Lifeways Community Care Limited

Lifeways Community Care (Halifax)

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Lifeways Community Care (Halifax) is a supported living service providing personal care to people living in West and North Yorkshire. The service provides support to people with mental health needs, people with a learning disability and autistic people. At the time of our inspection there were 127 people using the service across 27 'supported living' settings.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

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.

The service could not show how they met some principles of right support, right care, right culture.

Right Support:
People were not always safe and were at risk of avoidable harm.

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.

Accidents and incidents were not always reported. Where they were, outcomes were not always shared with staff and completion of relevant documentation was missed.

People lived in accommodation that was designed to fit into the local residential area.

Right Care:
People's needs were not always met.

Care delivery was not always person centred and the service did not always focus on people's quality of life.

Care, activities and goals were not always planned in a way which met peoples individual needs.

Risks to people were not always assessed or managed safely. Some people did not have the required risk

assessments in place for staff to follow, and some people's risk assessments were not being followed by staff.

Medicines were not managed safely.

People told us they were happy with the staff who supported them. We observed kind and caring interactions between staff and people, and staff knew people well.

People's communication needs were met and well documented in the support records. Information was accessible for people in a range of formats to ensure their understanding.

People were protected from abuse. The provider had implemented new systems for safeguarding people's finances, and arrangements were in place to continue to improve this system.

Right Culture:
There were widespread and significant shortfalls in service leadership. Leaders did not assure the delivery of high-quality care.

Governance systems were not effective and did not ensure people were kept safe and received high quality care and support in line with their personal needs.

The service did not ensure staff had sufficient time to give people the care they needed.

Training was not well managed and high numbers of staff were not compliant in some of the required and mandatory training, with some required training not being provided to staff by the provider.

People, relatives and staff told us the service was not good at communicating when concerns had been raised or when things had gone wrong.

Recruitment processes were safe and robust. They ensured staff were suitable to work with the people who used the service.

The management team were responsive to the inspection findings. Action had already been taken to improve systems and processes as outlined in the action plan from the last inspection, this was ongoing.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 28 September 2022), and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an announced inspection of this service on 3 and 10 August 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, medicine management, person centred care, governance and staffing.

We undertook this focused inspection in part to check they had followed their action plan and to confirm

they now met legal requirements, as well as being prompted due to concerns received about medicines, safeguarding people from abuse, staffing and management arrangements. This report only covers our findings in relation to the key questions safe, responsive and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lifeways Community Care (Halifax) on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to person centred care, safe care and treatment, medicine management, staffing and good governance at this inspection.

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

At the last inspection we reported the provider had failed to notify CQC about some significant events and this was being dealt with outside of the inspection process. We reviewed our information and decided no further regulatory action was required. The provider assured us they had improve their systems for notifying CQC and our records supported this.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Lifeways Community Care (Halifax)

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.

Inspection team
The inspection was carried out by five inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in 27 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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
This inspection was announced.

We announced visits to the 'supported living' settings because we needed to make sure people consented to a home visit from an inspector. We also gave a short period of notice for the office visit because we needed to be sure the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 12 January 2023 and ended on 2 February 2023. On 12 January 2023, 4 inspectors visited 7 'supported living' settings. On 13 January 2023 an Expert by Experience spoke to family members of people who used the service via telephone. Between 13 and 16 January 2023 an inspector spoke with staff members. On 17 January 2023, 1 inspector visited the registered office, and we provided feedback to the provider on 2 February 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 authorities, clinical commissioning groups and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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
We spoke with 6 people who used the service, 11 family members and 21 staff, including the regional director, registered manager, area manager, service managers and care staff. We reviewed a range of records, this included 9 people's care records and medication records. We looked at 3 staff recruitment files and a variety of records relating to the management of the service, including audits and policies.

After the inspection
We requested further information to be sent remotely relating to staff training, monitoring of commissioned hours, risk assessments staff rotas. These were received and reviewed as part of the inspection process. We shared the main findings of this inspection with local authorities who were commissioning care and support.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Risks to people were not safely managed and risk assessments were not always in place for people where needed. For example,1 person did not have a choking risk assessment in place despite care documentation stating they were at high risk of choking. Management responded and confirmed they would take immediate action once we brought this to their attention.
- Weights were not being effectively monitored, which increased risk of malnutrition to people. We saw 1 person was meant to be weighed weekly due to their increased risk of losing weight. This was not being done and there was no explanation as to why this was not being monitored. Another person had been losing weight and care documentation stated they were to have a food diary kept. However, this was not fully completed and contained gaps and missed entries particularly around lunch time. We were not assured people's weights were able to be effectively monitored.
- Accidents and incidents were not being managed effectively. Clear communication after incidents was not being maintained. For example, after a person had been subject to a serious incident, the incident form had not been completed with actions taken and mitigation for future occurrences. Staff had not been informed of the outcome of the investigation into the incident and were unaware of new risk assessments in place for the person.
- The provider did not have an accurate overview of what was happening in the service because systems for reporting and recording of incidents were not robust. We observed low level incidents were not being consistently recognised or recorded by staff members; therefore, the provider's overview of incidents was not accurate. We were not assured lessons were learnt as the providers systems were ineffective.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection and confirmed actions were being taken to address the shortfalls identified.

● Settings contained assistive technologies and all the equipment needed for the people they were providing care to. For example, specialist beds, track hoists, lifts, vibrating sensor alarm.
● Settings were clean and well maintained and all safety and equipment maintenance checks had been completed.

Using medicines safely

At our last inspection the provider had failed to ensure safe systems were in place for medicine management. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.
● The service did not manage medicines safely.
● Systems in place to manage medicines were not always effective. For example, across all 7 settings we visited we found discrepancies with the amount of medication in place compared with what their records stated they should have. In most settings stock counts were being completed however they were not accurate. At one setting,1 person's medication stock count had not been completed at all.
● The service did not have safe systems for monitoring the amount of medication being taken out of the service. One person's checking in and out sheets for their medication when the person was away from the setting, were not fully completed. The protocol for checking in and out medication was not being followed and this had not been identified by the service's internal audits or addressed. Therefore, we could not be assured the service was managing medication safely.
● Guidance was not always in place for 'as required' medication, and where it was the information was not detailed, person centred or sufficient to guide staff on safe administration. For example, 1 person did not have an 'as required' protocol for their pain medication, and 3 other people's protocols were not detailed, meaning staff did not have information about the specific circumstances when these medicines should be given.
● Handwritten medication administration records (MARs) did not contain sufficient information to ensure safe and effective administration of medications was practised. For example, 1 person had a handwritten MAR for the administration of a time specific medication. Guidance taken from the prescribers and manufacturer's instructions state the medication should be taken 30-60 minutes before food. However, this was not captured on the MAR. Failure to take this medication as prescribed reduces its effectiveness and increased risks to the person.
● The service did not have a system for monitoring the safe storage of prescribed creams. At 1 setting, 1 person's support plan contained a control of substances hazardous to health (COSHH) risk assessment, due to risks they would ingest products which could cause them harm. At this same setting prescribed, topical medication had been left out in the communal bathroom and was accessible by the person. This placed the person at increased risk of harm.

Medicine management systems were not always safe and placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were sufficient numbers of suitable staff to meet people's needs. This was a breach of regulation 18(1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The provider had failed to ensure they had an effective system for monitoring people's commissioned hours versus the hours of support people actually received. . One service continually under delivered on the commissioned hours by significant amounts. Agency staff were often used to help close the gap on the deficit however, documentation we received was not consistent and we could not be assured all commissioned hours were being delivered by staff.

● The provider did not have effective systems to monitor the commissioned 1:1 hours for people. We saw 1 person was commissioned 1:1 hours for personal care every day at the same time. However, on reviewing the staff rotas there were not sufficient staff on shift to meet this requirement. We were not assured there were enough staff to meet peoples agreed and commissioned 1:1 hours or requirements.

● Staff rotas and working hours were reviewed and we found some staff were working excessive hours in a week to cover shifts on a regular basis. In 1 setting we saw 2 staff members worked 57 and 59 hours in a week.

● Staff told us they worked a lot of hours due to there not being enough staff to cover shifts. One staff member told us, "I have to do extra hours and help out a lot to cover shifts. I can't just go home and leave the service with no staff; I have no choice."

● We reviewed the service's training matrices which showed noncompliance across the staffing group regarding some mandatory training and specific training which was needed to ensure safe care and treatment could be provided to people with specific medical needs. For example, we saw no evidence of catheter care, continence or learning disability training being provided.

● Documentation provided by the registered manager showed basic life support training had only been completed by 24.7% of staff. This meant the provider only had evidence 58 staff out of 234 had completed basic life support training. We requested additional training documentation to be sent, including a whole staff training document, but we were not provided with this. We cannot be assured the provider has an effective system for monitoring staff training.

The provider failed to ensure there were sufficient numbers of suitably trained staff to meet people's needs and had failed to develop an effective monitoring system for commissioned hours. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● The provider had safe and robust recruitment process which ensured staff were suitable to work with the people who used the service.

Systems and processes to safeguard people from the risk of abuse

● The provider had introduced new systems and processes for managing and monitoring people's finances. The process was more robust, and management were able to monitor people's finances more effectively. This reduced the risk of financial abuse to people using the service.

● Staff had received safeguarding training and knew how to report concerns and identify different types of abuse.

● Relatives told us they felt their family members who used the service were safe. A relative told us, "The staff in the house keep [relative] safe. The team leader is brilliant, and staff are attentive and friendly."

Preventing and controlling infection

● Systems were in place for controlling and preventing infection and the provider had an up to date infection prevention and control policy complying with current government guidelines.

● Settings we visited looked clean and hygienic.

● Staff had access to supplies of personal protective equipment (PPE) and we saw staff using PPE correctly

when we visited settings.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people's needs were not met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- The provider had failed to maintain contemporaneous care records and we saw conflicting information in some people's care records, and missing information in others. The quality of the care records was not consistent.
- Care did not always focus on people's quality of life and did not promote independence in tasks of daily living. People did not always take part in daily living tasks which were part of their planned care and support. For example, 1 person's support plan stated staff were to support them to go shopping to choose their own snacks and toiletries weekly. Daily care records and activities documentation confirmed this was not happening. We were not provided with any explanation as to why this was not being implemented.
- 1 person's diet and healthy eating care plan stated staff should support them by ordering their specialised food for them from online retailers. However, we saw this was not being carried out and staff were buying standard versions of the food from the supermarket instead, directly contradicting the support plan.
- 1 person confirmed the only day they could go out was on a Monday due to the service not having enough staff who could drive. This was contradictory to the support plan where the person was meant to have choice and control of when they wished to go out.
- Involvement of people in support planning and reviews was inconsistent. All support plans had been reviewed recently but some reviews lacked evidence of people or relatives having been involved in this process. Two people told us they were not involved in the support plan process, and there was a lack of evidence of family involvement for people unable to be involved themselves.
- Relatives feedback consistently showed they were not being given the opportunity to be actively involved in reviews. One person said, "I aren't involved with reviews, the staff do it but I would like to see it" and "I used to be involved in reviews but there hasn't been one for the past 3 years. I don't have a date for one in the future."

The provider failed to enable and support people to understand and participate in decisions about their care. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to confirm actions were being taken to address the shortfalls we had identified on inspection.

● Environments were person centred for people and many bedrooms had been recently re decorated to people's personal preferences.
● Staff were caring and knew people well. Some people provided positive feedback about the staff who supported them. One person said, "I love it here, I get on with most of the staff really well."

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

At the last inspection the provider had failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.
● The provider did not have effective systems for monitoring the implementation of activity plans and goals being set. We saw 2 people had goals set but they had not been achieved despite being set for completion prior to the date of the inspection. Another person did not have any goals set in their support plan. We were not assured people were being supported to achieve goals reflective of their preferences.
● Activities were not being consistently incorporated into people's planned care and support. We saw 1 person had activities planned such as going out for walks. However, when we reviewed the activity records there was no record of this happening for the past couple of months. Instead observations such as 'walked around the home' were included in the activity reports.
● The provider did not have effective systems and processes to guide staff on appropriate actions to take when people chose lifestyle habits which were assessed as unhealthy. For example, 1 person liked to smoke. We saw staff restricted the number of cigarettes this person could have, without a capacity assessment or best interest decision to support this action. We saw no formal risk assessment in place relating to smoking or the restriction, and this limit was not detailed or captured in the support plan. The person was not being supported appropriately to be able to make informed decisions.

The provider failed to ensure care and support was appropriate to meet people's needs. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately, and confirmed actions were being taken to address the shortfalls identified.

● We saw detailed information was captured in the daily notes which was sensitively documented.

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.

At our last inspection the provider had failed to enable and support people to understand and participate in

decisions about their care. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

● Peoples communication needs were being met effectively and communication support plans were detailed and specific to individual needs.

● We saw a good range of information captured in the services and in support plans specific to people's individual communication needs. One person could use Makaton and staff were able to use simple signs and understood this method of communication.

Improving care quality in response to complaints or concerns

● The service had a system for responding to concerns and complaints which showed how they had acted when concerns were received.

● Relatives told us they felt they could complain should they need to. One relative told us, "I haven't had any concerns in the past year, but they know I will contact them if I do."

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection the rating has remained 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our last inspection the providers systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Systems and processes to review, monitor and audit commissioned hours and 1:1 hours were not fully functioning. This meant the provider did not have clear oversight of people's commissioned hours and it could not be monitored effectively. We could not be assured people were receiving their full commissioned hours of support or that their care needs were being met.
- Systems and processes for monitoring quality and safety were not implemented effectively. Shortfalls were found with the management of risks, medicines, person centred care and training. Quality audits were still not effective despite the provider having employed an outside consultancy agency. Issues we identified had not been addressed prior to inspection.
- Staff training records show a potential non-compliance in areas such as basic life support, catheter care and autism and learning disability training. This had not been identified by the provider through their own governance systems.
- Quality of care records had improved since the last inspection. The content in the support plans was more detailed and person centred however, care documents were still not consistently accurate, and some were missing important risk assessments. Despite being reviewed regularly the providers audit system had failed to identify these discrepancies and shortfalls.
- The provider had failed to establish effective systems for leaders, to ensure service delivery met best practice for supporting people with a learning disability and autistic people.

Systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17(1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

- The new management team were more visible in the service and were keen to drive improvement. Relatives told us, "We know there is a new area manager, she is easy to talk to and comes in."

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

At our last inspection the provider had failed to submit required notifications which meant CQC were not made aware of some notifiable events, so we were unable to carry out their monitoring role. The provider was now meeting their statutory obligations under the Care Quality Commission (Registration) Regulations 2009.

● The service was meeting the requirements of the duty of candour. The registered manager was open and honest when there had been a notifiable safety incident, and people reported no issues around action taken when any concerns had been raised.

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

● Relatives informed us they were provided with surveys and questionnaires to gather their views, but 1 relative said, "yes, at least annually, but there is no opportunity to say what I want to say."
● Records showed meetings were held with people living in the settings, these were positive and showed actions were taken where new requests and ideas had been put forward.
● We saw evidence of staff meetings and staff confirmed these were held regularly. Staff said they found the meetings useful and they felt supported in their roles.

Working in partnership with others

● The service worked in partnership with other health professionals effectively. Care records showed staff were liaising with health professionals regularly especially when they had concerns with people's health and well-being.

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
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to enable and support people to understand and participate in decisions about their care. The provider failed to ensure care and support was appropriate to meet people's needs Reg 9 (1)

The enforcement action we took:

Serve WN with draft report

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess the risks relating to the health safety and welfare of people. The provider had failed to ensure safe systems were in place for medicine management. Reg 12(1) (a) (b) (c) (g)

The enforcement action we took:

Serve WN with draft report

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers systems to assess, monitor and improve the service were not sufficiently robust. Reg 17 (1) (2) (a) (b) (c) (f)

The enforcement action we took:

Serve WN with draft

Regulated activity	Regulation

Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably trained staff to meet people's needs and had failed to develop an effective monitoring system for commissioned hours. Reg 18(1) (2) (a)

The enforcement action we took:

Serve WN with draft report