Mr & Mrs D O'Donnell

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Mr and Mrs O Donnell is registered to provide accommodation and personal care for up to eight older people. At the time of our inspection, there were four people living at the home.

Our inspection took place on 8 & 9 June 2016 and was unannounced. At our last inspection in October 2014, we rated the provider as Good. Since our last inspection, the composition of the partnership responsible for this service has changed. We are currently in the process of resolving queries around this provider's registration. Where we refer to the 'provider' in this report, this refers to the person currently providing the regulated activities whilst the issues around the current registration are resolved.

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.

The home did not have a registered manager. 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.

People did not receive safe care. Support was not always provided in a safe way to ensure people's well-being. Staff were aware that care practices at the home were unsafe but had not taken action to safeguard people. Risks to people were not identified or managed to ensure that people were kept safe.

There were insufficient staff available throughout the night. People did not have access to staff should they require support during this time and had no means to call for support. People who required support to go to bed had to go to bed before day staff left as there would be insufficient staff to help them following this point.

Staff employed by the service had not undergone the appropriate checks to ensure they were safe to work. People who were not employed by the service had access to all areas of the home without having the appropriate checks made. Staff had not received appropriate training or support to ensure that they were competent in their role.

People were not supported to make their own decisions in line with the Mental Capacity Act 2005. We saw that some people were being deprived of their liberty without the provider applying for authorisation to do this.

The provider had failed to ensure that people were given choices with regards to their meals. People were not asked what they would like to eat at mealtimes or given a choice about where they would like to eat their meals. Where people had specific dietary requirements, these were not met.

People were supported to access healthcare services to maintain their health and well-being but this was not always sought in a timely way. Where guidance had been issued by a healthcare professional to maintain people's health, this was not followed by staff or the provider.

Staff and the provider had not always ensured people were given choices, treated with dignity and supported to maintain their independence. There were no systems in place to ensure people could access advocacy services if required.

People and their relatives were not involved in reviews of their care. Where people's needs changed, this was not documented or made clear to staff how this would affect how they should support the person.

There were no records of complaints made and people told us they had not been made aware of how they could do this if they chose to. People were given questionnaires to provide feedback on the service but where suggestions were made, these were not acted upon.

There were no systems in place to monitor the quality of the service. The provider did not have an understanding of the Heath and Social Care Act 2008 regulations or their legal responsibility to meet these.

You can see what action we told the provider to take at the back of the full version of the report.

Following the inspection, we shared the concerns we had with Dudley local authority and West Midlands Fire Service.

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.

People received support in an unsafe way. Where staff had identified that this was not safe, they had failed to act on this to safeguard people.

Risks posed to people were not managed in a safe way.

There were insufficient staff at night. People had no access to staff at night if they required support.

Staff had not undertaken the appropriate pre recruitment checks to ensure they were safe to work.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have access to training or supervision to support them in their role.

People did not have their rights upheld in line with the Mental Capacity Act 2005 and people were being unlawfully restricted.

People did not receive meals that met their dietary requirements or that they had chosen.

People had access to healthcare support but professional's guidance was not always followed.

Is the service caring?

Requires Improvement

The service was not caring.

Staff had not displayed caring values as they had continued to provide unsafe care without reporting their concerns to the relevant people.

People were not involved in the planning of their care or given choices over their daily support.

People were not supported to maintain their independence where possible.

Advocacy services were not accessible to people and the provider had no systems in place to support people to access this where needed.

Is the service responsive?

Requires Improvement

The service was not responsive.

The provider had not completed reviews of people's care. People's care records held out of date and inaccurate information about their needs.

There were no activities available for people to take part in.

People were not aware of how to complain and there were no records to indicate complaints were documented and resolved.

Is the service well-led?

Inadequate

The service was not well led.

The provider had no systems in place to monitor the quality of the service.

Feedback given in questionnaires had not been acted upon to make improvements to the care given.

People and staff did not speak positively about the leadership at the home.

Mr and Mrs O'Donnell

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 8 & 9 June 2016 and was unannounced. The inspection was carried out by two inspectors.

We reviewed the information we held about the home including notifications sent to us by the provider. Notifications are reports that the provider is required to send to us to inform us of incidents that occur at the home. We also spoke with the local authority for this service to obtain their views about the care provided.

We spoke with four people living at the home. We also spoke with two relatives, four staff and the provider. We looked at care records for three people, four people's medication records, two staff recruitment files and records kept on accident and incidents and complaints.

Inadequate

Is the service safe?

Our findings

Risks posed to people were not identified or managed to ensure people were safe. We saw that one person required support to re-position every two hours to treat a pressure sore. However, this support had not been given. We spoke with the provider about this who told us that they did not do this as the person would not stay in the position they had been placed in. The provider had failed to act on this concern and seek further support to ensure that the person could be supported to re-position. We saw that one person who required equipment to transfer from bed to chair was being lifted by staff as equipment to move the person safely was not available. Staff we spoke with were aware that this was unsafe and posed a risk to the person but informed us they had no other means to support the person as the required equipment had not been sourced by the provider. We saw that risk assessments had not been updated to ensure the information was correct and risks to people had been identified. We saw that for one person, the risk assessment identified them as being able to walk when this was no longer accurate. This meant that the risks to people had not been identified, documented or acted upon to ensure people were safe.

We saw that where accidents and incidents occurred, an accurate log was not always kept. Records we looked at showed that no accidents had been recorded between 2003 and 2016. Care records we looked at indicated that accidents and incidents had occurred at the home but these had not been identified or recorded as an accident. Where accidents occurred and had been recorded, it was unclear from records what action had been taken to reduce the risk of these reoccurring. This meant there was no clear record of accidents that occurred and the actions the provider had taken to minimise this risk in future.

We spoke with staff about the fire procedures at the home. Some people living at the home would need support to evacuate the building in the event of fire, due to their level of mobility. However, all staff spoken with gave different explanations of what action they would take if there was a fire. We spoke with the provider about this who also did not know what the required actions would be in case of fire. The provider had not implemented a fire procedure to ensure that people would be supported appropriately and kept safe in case of fire.

This is a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.

A relative we spoke with told us they felt their relative was safe at the home. The relative said, "Yes, [Person's name] is safe". Staff we spoke with told us they action they would take if they suspected people were at risk of harm. One member of staff told us, "If I thought there was a problem, I would report it". However, we saw that some people living at the home received care that placed them at risk. Staff we spoke with were aware that these practices were unsafe but had not reported this or taken actions to ensure people were kept safe.

Recruitment systems had not been implemented to ensure staff employed by the provider were safe to work. For two staff, there was no evidence of references being sought or checks being completed with the Disclosure and Barring Service (DBS). The DBS check would show if an employee had a criminal conviction or had been barred from working with adults. One member of staff confirmed that these checks had not been completed before they started work. Other staff who had worked at the home for a number of years

had not had their recruitment checks refreshed to ensure they remained safe to work. We asked the provider about this who said, "I didn't know they [the staff] needed them done. [Staff member's name] hasn't committed any crime". We saw that people who were not employed by the service, including relatives of the provider who were visiting, had access to all areas of the home without having the appropriate checks made. This meant that the home was not always secure.

This is a breach of Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2014.

People told us there was not enough staff at night and during this time they did not have access to staff support. One person told us, "The last time I see [Provider's name] is at 8pm, I am not really sure if she checks on me in the night". Other people told us that if they had an issue throughout the night, they would have to wait until morning for help. One person said, "If I needed [provider's name] I wouldn't be able to get hold of her at night". When asked what they would do if they needed staff at night, one person said, "Well I wouldn't do anything, I would just go without". Staff we spoke with felt there were enough staff during the day but expressed concerns about how nights were covered. Staff informed us and the provider confirmed that only the provider was available throughout the night to support people. The provider told us that they alone supported people overnight seven nights per week as they also lived in the home. This meant that people who required support to prepare for bed had to go to bed at 5pm each day when the day staff left in order to receive support. One member of staff told us, "One of my biggest concerns is that there is no night staff". There were no systems in place to ensure that people had access to support when there was only one member of staff on site. All the people living at the home confirmed they did not have access too or had been informed how to use the emergency call system to call for support if they required this. We saw that the call bells in each room were not within people's reach. This meant that if there was an emergency, people had no way to call for staff support. There were no records available to show that people had received support during the night. We spoke with the provider about this who told us they did check on people throughout the night but that no records are kept to evidence this. This meant that there were insufficient staff and systems in place to ensure that people were kept safe and had access to staff throughout the night. Following our inspection we shared our concerns about staffing levels at night with the local authority. The local authority have informed us that additional staff have now been provided at the home to cover nights alongside the provider. This action was taken by the provider in response to the concerns we expressed during the inspection.

People told us they were happy with how their medications were managed. One person told us, "I am happy with how they [staff] give it [medication] to me". Medication records we looked at indicated that people received their medication as prescribed. However, we saw that where people were supported to take their own medications, the Medication Administration Record (MAR) had been signed to say that these medications had been taken, although the person had not yet taken their medication. This meant that records were not being completed accurately in relation to people who self-administer. We saw that there were no risk assessments in place for people who wished to take their own medication to ensure they were able to do this safely. We saw that medication had not been stored securely. The room that held medication had not been locked to prevent access and the cabinet that held the medications was not fit for purpose. We told staff about this and saw on the second day that this room had been locked.

Inadequate

Is the service effective?

Our findings

Relatives we spoke with told us they believed staff had the skills required to support people. One relative told us, "As far as I know the staff are well trained". Staff we spoke with told us that they had previously been supported to access training to support them in their role but that this had not been updated. One member of staff told us, "We used to do a lot of training but this is overdue and I haven't done any in ages. [Provider's name] doesn't believe in it, she says that it is common sense". Another member of staff said, "No training has been given, [provider's name] said we do not need it as she will show us what to do". Records we looked at showed that two members of staff had no training certificates to evidence they had received training relevant to their role. Two staff who had received training, had not had this updated in a timely way. Some training provided had not been updated since 2012. We saw no evidence of an induction to introduce people into the home and their role. We spoke to the provider about this who told us that they had contacted a care home manager of another service who would be advising her on what training needed to be provided to staff as she was not aware of what training was required. However, the provider had not yet received this support and actions to address the training gaps had not been implemented.

Staff told us they did not receive supervision from the provider to discuss any training needs or get support in their role. One member of staff told us, "We used to be called in for supervision and ask if we had any problems but haven't had one since December". We did not see any records to indicate that people had received supervision since last year. Staff we spoke with told us they could raise issues with the provider in an informal way but were not confident they would receive the support the required.

This is a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Staff could tell us how they would gain consent from people. One staff member told us, "Because I know [Person's name], I know if she is ready [to have support] but I would always ask first". However other staff informed us that people were not supported to make their own decisions with regards to their care. We saw that people were not supported to make decisions for themselves in line with the MCA. People had no input on what they would like to do each day, what area of the home they would like to sit in or when they would like to go to bed. One person we spoke with said, "I don't have any level of freedom". We spoke with the provider about MCA but the provider admitted that they did not know what this was.

We saw that one person was being deprived of their liberty without the appropriate authorisations being

sought. This person was being restricted and had furniture placed in front of them to prevent them being able to get out of their chair. We spoke with staff about this who informed us they were aware that this person was being prevented from moving out of their chair and that this had been an intentional restriction as the person was at risk of falls. Staff told us they were aware that they should not be restricting the person in this way. We saw that people were restricted in their movements around the home and the provider had guidelines in place that would prevent people being able to access different areas. This included not allowing people to use their wheelchairs around the home. We saw that people did not have their walking aids within easy reach to support their free movement. We spoke with the provider about Deprivation of Liberty Safeguards. The provider evidenced a lack of understanding of what DoLS are and told us, "No, I don't know what that is".

This is a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014.

People told us they were not given choice with regards to their meals. One person told us, "The food is good but no one asks you what you want or fancy". Another person said, "They [the staff] give you what they think you like". This was confirmed by staff who informed us people did not have a choice with regards to their meals. We saw that meals were prepared by the provider who knew people's likes and dislikes. However, the provider had failed to ensure that people received meals that met their health needs and had failed to provide one person with a specific diet in order to support their weight gain. This meant that this person had not had their dietary needs met. People told us that as there was only one person available throughout the night, they were unable to request further hot drinks or food if they needed this. We saw that mealtimes were not a sociable experience for people at the home and that people mainly ate in isolation.

This is a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2014

People told us they were supported to access healthcare services when needed. One person told us, "[The provider's name] would call the doctor if I needed him" and "[The provider's name] is good at taking me to appointments". We saw that people were being supported by district nurses. However, the guidance issued to support people to maintain their health and well-being was not followed by staff. We saw that guidance left regarding pressure area care and one person's new dietary requirements had not been implemented. We saw that health professionals had informed the provider that one person required a fortified diet following illness and subsequent weight loss. The provider was aware of the dietary need but had not taken action to ensure the person received meals that met this dietary requirement to support the person's health. This person's weight had not been monitored by the provider to ensure the person was gaining weight in line with health professionals guidance. We also saw that the provider had not always made timely referrals for healthcare support where people needed additional support. We saw that one person had damage to their skin that had needed medical attention. However, a referral to community nurses was not made for a week. This meant that people had not been supported to seek medical advice in a timely way.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were caring in their approach. One person told us, "The staff are nice". Another person said, "They [staff] go out of their way for you". One relative we spoke with described the staff as 'kind and caring.' Staff spoke about people in a caring way. We saw that staff displayed concern about the people living at the home and were keen to make improvements. However, staff had not reported their concerns regarding the quality of care previously and had continued to support people in an unsafe way.

People told us they were not involved in their care. One person said, "No one has ever involved me in planning for my care or asked me what I want". Another person said, "You can't do what you want, when you want here". Staff we spoke with confirmed that people were not given choices or supported to be involved in their care. We saw that people were not able to make choices with regards to their care. We saw that some people ate their meals in their bedrooms. We asked one person why they did this and they informed us they had used to eat in the dining area but had been told by the provider that they could no longer do this and should eat in their room. We asked the provider about this who informed us that this was because the person had been unwell and did not have access to their walking aid. However, this action had been implemented by the provider without consulting the person about their wishes. Relatives we spoke with told us they did feel involved. One relative told us, "The staff and the provider talk to us, we know what is happening and feel involved".

We saw that people were not always treated with dignity. We saw that people were addressed by their preferred name and staff spoke to people in a caring way. However, we saw that people were prevented from accessing different areas of the home and had been expected to adhere to certain ways of living as put forward by the provider. We saw that only one person used the dining area at mealtimes. This person was sat in the dining area alone with the lights switched off. The person and staff confirmed that this was because the provider did not like the dining room lights on and so the person had to eat in the dimly lit room. We also saw that some people would require personal care throughout the night but as there was only the provider available, this support to maintain good hygiene was unavailable.This meant that people were not being treated with dignity by the provider within their own home.

We saw that people were not supported to maintain their independence. We saw that one person was capable of preparing themselves drinks. However this person told us that they had never done this and were not aware that they would be able to do this. We saw that people were unable to take part in daily tasks to maintain some independence where possible due to a lack of support from staff and the provider.

This is a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014.

The provider informed us that an advocate visited the home to speak with people every week. We asked the provider to tell us more about this and found that the provider did not know who this person was or who they were advocating for. We looked into this issue and found that the person visiting was not an advocate but a volunteer for a local charity who visited people as a befriender. This meant that the provider did not have an awareness of advocacy services and what these were for. We spoke with the provider about this

who informed us that as the person wore an ID badge, they had thought he was an advocate. From our observations, no person at the home currently required the use of an advocate but there were no systems in place to support people to access these services if required.

Requires Improvement

Is the service responsive?

Our findings

We saw that before people moved into the home, an assessment took place so that the provider could find out about people's care needs, likes and dislikes. Records we looked at indicated that these assessments had taken place. We saw that reviews of people's care had been held previously to ensure people received support to meet their current needs. However we saw that these had not taken place since December 2015. This was confirmed by a relative who told us, "We had a full consultation when [person's name] moved in but to my knowledge there are no reviews". We spoke with staff and the provider who confirmed that reviews had not taken place. One member of staff told us, "There has been no paperwork done since December".

The lack of reviews of care meant that staff did not have access to the most up to date information about people's care needs. We had been informed by the local authority that one person had recently been unwell and required hospital treatment. However we saw that staff did not know exactly how this person had been unwell or how this may impact the support they need. Records held for this person failed to mention their new health condition and the support the person required as a result of this. We asked staff about this person's health needs and their recent illness. One member of staff told us about the person's recent health concerns and said, "This is only hearsay, there has been nothing documented". This meant that staff had not had access to the information they required to support people's changing needs.

People were not given choices or provided with care that met their personal preferences. One member of staff told us, "Two people [living at the home] do not get choices on what to wear and when to get up". This was confirmed by another staff member who said, "Getting up and going to bed, two people do not get a choice on this".

People told us they were not supported to take part in activities. One person told us, "No, I don't ever leave the house, there are no activities organised". Another person said, "I occupy myself by reading a book or the paper, I don't go out, they don't offer". The staff we spoke with confirmed that no activities took place at the home. One member of staff told us, "The service users shouldn't be here, they should be with homes that will take them out. [People] can't leave their rooms as they need wheelchairs and [provider's name] won't allow them". Another member of staff said, "People are just in their rooms all day just looking at the television". We saw that there was a lack of activities available for people. People spent all day in their own bedrooms without interaction, other than with staff when they were supported with personal care or meals. One person confirmed this and said, "No one else comes out of their rooms, I have never really met [the other people living at the home]". We spoke with the provider about this who told us, "If [person's name] wanted to go for a walk, then they could". However our discussions with people found that they did not feel that they could ask to go out if they wanted to.

People we spoke with told us they were unaware of how to make a complaint. One person told us, "No, [I don't know how to complain] but I wouldn't anyway". A relative we spoke with said, "I have never had to complain". We saw that information was displayed informing people of how to complain. We saw that the last recorded complaint had been in 2004. The provider informed us they had not received any complaints.

Inadequate

Is the service well-led?

Our findings

The provider is currently registered with CQC as a partnership. However, the composition of this partnership has recently changed and we are looking into the provider's registration as a result of this change. Where we refer to the 'provider' in this report, we refer to the person currently carrying on the regulated activity while the issues around the provider's registration is resolved.

We spoke with the provider about the systems they have in place to monitor the quality of the service. The provider informed us that they did not complete any quality assurance audits. The provider demonstrated a lack of understanding of the importance of monitoring the service and how any audits should be completed. When asked about audits completed, the provider said, "You have to teach me what to do and then I will do it". We saw that accurate records of accidents, incidents and complaints were not kept.

Records we looked at did not hold accurate, up to date information about people's needs. We saw that where people's needs had changed, this was not always recorded in the person's records. We saw that there was no review of people's care or auditing system in place to ensure these records were accurate.

We saw that a questionnaire had been given to people living at the home to complete in 2015. We saw that feedback given was mostly positive. However where people had made suggestions on how their experience could be improved, this was not acted on. We saw that one person had fed back that that they had never been involved in their care. Our observations and the feedback we received from people demonstrated that this had not been addressed following the questionnaire and that people were still not involved in their care. This meant the provider had failed to act on feedback given to make improvements to the service.

The provider did not have a clear oversight of the service or a clear understanding of what was required of them in order to provide safe care and meet the requirements of HSCA 2008 (Regulated Activities) Regulations 2014.

This is a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

At our last inspection in October 2014 we rated the service as Good. Providers are required to display this rating of their overall performance. This should be both on any website operated by the provider in relation to the home and displayed conspicuously in a place which is accessible to people who live at the home. We were unable to see the rating displayed at the home. We asked the provider about this who told us, "Does it need to be displayed? I don't know".

This is a breach of Regulation 20A HSCA 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post. As part of the provider's registration, they are required to have a registered manager but had not had one since December 2015. The provider was aware of the need to have a registered manager in post but informed us that this would not be possible unless they began to receive a further income. The provider had not taken steps to recruit a registered manager. The provider was in

charge of the daily management of the home. However our conversations with the provider evidence that they lacked an understanding of the requirements of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The provider told us they they did not know what the regulations were. The provider also informed us that they did not know of the Mental Capacity Act 2005 or what a Deprivation of Liberty was. The provider displayed a lack of understanding on how to implement systems to keep people safe, including assessing risks, reviewing care needs and working alongside other professionals.

People did not always speak highly of the provider and the management of the home. One person told us, "She [The provider] is a bit strict, over all sorts of things, something different all the time". Another person said, "She [the provider] can be a bit officious". Relatives we spoke with were positive about the provider. One relative told us, "[Provider's name] looks after [person's name]". Another relative said, "We are happy with the care".

Staff we spoke with told us they did not receive support from the provider and did not feel that the provider would act on any issues that they raised. One member of staff told us, "I can raise issues but it is never resolved. It is [provider's name] or the high way". Another member of staff said, "It is hard to raise issues as [provider's name] is very hard to talk to. You can't discuss things unless you are agreeing with her". Staff we spoke with indicated to us that this was why they had not reported the concerns they had with regards to people's care as they felt that they could not approach the provider. This had led to a culture developing within the home where staff felt unable to challenge poor practice and so continued to provide unsafe care. We saw that staff did not receive supervisions and that no staff meetings were held to discuss the service and gather feedback from staff. Staff told us they had made suggestions to the provider previously about how the service could be improved. This had included implementing menu's to give people meal choices and taking people out more. However, staff reported that their suggestions were always refused by the provider who did not want to change the way in which care was delivered. We saw that the provider was reluctant to change practices within the home and had no awareness of the risks posed to people under the current care practices.

The provider had not implemented recruitment systems to ensure that people employed by the service were safe to work. Not all staff employed by the service had a current DBS check and references from previous employers were not obtained. The provider demonstrated a lack of understanding about why these checks were required. Staff had not received training to ensure they remained competent to support people safely. Staff, who had received training, had not had this updated to ensure they had the skills required to support people.

The provider had not ensured that systems were in place to provide safe care to people. Equipment needed to move people safely had not been provided and there were no procedures to keep people safe in the event of fire. This meant that people had been left at risk of receving poor care as the provider had not implemented systems to ensure risks were minimised.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. People were not involved in their care or given choices. People had to adhere to guidelines put in place by the provider that did not respect their dignity. People were not supported to maintain their independence.

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 failed to identify and manage risks to keep people safe. Staff had not given people the required support to manage risks to their health. People did not have access to the equipment they required in order to receive safe care. There were no fire procedures in place to support people in the event of fire.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People living at the home had been deprived of their liberty. The provider had failed to ensure that any restrictions had been done in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutrition and hydration needs were not met. People did not receive meals that met their dietary requirements in order to support their good health. People were not able to make choices with regards to the meals they were provided with.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not implemented systems to monitor the quality of the service. Where feedback had been given, this had not been acted upon. Records held about people's care needs were not accurate or kept up to date. The provider did not have an oversight of what was required of them or how they should meet the requirements of the Health and Social Care Act 2008.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not implemented recruitment systems to ensure that unsuitable people would not be employed. Some staff had not completed checks with the Disclosure and Barring Service (DBS) or had references obtained from previous employers. Where staff had worked at the service for a number of years, their DBS check had not been refreshed to ensure they remained suitable for the role.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display their ratings following their previous inspection in October 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff received training and supervision to enable them to carry out their duties. Staff had not received training relevant to their role and when training had been provided previously, this had not been updated in a timely way.