they had last completed safeguarding training. One staff member said they had completed the training over a year ago and another person told us they had completed it with their previous employer. Training records we looked at were unclear. The acting manager confirmed in information sent to us following our visit that two staff had received safeguarding training and four staff had not received this training to ensure that they knew how to protect people who lived there from abuse and improper treatment.

We asked to see the providers safeguarding procedures. These did not provide staff with clear guidance on their role to ensure people were protected and did not refer to local protocols agreed with external agencies such as the local authority or police. The acting manager was not aware of the local authority's procedures for safeguarding and there were no multi- agency protocols available in the home.

The provider had not ensured that they had implemented robust procedures and processes that ensured people were protected from the risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the arrangements in place to assess and minimise risks were not effective. Staff spoken with told us about some recent concerns when supporting people to access the community. They were concerned about a person who had run away from staff and staff were concerned about the person's safety. A staff member told us, "I would not go out on my own with [Person's name] we need two staff". We saw that staff had recorded their concerns about this in the care records. Although the person's risk assessments had been updated. These incidents had not been considered in the review of the risk assessment so action could be taken to mitigate the risk of further incidents. Staff told us about other incidents that had happened that had impacted on people's safety and we saw records of incidents that had happened in the home. However, risk assessments had not been implemented to manage these risks. There was no system in place to identify and analyse themes and trends so steps could be taken to mitigate the risk of further incidents.

We saw that there were a number of potential risks to people in the environment. We discussed these with the acting manager and Operations Director. However, when we returned on day two of the inspection no action had been taken to reduce the risk. This showed that the provider had not done all that was reasonably practicable to mitigate any such risks. For example we saw that bleach was stored in an unlocked spare bedroom and was not secured. We saw broken furniture in the garden and these presented as a trip hazard. The garden had been partly dug up with exposed pipe work and the ground was uneven

and presented a risk of falling. The gate leading from the garden was not locked so people could potentially access or leave the home. In addition there was a drop to street level. The provider had not ensured that care and treatment was provided in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records looked at showed that there had been eleven shifts in August 2015 covered by bank or agency staff. On the second day of our inspection an agency staff member was working. We asked to see the records to confirm the suitability of any agency staff who worked in the home including confirmation that they were suitable to work with vulnerable people. The Operations Director told us that they did not have these records.

Two staff that we spoke with told us that recruitment checks had been completed prior to their employment. We looked at six staff recruitment files and found that robust recruitment procedures had not been followed. For example all pre–employment checks as required by law had not been completed before staff started working. For example not all staff had evidence that satisfactory references from their previous employer had been obtained prior to their employment date. This would ensure that the provider could assess their conduct in their previous employment to determine if they were suitable. Some Disclosure and Barring Service (DBS) checks from a previous employer were on staff files. However, there was no evidence that a risk assessment had been completed to ensure the suitability of the person. The provider did not ensure that robust recruitment processes were followed and did not have a procedure in place for the on-going monitoring of staff. This was a breach of regulation 19 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

One person told us that staff were available when they needed help. We observed during our visit that there were long periods of time when staff were not available in communal areas of the home to respond to people's requests for help. We saw that staff were involved in cleaning, cooking and laundry tasks. On two occasions we needed to alert staff so that they could respond to people's request for help. We saw that guidelines were in place for one person that stated two staff should be available to carry out a person's personal care to ensure their and the staff members safety. However, rotas looked at and staff confirmed that only one staff member worked from 8.00 pm to 8.00 am each day. The Operations Director told us that there was no system in place for assessing staffing levels to ensure staffing levels were adequate to meet people's needs. They told us that staffing levels had been determined by the local authority's assessment of people's needs and the care hours needed to meet those needs. The acting manager told us that the night time staffing levels had been reduced from one staff member on waking night duty and another sleeping in on the premises to one waking night from June 2015. There was no risk assessment in place to ensure that one staff member on duty was adequate to meet people's needs. Arrangements in place did not ensure that sufficient numbers of staff were deployed to ensure people's needs were met. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that they got their medicines when they needed them. All the people required staff support to take their medicine safely. We observed staff giving out people's medication during our visit. People were given a drink to help take their medicine and staff stayed by people until they had taken their medicine. We saw that people's medicines were stored in the office in a locked trolley. However, the office was not lockable. We saw that medicine's to be returned to the pharmacy were also stored in a bag in the office and this was not secured. We saw that Medication Administration Records (MAR) chart had not always been completed accurately and we saw records stating that some people had been given the medication at the wrong time of the day. We saw that some discontinued medicine was still being stored in the medicine trolley. Following our inspection we asked that a pharmacy inspector from the CQC visited the service to assess if people's medicines were managed safely. The outcome of their visit will be reported in a separate 'focused' inspection report.

Requires improvement

Is the service effective?

Our findings

One person told us, "I like [Staff member's name] she is really nice to me. One staff member told us, "I have done some training, not sure of when and what. The new manager is organising some updates". Another staff member told us, "I have done training but most of it was with my previous employer". We observed that staff did not always engage with people in a way that showed that they understood people's needs. For example we saw that staff had little contact or communication with one of the people that lived there. We asked staff about how they supported people if they became upset and distressed. One staff member told us, "We keep out of their personal space" We asked staff about what specific training they had completed so that they understood the specialist needs of the people that they care for and support. For example training related to autism, diabetes or behaviours that challenge. Two staff that we asked told us they had not completed this training and records looked at showed that training specific to people's care needs had not been provided to any of the staff team.

A relative told us, "The care staff seem really nice and work hard. However I am concerned that there seems to be no one that seems qualified. There seems to be different staff working when we visit."

Two staff told us that they were unable to administer a person's emergency rescue medication because they had not been trained to do so. They told us they would contact the emergency services, if needed. The acting manager confirmed that only one staff member out of six had been trained to administer the person's rescue medication. All staff that we spoke with were unsure what they would do in the event of a fire and told us that they had not completed fire safety training. The acting manager told us that this training had not been completed. Only two of the six staff had completed first aid training. There was no formal induction programme in place. There was no system in place to review staff's training, learning and development needs. All staff spoken with told us they had not received supervision for over twelve months. Staff supervision would ensure competence is maintained. The provider told us after our inspection that staff received supervision every six weeks. Two staff told us that they felt supported by the new manager and she was starting to organise things. The acting manager told us that she was taking steps to ensure that staff received the training they needed and had started to plan staff training. We found that staff had not received the appropriate support, training, professional development and supervision they needed to carry out their role. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) sets out what must be done to protect the human rights of people, who may lack mental capacity to make decisions to consent or refuse care. Deprivation of Liberty (DoLS) requires providers to submit applications to a supervisory body for permission to deprive someone of their liberty in order to keep them safe. The acting manager told us that DoLS applications had recently been made following concerns raised by a visiting professional about one of the people living in the home opening the front door to them. In response to this the door was kept locked and DoLS applications were made for all the people living in the home. Prior to these applications being made the provider had not recognised that there may have already been possible restrictions on people's liberty in place. As people were not free to leave and were under continuous supervision by staff.

Training records showed that two staff members had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) in January 2014 and none of the other staff employed there had received this training . We saw in people's care records that some healthcare professionals had been involved with supporting people to make decisions about medical treatment. Staff were able to tell us how they provided person centred care and encouraged choices, which showed their practice was in line with what was required by this legislation. However, when we observed staff we saw that this was often not carried out in practice. One care staff member that we spoke with was able to explain what restrictions were in place and why the DoLS authorisations had been requested for people. However, another care staff member told us that no DoLS authorisations had been requested. This showed that they were not aware of the restrictions in place and that this information had not been communicated to them.

We did see some instances when staff did asked people's consent to their care and treatment. This included a staff member supporting a person to choose and select the

Is the service effective?

music they wanted to play and helping the person to put the music on. We also saw that a person was asked if they wanted to return to their room to rest after they had eaten their lunch and they were supported by staff to do this.

One person told us that they would see the doctor if they were not well. We asked staff how they supported people so that their healthcare needs were met including diabetes and epilepsy. Two staff member told us that a person was, "A little bit diabetic" and another person was being monitored by the GP to establish if they were diabetic and they were on a sugar free diet. The acting manager told us that the person being monitored by the GP was not diabetic. However, this information had not been passed onto the staff and we could not see where this was recorded in the person's care records. We asked a staff member what regular checks the person received to ensure that their diabetic needs were met. The staff member told us, "I don't know I am not their key worker". All staff that we spoke with did not know what type of epilepsy people had, although all staff told us that they knew when the circumstances in which they would need to call the emergency services.

Records showed that people had been supported to attend some medical appointments including optician, GP and consultant appointments and also some health care specialist appointments. However, there were no care plans in place on specific healthcare needs. These would inform staff how to support the person to meet their healthcare needs. For example there was no care plan in place for the management of diabetes, asthma and weight monitoring. We saw that one person had lost some weight over a number of months. Staff were not able to tell us if this issue had been shared with healthcare professionals that were involved with the person's care as care records in place to record the care delivered were incomplete. People had Health Action Plans (HAP) in place. However these had not been maintained and had not been updated since 2012. (HAP tell you about what you can do to stay healthy and the help you can get. The department of health says that all people with a learning disability should have a HAP). There was no evidence in any of the care records that people were involved in their care planning. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that they liked the food. We observed how people were supported at lunch time on both days of our visit. We saw that people were not offered choices about what they would like to eat. Meals were served up in the kitchen and then handed to people. We asked a person what they were eating they told us, "I don't know what it is, and I don't like carrots". Staff made no attempt to explain what the food was and did not respond to what the person had said. We saw that the person ate all the meal apart from the carrots. Soft drinks were poured for people without a choice and people who could pour their own were not encouraged to. We asked staff about this they told us, "We know what they like". We asked staff how meals are planned. A staff member told us, "The menu is on the fridge we follow that. We know what they like or dislike. We used to have residents meeting to discuss things like food but these don't happen now". We asked staff if the menu was available in a format accessible to the people living there. For example in a picture or photograph format to help people make choices about what they may want to eat. Staff told us that this was not available. All the staff that we spoke knew about the specific support each person needed to eat and drink.

Requires improvement

Is the service caring?

Our findings

People told us that the staff were caring. One person told us, "Good". Another person told us, "I like [Staff member's name] she is nice". We observed that people were relaxed around the staff supporting them.

People's privacy and dignity was not always promoted. We saw that one person was resting on their bed and their bedroom door was open. The bedroom was off the entrance hall of the home. We asked staff about this. A staff member told us, "Their bedroom door is kept open so that we can check on them and make sure they are safe". We asked staff if other possible ways had been explored that may be less intrusive to people. Staff told us that this was the practice in place for all people that lived there. However, the provider told us that this person prefer to have their door open as they like to remain aware of what is going on in the home. And do not like to feel closed in. This person's door is left open for this reason . keeping the door open is in keeping with the person's expressed wishes and so reflects a person- centred approach.

During our inspection we heard staff tell a person on a number of occasions to go to the toilet. This was shouted across the lounge and other people were present. People's care records did not show that their privacy needs and expectations had been identified and recorded. Care records were stored in the lounge in a cardboard box which did not ensure the security and confidentiality of people's information had been provided. This did not show that people were provided with care and treatment in a way that ensured their privacy and dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that they could get up and go to bed when they wanted. During our visit we spent some time in the communal areas of the home and observed that there were limited opportunities when staff encouraged people to make every day decisions about their care. We saw that staff were mainly task focused. However, we did see some interactions when staff took time to speak and listen to people and supported them to make decisions. For example, one person wanted to listen to their music and they were supported by staff to do this. Another person wanted to go out into the garden and staff supported them to go outside. We saw and staff told us that there were no communication systems in place to help people make decisions about their care. For example, there were no photographs or pictures to assist people with communicating their views.

Staff told us that people's independence was promoted when they assisted people with their personal care. We observed during our visit that the involvement of people in the running of the home and the promotion of people's independence was minimal. One person freely accessed the kitchen to make themselves a drink and this was encouraged. However, people were not encouraged to be involved in everyday tasks such as laying the tables at meal time, or pouring their own drinks or helping where needs allowed with every day household tasks.The provider told us that the people have set routines that they do not like to change, having been residents in homes for many years and all being beyond retirement age. The provider informs us that they have explored changing some of the people's activities and routines but they did not wish to change anything. The provider explained that the occupational therapist will continue to visit people to explore whether changes might be beneficial and acceptable to people.

Two people told us that they liked to see their relatives. During our inspection we saw that one person's relatives visited them. They told us that they could keep in touch and visit the home when they wished. We saw that staff made relatives welcome and made them drinks and took time to speak with them. Staff told us that they also supported people to make visits to their family member's home. This showed that people were supported to maintain contact with family relationships.

Requires improvement

Is the service responsive?

Our findings

One person told us, "I would speak to [Staff member's name]". If they were not happy about something. A relative told us that they were very dissatisfied with how their concerns had been dealt with by the previous manager and current Operations Director. They told us that communication had been poor and their concerns had been passed to different staff within the organisation.The Operations Director told us that the complaints procedure had recently been updated in July 2015. The concerns that the relative told us about had not been recorded in the provider's records and this did not ensure that their own complaints procedure had been followed. The provider did not operate an effective, accessible system for identifying, receiving, recording and handling complaints. This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that information about how to raise concerns and who to speak with, was not available in public areas for the people that lived there and their visitors to see. We asked staff if meetings with people who used the service and their relatives were held to gain their views about the service provided and make suggestions for improvement. We were told by staff that no meetings had taken place for over twelve months. Records seen confirmed this.

We observed that when staff supported people with their care they often did not explain what they were doing or ask people their views about their care. For example at meal time a staff member put an apron on a person but did not explain what they were doing. One person was told, "It is time for you to go to the toilet now". They responded back by saying, "I don't want to go now" and staff responded back and said, "But you must go now". There was no attempt by staff to reassure or explain quietly to the person or to seek their views about their care.

Staff that we spoke with told us that they knew people's needs well because they had supported people for a long time. They told us they knew what people liked and disliked. The acting manager told us that she had needed to rewrite people's care plans and records because they had not been updated since people moved into the home from another service. We saw that care records did not reflect how people would like to receive their care and did not reflect people's involvement in planning their care.

People who could tell us told us that they could take part in some group activities that the home had organised or follow individual hobbies and interests. One person told us, "I went out to the shop yesterday I bought a clock". They told us they liked going out and enjoyed looking at magazines. During our inspection we saw that they spent a lot of their time looking at magazines. This showed that the person was doing something they liked. One person listened to some music and watched television and another person sat in the lounge for most of the time during our visit and also went out into the garden. Staff told us that people enjoyed trips out to the local community. They told us that usually all three people went out together and that this was determined by staffing levels. People told us and records showed that they visited a coffee shop, cinema and local shops. The acting manager told us that they were looking at how the range and planning of activities for people could be improved.

Inadequate

Is the service well-led?

Our findings

The acting manager had recently completed infection control, medication and health and safety audits. However there was no action plans in place in response to issues that had been identified and these audits had failed to identify concerns that we found during our inspection. We found multiple breaches of the regulations. This included a lack of robust procedures and processes to reduce the risk of abuse. The arrangements for care and treatment did not ensure that this was provided in a safe way. Recruitment procedures were not robust. Staff had not received appropriate training and support to carry out their role. People were not always treated with dignity and respect. The provider had not operated an effective system for handling complaints. Records were not secure, accurate and complete. The provider did not have an effective system in place that enabled them to identify and assess risks to people. Where risks are identified the provider must have measures in place to minimise, reduce or remove the risk. This was not in place. The provider did not have a system in place to seek and act on feedback from people using the service or people acting on their behalf, or their carers. The provider did not have an effective system in place to assess, monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our records showed that the provider had not informed us of any notifiable incidents concerning people who used the service. For example we were not informed of a serious injury to a person. This meant that they had not fulfilled their legal obligations as required by law. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This was the first inspection of the service since its registration in 2013. There was no registered manager in post. The registered manager had left in March 2015. When we inspected an acting manager had been employed on a temporary basis and they told us that they took up the position on 8 July 2015. We were told that a permanent manager had been appointed and would take up their position 21 September 2015. We asked the acting manager if they were familiar with and had a copy of the 'Guidance for providers on meeting the regulations'. They told us that they had not seen this publication and did not have a copy. Without an awareness of this guidance the acting manager would not be aware of their responsibilities on meeting the regulations.

A relative told us that they were concerned about the staff and management changes at the service and that communication had been poor. We found that there was no evidence of an open culture that involved and empowered the people living in the home. Staff had not been led by an effective management team and there was no clear vision or values. There was no evidence that poor practice had been challenged.

We asked the acting manager if they had identified the shortfalls we saw at this inspection and if they had an action plan or improvement plan in place that they were working to address the failings of the service. They told us that verbal discussions had taken place with the Operations Director but there were no structured plan in place to show how these will be considered. The Operations Manager told us that they recognised that a lot of improvements were needed and that they were starting to address these.

Staff told us that the changes in management had meant the service had experienced some difficult times. However, staff were very positive about the current acting manager. We spoke with three staff members about what they would do if they had any concerns about the service. They told us that they would speak with the acting manager or Operations Director and felt confident about doing this. Staff told us that they had no concerns about the care of people using the service.

Staff meetings provide an opportunity to encourage open communication and question practice. All staff that we spoke with told us that they had not had a staff meeting for over twelve months and records looked at confirmed this. Staff told us that meetings with the people that lived there no longer took place and that they were unsure why.

Staff told us that they had not received regular supervision to monitor their practice, learning and development for over twelve months. However, staff told us that the acting manager had started to make arrangements and a staff meeting had been planned and staff training dates were being scheduled and they told us that they felt positive about this.

Inadequate

Is the service well-led?

Following our inspection we met with the provider to share our concerns about the service and the breaches in the regulations. They told us that they had taken action to make improvements.

We shared our concerns with the Local Authority who visited the home. They told us that they had identified a number of concerns and that they had required the provider to address these concerns and make the improvements needed.

We also contacted West Midland Fire Service because we were concerned about fire safety arrangements in the home. West Midland Fire Service told us that they had visited the service and that they were working with the provider to ensure that all the necessary fire safety measures were in place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider had not taken action to ensure that each person received person- centred care based on an assessment of their needs and preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider had not ensured that they provide care and treatment in a way that ensures people's dignity and respect at all times.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not taken steps to ensure that people were prevented from receiving unsafe care and treatment.**

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 had not taken steps to ensure that people were safeguarded from abuse or improper treatment.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not ensure that they had an effective and accessible system for identifying, receiving, handling and responding to complaints.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that they had effective governance, including assurance and auditing systems.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times. The provider had not ensured that Staff received appropriate support, training professional development, supervision and appraisal to enable them to carry out their duties. 18 (1) and 18 (2) (a)
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not taken steps to ensure that CQC were notified of occurrences so that where needed CQC can take follow- up action. 18 (2) (b) (ii)
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Action we have told the provider to take

The provider had not taken steps to ensure that they operated robust recruitment procedures. 19 (1) (b) (c) (2)