

Chaseview Enterprises Limited

Oak Tree House

Inspection report

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Staffordshire
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27 June 2023

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Oak Tree House is a residential care home providing personal care to up to 4 people in 1 adapted building. The service provides support to autistic people and people living with learning disabilities. At the time of our inspection there were 4 people using the service.

People's experience of using this service and what we found

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

Right Support:

People did not always have risk assessments in place to guide staff how to manage their clinical needs. People were not supported by a sufficient number of staff to meet their needs safely and effectively. People did not always receive 1:1 support when needed and insufficient staffing levels impacted upon their ability to engage in activities of their choice. People were not always encouraged to do things for themselves and did not always have their independence promoted. Care records did not always identify the level of 1:1 support people required which meant the provider could not ensure people were receiving the care they needed.

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 and in their best interests; the policies and systems in the service did not support this practice. Mental capacity assessments had not been completed when needed and Deprivation of Liberty Safeguards (DoLS) authorisations were not in place despite people being prevented from leaving the home on their own.

Staff followed procedures in place to ensure medicines were stored and administered safely. The principles of STOMP (stop over medicating people with learning difficulties) were applied when people were prescribed 'when required' medicines. Where risk assessments were in place, they provided detailed guidance to staff about how to manage risks to people.

Right Care:

People were not always supported in a person-centred way. Staff did not always communicate with people using strategies set by professionals. Professionals told us staff were caring towards them but didn't always have the knowledge to meet their needs effectively. Staff had undergone training but did not always feel adequately trained to meet people's specific needs. People's preferred activities had been identified but activities were not always planned in advance. People were not always able to do the activities they wanted when they wanted. People's care plans were detailed but care was not always delivered in line with their

care plans. People had assessments in place completed by professionals but there was little evidence of regular review.

People were supported by staff who promoted their dignity and respected their privacy. People were supported to choose their own furniture and were enabled to decorate their bedroom how they wanted it. People told us they were supported by staff who generally treated them well. People were supported to see their families and maintain relationships that were important to them. People were supported to access employment opportunities if they wished.

Right Culture:

The provider did not encourage a culture that promoted positive outcomes for people. Professionals told us there was a closed culture at the home. Systems in place to check the quality of the service had not yet been fully embedded and audits were not effective in identifying risks. A safeguarding procedure was in place and staff understood the types of abuse. However, the registered manager lacked knowledge regarding safeguarding procedures and when to submit statutory notifications to the CQC which placed people at risk of harm. Professionals told us the home lacked leadership and oversight and people and relatives did not always have confidence in the management of the home. Relatives were not asked for feedback or input regarding the home. Lessons were not always learnt when things went wrong. Professionals told us the provider regularly made referrals to them but did not always ensure staff followed their strategies to promote optimum outcomes for people.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was good (9 March 2018).

Why we inspected

We received concerns in relation to safeguarding, quality assurance and the management of the home. As a result, we planned to undertake a focused inspection to review the key questions of safe and well-led only. However, when inspected we found there were additional concerns which related to all other key questions, so we widened the scope of the inspection to become a fully comprehensive inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oak Tree House on our website at www.cqc.org.uk.

Enforcement

We have identified breaches in relation to safeguarding, mental capacity and people being unlawfully

deprived of their liberty, person centred care, staffing and the governance of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not well led.

Details are in our well led findings below.

Inadequate ●

Oak Tree 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection team consisted of 1 inspector.

Service and service type

Oak Tree 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. Oak Tree 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 a registered manager in post.

Notice of inspection

We gave a short period of notice of the inspection so the provider could inform people they supported we would be undertaking a home visit due to their needs. .

Inspection activity started on 13 June 2023 and ended on 29 June 2023. We visited the location's service on 13 June 2023 and 27 June 2023.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

During the site visit, we spoke with 2 people who lived at the home, the nominated individual and the registered manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We spoke with 4 relatives and 5 additional staff including support workers and the deputy manager by telephone following the site visit. We also communicated with 4 healthcare professionals who worked closely with people residing at the home.

We looked at 4 people's care records and 3 people's medicine administration records (MARs). We also viewed 3 staff files and documentation related to the governance of the service.

The provider sent us further documentation we had requested following the site visit including information regarding training and risk assessments.

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 good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Relatives told us they did not think people were at risk of immediate harm but were not always confident safeguarding concerns would be addressed in an appropriate way. One relative told us, "I don't know if they would deal with safeguarding issues in the right way as I don't think the registered manager knows what they're doing."
- Safeguarding referrals had not always been made when incidents of abuse occurred. This meant people were not always being protected from the risk of abuse. For example, where there had been an incident of self-harm, a safeguarding referral had not been made.
- A safeguarding procedure was in place. However, the provider's knowledge of safeguarding processes was not sufficient to ensure people were protected from the risk of abuse. For example, when the registered manager submitted retrospective safeguarding referrals when prompted by the local authority, they had been submitted to the wrong local authority safeguarding team.

Systems had not been established and operated effectively to ensure safeguarding referrals were made and people were protected from abuse. This placed people at risk of harm. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they generally felt safe at the home. One person told us, "I don't feel unsafe, I just feel unsettled."
- Staff had completed safeguarding training and knew the types of abuse. Staff told us there was a safeguarding policy in place and they would report any safeguarding concerns to management.

Staffing and recruitment

- People were not always supported by sufficient staff to meet their needs safely.
- Staff rotas showed that people were only supported by 1 staff member at night despite their being known risks to people. One staff member told us, "1 staff member works at night on their own. The risks are there, they should have sleeping staff as a backup in case of emergency." This meant people may have been placed at risk of harm from insufficient staffing levels.
- One relative told us the provider requested their loved one stayed with them for the weekend as they did not have sufficient staff to meet their needs as all other people they supported were visiting relatives. We discussed this with the provider who told us they had never requested a person visited relatives due to insufficient staffing levels.
- Professionals told us people were not always receiving sufficient 1:1 hours to meet their needs safely. One

professional told us, "[Person's Name] has 4 hours 1:1 support per day. I'm not sure they're getting it.". We checked care records and rotas but these did not make clear where 1:1 hours had been allocated.

Systems had not been established to ensure a sufficient number of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs safely. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Recruitment checks were undertaken to ensure people were supported by staff who met their needs safely. We found one example where one staff member had significant employment history working in the care sector but the provider had accepted character references rather than references from previous employers. We discussed this with the provider who told us this staff member had not yet completed the recruitment process."
- People were supported by staff who underwent Disclosure and Barring Service (DBS) checks prior to them starting work. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management

- Risk assessments were not always in place to guide staff how to meet clinical needs for people. We raised this with the registered manager during the inspection and risk assessments were implemented immediately.
- Where risk assessments had been completed, they were detailed and provided clear guidance for staff to meet people's needs safely.
- Accidents and incidents were not always consistently recorded which made it difficult to identify patterns and trends. For example, people had behaviour logs, diaries, body maps and accident records in place that were all used to record where incidents had occurred.
- Positive behaviour support plans were in place when needed to guide staff how to support people when they were distressed. However, professionals told us the provider often contacted them to intervene when a person was distressed.

Preventing and controlling infection need to use the standard sentences

- We were assured that the provider was preventing visitors from catching and spreading infections.
 - We were assured that the provider was supporting people living at the service to minimise the spread of infection.
 - We were assured that the provider was admitting people safely to the service.
 - We were assured that the provider was using PPE effectively and safely.
 - We were assured that the provider was responding effectively to risks and signs of infection.
 - We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
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- Some communal areas of the home had chipped paint that increased the risk of spread of infection.
 - Where people had used the kitchen during the inspection, we observed it had not been cleaned for some time and the work tops were dirty. This increased the risk of spread of infection.
 - Infection prevention and control quality audits had only been in place for a short period of time so we could not be fully assured these had been successfully embedded and were effective in identifying any concerns.
 - An infection prevention and control policy was in place and there was evidence of cleaning throughout the rest of the home.
 - Staff had undergone infection prevention and control training and people and relatives told us they

followed this.

Visiting in care homes

- Visitors were able to visit their loved ones when they wished, in line with current government guidance.

Learning lessons when things go wrong

- Lessons were not always learnt when things went wrong.
- Fire risks had been identified in December 2021 but the actions had only just been addressed prior to the inspection when prompted by the local authority.

Using medicines safely

- People's medicines were stored safely in a secure cabinet in a locked cupboard.
- People's medicines were administered safely. Medicine administration was recorded on a medicines administration record (MAR).
- Protocols were in place to guide staff when to administer 'when required' medicines. The time and reason for administration was recorded and the principles of STOMP (Stop Over Medicating People with Learning Disabilities) were applied.

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

Staff support: induction, training, skills and experience

- People were supported by staff who had undergone training. However, staff told us they did not always remember the training as they had done so much in a short time period.
- Staff did not always feel adequately trained to meet people's autism needs. One staff member told us, "We have not really had enough training to meet [person's name] needs."
- Professionals told us staff did not always have sufficient knowledge to meet people's specific needs. One professional told us, "They have a lack of knowledge around autism and positive behaviour." We discussed this with the provider who told us all staff had received learning disability and autism training and they had now registered them on additional learning disability and autism training provided by the NHS.
- Staff told us their induction to the role was sufficient to meet people's needs effectively. However, the provider was unable to provide any completed induction documentation at the inspection for us to check this.
- Staff supervision had recently been implemented but staff did not always find this useful. One staff member told us, "The registered manager has done a couple of supervisions. They were like 10 minutes and you try and explain if there's any issues but I don't think anything would have come from it."

Systems were not in place to ensure staff received appropriate support, training and supervision to enable them to carry out their duties and meet people's needs effectively. This was a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had recently participated in specific training around clinical needs. Positive feedback was received regarding the provider and staff engagement in the training.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Mental capacity assessments had not been completed when needed to determine if people were able to make decisions themselves. This meant the provider had not ensured people's consent was being sought in accordance with the MCA.
- Staff had completed mental capacity training but those we spoke with did not always understand the principles of the MCA.
- Consent to care and best interests' decisions was not always obtained in line with the MCA.

The provider had failed to undertake mental capacity assessments where required by the Mental Capacity Act 2005. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- DoLS applications had not always been made when needed. Where people were unable to leave the home independently, the registered manager told us DoLS authorisations were in place. However, DoLS authorisations were not in place for all people who were being restricted and there was no evidence of DoLS applications being made by the provider. This meant people were being unlawfully restricted and deprived of their liberty.

Systems were not in place to ensure care was provided to people in a way that ensured people were not unlawfully deprived of their liberty. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's initial assessments completed by professionals were evident in their care files. However, the provider had not always undertaken their own assessments or reviewed people's assessments to ensure they were up to date.
- Assessments of people's needs did not always explore their diversity and protected characteristics under the Equality Act 2010 such as their religion or sexuality.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

- People's dietary needs were documented in their care plans and staff were aware of these needs. We saw some evidence of staff encouraging people to maintain a healthy diet. However, 1 relative and 1 staff member told us staff did not always support people to eat a balanced and healthy diet.
- People's weights were monitored when needed to ensure they maintained a healthy weight.

Staff working with other agencies to provide consistent, effective, timely care

- The provider made regular referrals to other agencies when needed for support to meet people's needs. However, professionals told us the provider did not always engage positively with them and did not always follow strategies set.
- Professionals told us they found the provider was sometimes dependent on them to address behaviour in the home that they should be able to manage themselves through following positive behaviour support

plans in place.

- The provider made referrals to health professionals such as GP's and occupational therapists when needed to meet people's needs.

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

- People were supported to choose their own room decoration and furniture and people's rooms were personalised to their specific preferences.
- People had access to a communal kitchen, dining room and living room where they could choose to spend their time.

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 inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People's individual needs and differences were not always recognised. For example, some people felt they were not receiving the level of support they needed due to the needs of others living at the home. One person told us, "Everyone else's needs have been put on the back burner."
- Professionals told us staff were well meaning but did not always have the knowledge to ensure people were supported in a way that respected their needs. One professional told us, "They do genuinely care but they just don't have knowledge about autism."
- People told us the staff generally treated them well. One person told us, "Some staff are good. They are there but it feels not like it could be and not like it was."

Respecting and promoting people's privacy, dignity and independence

- People's independence was not always promoted by staff. One relative told us that staff completed tasks for them rather than support them to undertake them themselves. One professional told us that the person they worked with had become deskilled as staff were doing things for them that they could do themselves.
- Staff recognised their approach to promoting people's independence was sometimes inconsistent. One staff member told us, "We encourage everyone to do things for themselves, but I think it can depend on the staff members and the resident."
- Staff understood how to preserve people's dignity and respect their privacy. Staff told us they shut people's doors and used towels to preserve their dignity.

Supporting people to express their views and be involved in making decisions about their care

- People were supported to express their views but decisions that were made regarding their care were not always person centred and in accordance with their views.
- The provider did not always disseminate a caring ethos that enabled people to feel heard and listened to.

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's care plans were detailed and guided staff how to meet their needs. However, people's care was not always delivered in a personalised way. For example, a person's care plan detailed the meal preparation tasks they were able to complete themselves, but the registered manager told us they couldn't do these tasks.
- People had lists of activities they enjoyed recorded in their care files. However, activities were not always planned in advance and sometimes were dependent upon service needs. For example, one staff member told us, "If they [people] want a full day out, we can't do anything with anyone else." One relative told us, "Staffing has been more of an issue with activities, not safety."
- One person told us staff told them they did activity planners but there was no structure and other people's needs were prioritised. This meant they did not always do activities they wanted to do.
- Relatives told us they did not think there were sufficient activities in place. One relative told us, "There's no plan in place for activities. When [person's name] first went there, we were very impressed. There was always something for them to be doing, that doesn't happen anymore."

Systems in place failed to ensure people received care that was appropriate to meet their individual and personalised needs. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were supported to see their families and maintain relationships that were important to them. Relatives were able to visit the home or people were supported to visit their relatives' homes.
- People were supported to access employment opportunities if they wished.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People were not always supported with communication in the way they understood it.
- One professional told us they had provided the home with communication aids and strategies to aid a person's communication but only certain staff members had been using them.

- People were provided with some documentation in easy read format such as a service user guide which enabled them to understand the rules of the service and how to complain.

Improving care quality in response to complaints or concerns

- A complaints policy was in place but no concerns or complaints were recorded. The registered manager told us they had not received any complaints. However, 1 relative told us they had raised concerns with the provider and they did not feel they were adequately addressed.
- Professionals told us their concerns were not always addressed when they raised them with the provider.

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 good. At this inspection the rating 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager did not understand when statutory notifications should be made to CQC. Statutory notifications had not been submitted where there had been abuse or allegations of abuse or where DoLS outcomes had been received.
- The registered manager did not know when to submit safeguarding referrals and which local authority to raise them with which placed people a risk of harm.
- People and relatives did not have confidence in the management of the home. One person told us, "The registered manager means well but I feel like the previous manager had more of a foundation. The registered manager is not a complete manager." One relative told us, "There is just no management, there is no way the registered manager is managing anything."
- Professionals told us the home lacked leadership and oversight. One professional told us, "My concerns are around leadership. I've been working with them but it's like I'm micro-managing them." The registered manager told us they worked part time hours and no quality checks were undertaken in their absence.
- The provider had failed to implement any formal quality checks until prompted following a local authority quality visit. The checks that had been implemented since were not effective in identifying concerns. For example, accidents and audit logs failed to record accidents and incidents that had occurred at the home so trends could not be effectively analysed.
- Care records quality checks did not identify where mental capacity assessments had not been completed and where DoLS authorisations had not been requested when needed. This meant decisions were being made on people's behalf without lawful authority and people were being unlawfully deprived of their liberty.
- There was no evidence of management oversight of daily care records or behaviour logs. This meant people were placed at risk as patterns and trends could not be identified to reduce the risk of reoccurrence.
- Systems in place to check staff competency were not effective in ensuring all staff had adequate skills and knowledge to meet people's needs.
- Systems in place to check care records were not effective. For example, they failed to identify where people did not have clinical risk assessments in place or where people's 1:1 care hours were not recorded. The registered manager told us they didn't know how many hours 1:1 support they needed. This lack of oversight meant they could not be assured people received the support they needed to meet their needs safely and effectively.

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

- The culture of the home was not open and inclusive and did not empower people to achieve good outcomes. One professional told us, "There's a bit of a closed culture there."
- The culture at the home was not person centred. One professional told us, "It's like [person's name] has got to work around the needs of the service rather than them providing a person-centred service."
- Staff lacked faith in the leadership at the home. One staff member told us, "The registered manager isn't very good. You can tell they don't want to be there and are just waiting to go home."
- People and relatives provided mixed feedback regarding the home. One person told us, "It's not the place, it's not the staff. It's the setting and the atmosphere that's been created here." One relative told us, "The management are quite open with me."

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager did not know what the duty of candour was. Relatives provided mixed feedback regarding whether they were contacted when something went wrong. One relative told us, "Generally when I visit, they update me regarding what's been going on." Another relative told us, "I don't hear so much from the new manager as the old manager."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Relatives told us they were not always involved in the service. One relative told us, "I would expect the manager to be totally on top of things but I have no contact."
- Relatives told us they were not asked for feedback regarding the service and had not been sent any surveys or questionnaires recently.
- Staff told us the provider was not proactive in requesting feedback regarding the service. Team meetings were not undertaken to give staff the opportunity to provide input.

Working in partnership with others; Continuous learning and improving care

- The provider did not engage positively with other agencies. Professionals told us they did not always follow guidance set to improve outcomes for people.
- The provider and registered manager were not proactive in learning and improve the care provided to people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Systems in place failed to ensure people received care that was appropriate to meet their individual and personalised needs.
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to undertake mental capacity assessments where required by the Mental Capacity Act 2005.
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems had not been established and operated effectively to ensure safeguarding referrals were made and people were protected from abuse. Systems were not in place to ensure care was provided to people in a way that ensured people were not unlawfully deprived of their liberty.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems had not been established to ensure a sufficient number of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs safely.

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 17 HSCA RA Regulations 2014 Good governance Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service.

The enforcement action we took:

We served a warning notice and asked the provider to evidence how they had made improvements to evidence compliance with the regulation.