Iverna North Devon Limited

Iverna (North) Devon

Inspection report

Unit 3a
Clovelly Road Industrial Estate
Bideford
EX39 3HN

Tel: 01237425642
Website: www.ivernacare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Iverna North is a supported living service providing personal care to people with a learning disability in shared housing. 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. At the time of the inspection nine people were receiving personal care.

People's experience of using this service and what we found
People said they enjoyed living in their supported living accommodation. Not everyone was able to communicate their views, but our observations showed people were relaxed in the two houses we visited.

People were not supported to have maximum choice and control of their lives. This was because people had shared hours of care and it was difficult to see how those who had enhanced one to one hours, were benefitting from this arrangement. Staff did not always support people in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. This was because some people's mental capacity had not been assessed. We were also informed there were incidents of unlawful restraint which was investigated by the local authority safeguarding team.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
Model of care and setting maximises people's choice, control and independence. We found people's choice was not always being considered. We heard how some people were being asked to move to different dwellings or rooms to suit the service rather than their individual needs. We heard concerns around how people's finances were being managed, which may not allow them choice or control about how their individual monies were being spent.

People were not always supported by enough staff on duty who had been trained to do their jobs properly. People did not always receive their medicines in a safe way. People were not always protected from abuse and neglect.

People's care plans and risk assessments were not always clear and up to date.

Right care:
Care is person-centred and promotes people's dignity, privacy and human rights. Some practices and ways of providing personal care did not promote people's dignity and privacy. We had concerns from a large number of anonymous staff whistle-blowing contacts that people's human rights might not always be fully protected. In particular people's rights as tenants and their rights to spend their personal finances how they wished. In one or two isolated incidents, items were withheld from individuals as a form of control, for example someone's cigarettes were withheld by some staff.

Right culture:
Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives. We were not confident or assured by the leadership of Iverna North. Two local management staff had left the organisation recently. A high volume of staff contacted us about their concerns in relation to the leadership style by members of the senior head office leadership team. This had been described as "bullying and unprofessional." Several staff had also raised concerns about the lack of confidentiality from senior leaders.

There was a closed culture where incidents and concerns were kept in-house. There was little evidence to show any lessons were learnt when things went wrong. There was a constant change of leadership which left staff found difficult to manage. Complaints were not always recorded and outcomes reached.

The ethos of people leading empowered lives was not evident in the records we reviewed, the practices staff described and our findings during our visits. For example, staff going in and out of the different houses to chat to each other and asking staff from one house to come and sit with a person from another house, so staff could take other people out. This sharing of resources, which included a clinical waste bin shared across three houses, did not promote a person-centred supported living model.

The impact for people was that they were generally cared for. However, the lack of consideration for meeting the Right support, right care, right culture meant people may not always have choice, their dignity respected and their rights upheld. The high volume of concerns we received from staff led us to be concerned about the services ability to retain a workforce who knew people and could provide the right support.

We have asked the provider to send us their investigation of all the concerns raised with us and any actions they have or will put in place to mitigate any risks as an outcome. We have also shared our concerns and the whistle-blowing information with the local authority safeguarding team and the commissioning team. The service is part of an ongoing whole safeguarding process which means the local authority are co-ordinating and reviewing the safeguarding concerns raised. Judgements have not yet been made on all the concerns raised.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
This service was registered with us on 21 November 2019 and this is the first inspection. Due to being in a national pandemic we had not being able to complete a rating inspection as early as we would have normally. However, due to the number and nature of concerns being raised, we decided we needed to inspect this service.

Why we inspected
The inspection was prompted in part due to a high volume of concerns received. These indicated the Right support, right care, right culture was not being followed. A decision was made for us to inspect and examine those risks. Initially we commenced a targeted inspection. However, during the inspection we received

further concerns and whistle-blower information. Therefore, we extended the inspection to look at all the five key areas.

The themes of the concerns we received which put people at unnecessary risk included:

- Not enough staff on duty to meet people's needs fully.
- People not receiving their contracted hours of care and support.
- Staff feeling bullied and not listened to by senior staff from head office.
- People and staff's information not always kept confidential by staff members.
- Some people named where there were potential safeguarding issues or risks identified.
- Allegations of personal protective equipment (PPE) not being worn correctly and lockdown rules being broken.
- Some themes of best interests not being followed, so people's rights not being protected.
- Lack of dignity and respect for some individuals.
- Institutional practices identified in some areas of the service.

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.

Following the inspection, we asked the provider to investigate several areas of concern highlighted during the inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified five breaches in relation to: poor leadership of the service; not acting in an open and transparent way; poor complaints management; reduced staffing numbers and lack of staff training, not keeping people safe from abuse and poor infection and control practice.

We also identified four recommendations to improve practice in relation to people's risk assessments, people's rights under the Mental Capacity Act (MCA) and following the Right support, right care and right culture.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
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**

Iverna (North) Devon

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection visits were carried out by two inspectors on 12 January, 28 January and 23 February 2021. A third inspector carried out telephone calls to relatives.

Service and service type
This service provides care and support to people living in 'supported living' settings, so that they can live as independently as possible. There are seven houses in Westward Ho! and two houses in Holsworthy. 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.

The service did not have a manager registered with the Care Quality Commission.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to ensure someone would be available in the office to speak with us. Also, we needed to seek permission to visit people in their own homes.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report

This was the first inspection of the service since it was registered in November 2019. Therefore, there was no previous inspection history. We reviewed and analysed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service. We spoke with five members of staff as well as the interim manager and the operations manager. On the first day we visited the office, on the second day we visited 'The Nook' and on the third day we visited 'Sunnyside'.

We emailed the whole staff team and spoke by telephone to three relatives to get their views on the service.

We reviewed a range of records. This included two people's care records and risk assessments. We looked at two staff files in relation to recruitment, training and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and asked for further documentation and policies.

We continued to receive further whistleblowing concerns relating to poor practice at the service.

We liaised with health and social care professionals about concerns we received and attended a further safeguarding meeting.

We also requested and received regular updates from the provider and a copy of their changed management structure.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- When we started the inspection, there had been three safeguarding concerns raised by whistle- blowers to the Care Quality Commission (CQC) and Devon County Council (DCC) safeguarding team. These related to poor care and practice, low staff numbers of duty and medicine errors.
- During and following the inspection, CQC received further information of concern from people working at the service. At the time of writing this report, we had received 27 in total. The areas of concern increased and are detailed under the specific areas of the report they relate to.
- Staff said they could discuss any concerns with the manager of the service. However, they told us they had no trust or confidence in the senior management team from head office investigating their concerns. Staff had been told not to take concerns outside of the service. This was confirmed by the manager of the service, the director, and which was confirmed in the whistle-blowing policy, that staff should approach an outside agency only if they were not satisfied with the outcome. However, one staff member reported they were "scared" to raise concerns. Another said they were not listened to and their views not taken seriously. One staff member reported being told in a response to raising an issue about bullying to, "Take it with a pinch of salt."
- The service is currently in a 'whole home safeguarding process' with Devon County Council (DCC). This meant DCC are concerned about the safety of all the people being supported by Iverna North.
- Staff confirmed they had undertaken safeguarding training, but it was not clear when this was due to incomplete training records which meant they might not be aware of the latest guidance. The manager said they needed a "new training matrix" which showed all staff training undertaken.
- There had been a recent incident where one person had been inappropriately physically restrained by a staff member. This physical intervention was not in line with best practice guidance and therefore infringed the persons human rights. This was unlawful restraint and we referred this to the local authority safeguarding team
- We asked the provider to respond to some of the whistleblowing concerns. We have received some of the provider's investigation reports into allegations of poor practice. We were not satisfied they had been fully investigated without further prompting from us. They did not contain any actions or learning to move forward and to minimise the risk of reoccurrence.

We were not assured people were protected from abuse. This is a breach of Regulation 13 (Safeguarding) of the Health and Safety Act 2008 (Regulated activities) Regulations 2014

- Staff confirmed in their feedback they knew what constituted physical and financial abuse and how to recognise the signs. Staff's knowledge of this was supported by the whistle-blowing concerns raised, for example the inappropriate use of one person's private monies. One staff member said, "We regularly discuss

safeguarding in our meetings and it is always on the agenda."
●As a result of receiving so many whistle-blowing concerns, we asked the provider to ensure staff teams understood and had copies of their whistle-blowing policy. This had been actioned.

Learning lessons when things go wrong
●We reviewed the accident and incident book to look at any trends or patterns. The manager said the incident book was out of date and there were no reported accidents recorded.
●The manager said they felt accident and incidents were not always being recorded, possibly because staff were afraid to report concerns. They were working with the staff to improve practice in this area.
●There had been one incident recently which had meant one person was not taken for health care treatment for some hours. This meant they had been in unnecessary pain. We could not see any lessons had been learnt from this and any action taken to prevent a reoccurrence.
●There were no lessons learned from the safeguarding incidents which had occurred. Reviews from investigations had not been routinely carried out or any deficits in practice identified.

We were not assured lessons were learnt from incidents which had occurred. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
●There was a high turnover of staff leaving the organisation in the previous months. One staff member said, "Changeover of staff is great." This had resulted in significant amounts of new staff joining the organisation without any formal training. In one house, there was 60% new staff employed. This also contributed to the low morale of the staff team who felt there was no consistency from managers to support them. A staff member said, "There is a lack of management and senior workers."
●The service was very understaffed. Staff were not employed in sufficient numbers to fully meet people's needs. Staff comments included, "Lately we have had lots of periods when we are understaffed, especially at weekends", "We typically tend to find ourselves understaffed most days due to the low volume of staff" and "We are understaffed."
●Several senior staff told us they were not routinely able to use agency staff to cover the shortfalls in practice. Staff told us they had instructed by head office staff not to use agency cover due to the cost. One house had over 20 shifts to cover in a week; head office allowed the use of agency staff on this occasion due to the number of vacant shifts to be filled. However, after this crisis, agency cover was again removed.
●The shortfalls in staffing had led to staff working excessive hours over their contracted hours. The manager of the service had not been able to take any leave for the past year due to covering gaps in staffing levels. They had also had to work weekends as the service had been unsafe due to the lack of staff on duty. One staff member told us they had worked around 190 hours in 2.5 weeks.
●Medication training had been organised and staff were told to leave 'skeleton' staff on duty in the houses while it was taking place. Staff voiced concerns this was not appropriate and unsafe but were instructed to do this by head office. This meant there were inadequate numbers of staff on duty to keep people safe.

The lack of deploying suitably qualified staff in sufficient numbers to meet people's needs is a breach of Regulation 18 (Staffing) of the Health and Social Care 2008 (Regulated Activities) 2014

●Staff were recruited appropriately. The manager and operations manager ensured all staff had the correct pre-employment checks completed before starting work at the service.
●The manager was actively recruiting to staff vacancies to increase the numbers of support staff for people.

Using medicines safely

●People's medicines were held in their individual bedrooms in line with what would be expected for people in their own homes.
●There were not enough staff trained in medicine management within each house for this to be safely completed each day. We heard how often there was only one senior across a number of houses to administer people's medicines. For example, one staff member was regularly called upon to give out medicines to people in three of the houses.
●There was a large amount of medicine errors which meant people may not always receive the medicine they were prescribed. This meant their health conditions may not be being managed with the necessary medicine.
●Medicine administration records (MAR) did not contain information relating to medicine people required on an 'as and when' basis. They did not contain detail of what the medicine was required for. For example, one person's MAR showed they had two types of pain relief medicine prescribed. However, there was no guidance for staff to follow on which type of pain these medicines related to and when they should be given. This meant the person may be given the wrong pain relief medicine for their health condition.
●We received whistle-blowing information about one particular staff member would hide missed medicines by placing the tablet on the floor and then saying that due to it being dropped it now had to be destroyed. This came from more than one source. The provider was asked to investigate this issue. The staff member denied the allegation and has now left the service.
●The provider had sent a manager from another part of the organisation to review medicine management and provide training. At the time of writing this report, we have not received the outcome of this review. However, we have been made aware that there continues to be a shortage of staff who were suitably trained in medicine management.

Lack of suitably trained to administer medicines safely places people at potential risk. This is a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
●When we visited one house, we saw staff were wearing their own cloth masks. The manager told us despite having a good supply of the correct surgical masks, some staff preferred to wear their own masks. We directed them to the national guidance for care providers.
●Following our feedback staff were advised they needed to wear correct personal protective equipment (PPE) at all times.
●There was close contact with service users. Staff were not wearing gloves and aprons in line when doing so in line with Government guidelines. We observed one member of staff carrying dirty laundry through a house to the laundry room. This was carried loosely and against their own clothing with no protection in place.
●Staff did not in all cases change PPE between tasks. One staff member sat very close to one person whilst eating their breakfast. They did not change their mask when this was finished.
●Staff did not in all cases have sufficient knowledge of risks relating to infection and the safety measures in place to reduce the risks.
●We were made aware of a staff member breaking lockdown rules to take one person using the service to their own home in order to share a meal with their family.
●We asked to see any infection control audits but have not received this information.

Lack of appropriate use of PPE and staff taking a person to their own home placed people at risk of being exposed to COVID-19. This is a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected on the second day, infection prevention and control measures were in place in the house we visited.

●There were hand sanitisers available at the entrance and in communal areas of houses to encourage good hygiene practices.

●Staff asked people entering the home to have their temperature checked and to wear full PPE.

●Staff were undergoing regular testing and there had been a reasonable uptake of vaccination against Covid-19.

●Staff confirmed there were lots of available PPE. They had completed training on infection control and they were ensuring extra cleaning of high touch points.

Assessing risk, safety monitoring and management

●People had risk assessments in place. The quality of the risk assessments was varied between different houses.

●In one house, risk assessments were in place, but they had been updated for some time. The assessments were difficult to read and follow. Where a risk assessment had been highlighted, the support plan did not always document the action staff should take to minimise the risk. For example, one person displayed behaviours which might affect other people living at the house. There was not enough detail to ensure staff identified the triggers to this behaviour and how to manage it appropriately and consistently. Another person's risk assessment had not been updated since March 2020. This meant staff did not have up to date information on how to manage risks.

●In one house, the risk assessments were clearer and easier to read. There was some good documentation to show how risks of behaviour that may challenge could be mitigated. However, it was less clear how often this information had been reviewed and updated. For example, for one person staff had listed things the person enjoyed doing and some of these were no longer available and had not been for some time.

●The manager said they were aware of the inconsistency with risk assessments and were in the process of introducing new paperwork with the area manager. They had identified the risk assessments needed to be clearer and easier for staff to read.

●Although the risk assessments required updating, the impact on people was minimised as staff knew people well and how to support them in a safe way.

We recommend the provider follows best practice guidance in ensuring risk assessments contain up to date information based of people's current risks.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- Staff did not receive appropriate induction and on-going training; many did not have the skills, knowledge and competency to do their jobs properly. This meant people had received ineffective care.
- Several incidents had been reported to CQC and the local authority about a lack of training for staff. This related to medication errors, safeguarding incidents, poor health care and care practice.
- When staff first started at the service, they did not receive the training and induction they required. One senior staff member said, "I have worked here for several weeks and I have had no induction or training, I've just been left to it." Another staff member said, "I have not been trained in safeguarding."
- Another staff member, who was new to care, had received no induction training. They were still in their induction which meant they were not allowed to work unsupervised and had to follow more experienced staff to see the work (shadow). However, this staff member was left in charge of people's care on one occasion with no other staff on duty. This meant people were at risk of being supported by staff who were not adequately trained or knowledgeable in their care practice. A staff member said, "…I can clearly see new staff now do not have the supervisions needed."
- Staff did not routinely undertake the Care Certificate (recognised as best practice induction). The manager was unaware of the Care Certificate and was not trained to support staff to complete this should they wish to. They were unable to tell us how many people had completed the Care Certificate.
- Staff reported they used 'social care tv' for their online training. Feedback from staff was that this provided them with basic training, but they did not have opportunities to discuss any issues after their training, such as discussing different safeguarding scenarios and how it might apply to their workplace. A lack of competency checks meant the manager could not be assured the staff had the skills to meet the needs of people they cared for
- The staff training matrix showed some staff were up to date with their training and others were far behind. This was discussed with the manager who was aware this was an issue. They said staff were reluctant to undertake training at home as they did not get paid for it. They were unable to complete it at work due to the workload. The provider later told us staff were paid for training. This was not the understanding of staff who gave us feedback.
- Staff supervision was not up to date. The manager was aware of this and the senior management team were putting a system in place to address this. This meant staff training needs and competencies were not monitored, addressed and discussed on a regular basis.
- There was a high turnover of staff leaving the organisation in the previous months. One staff member said, "Changeover of staff is great." This had resulted in significant amounts of new staff joining the organisation without any formal training. In one house, there was 60% new staff employed. This also contributed to the

low morale of the staff team who felt there was no consistency from managers to support them. A staff member said, "There is a lack of management and senior workers."

●The service was very understaffed. Staff were not employed in sufficient numbers to fully meet people's needs. Staff comments included, "Lately we have had lots of periods when we are understaffed, especially at weekends", "We typically tend to find ourselves understaffed most days due to the low volume of staff" and "We are understaffed."

●Several senior staff told us they were not routinely able to use agency staff to cover the shortfalls in practice. Staff told us they had instructed by head office staff not to use agency cover due to the cost. One house had over 20 shifts to cover in a week; head office allowed the use of agency staff on this occasion due to the number of vacant shifts to be filled. However, after this crisis, agency cover was again removed.

●The shortfalls in staffing had led to staff working excessive hours over their contracted hours. The manager of the service had not been able to take any leave for the past year due to covering gaps in staffing levels. They had also had to work weekends as the service had been unsafe due to the lack of staff on duty. One staff member told us they had worked around 190 hours in 2.5 weeks.

●Medication training had been organised and staff were told to leave 'skeleton' staff on duty in the houses while it was taking place. Staff voiced concerns this was not appropriate and unsafe but were instructed to do this by head office. This meant there were inadequate numbers of staff on duty to keep people safe.

The lack of deploying suitably qualified staff in sufficient numbers to meet people's needs is a breach of Regulation 18 (Staffing) of the Health and Social Care 2008 (Regulated Activities) 2014

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

●We found mixed results in terms of people's documented assessed needs. Care records did not always make clear that people's individual choices had been explored with them. For example, there were shared menus in each house. We saw no evidence of people choosing food outside of what the other tenants ate. Menu planning appeared to be in line with residential care, rather than supported living.

●Daily records were used to evidence how people's one to one support hours were being used. However, the records we reviewed did not clearly show how peoples one to one hours were used or that people were offered individual choices throughout their day.

●The provider said they were aware work was needed to bring people's plans and daily records up to standard, that this was being worked on.

Supporting people to eat and drink enough to maintain a balanced diet

●We saw shared menu plans which we were told people chose each week. These appeared to be balanced, but we did receive information of concern stating staff were told to purchase value brands to keep costs down. This would need to be agreed with people being supported as its their own budget. It was unclear why value brands had been suggested and we have asked the provider to explore this further.

●We did not identify anyone who was at risk from poor nutrition or hydration.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

●We saw some people had hospital passports to help ensure if they were admitted for care and treatment, hospital staff would understand their needs.

●There was evidence that staff liaised with healthcare professionals to ensure people's health was being monitored.

●We did receive some information of concern about how staff may or may not be managing one person's catheter care. We have referred this to the local safeguarding team to follow up.

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 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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- No one whose file we reviewed had been subject to a Deprivation of Liberty Safeguard (DoLS).
- Some files had mental capacity forms which had not been completed. We spoke with the manager at the time of the inspection and was told this was still work to be done.

We recommend the service works with advocates, representatives, families and health care professionals to ensure people's rights are upheld using the MCA.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
●There had been some reported incidents from whistle-blowers where people's dignity and rights in line with the Right support, right care and right culture were not fully considered.
●People's privacy was not always upheld as there had been a culture of staff popping between people's houses to chat with each other. Also, incidents where one person was asked to go to another house to have support whilst their fellow tenants went out with staff. This did not promote this person's rights to privacy in their own home.
●People's independence was not always promoted in the culture of the service. Shared hours and not being able to evidence how people's one of one support hours were being used meant the service could not easy show how they were being proactive in supporting people to be individuals and to ensuring their independent living skills were being promoted.

We recommend the service reviews people's care in line with the Right support, right care and right culture guidance.

●People were treated with kindness by caring by most staff. All staff told us how much they enjoyed supporting the people they cared for and it was the people who kept them working there. A relative said, "I am very happy with the care". Another relative described staff as "bricks".
● A relative told us they were confident staff gave their family member the right support. They said, "Lots of effort has been taken by the staff over (person's) appearance" which they felt was very important.
●Staff used a video for one person to show them how to clean their teeth properly. Their dental hygiene had been poor and was now much improved.
●We observed positive interactions between people and staff. The interim manager and house manager knew people well and people were comfortable speaking and chatting with them. Some people had banter and jokes with staff. There was a homely atmosphere in the homes with people doing what they wanted.
●Managers and staff knew people and their family or friends very well. They knew their preferences, interests and hobbies. Staff spend time sitting with people and having conversations with them. One relative said, "The team is excellent … my family member is complex … all the staff are aware of this and understand them." Another relative said, "… happy with the staff … know them all well … They know (family member) inside out."
●Care records were kept confidential and stored in locked cabinets. However, there had been breaches of staff confidentiality to other staff members.

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

●The interim manager had created a supportive environment that allowed people to feel supported and cared for. One person told us "I am looked after and I can do what I want."

●The manager and staff told us they promoted inclusion, equality, diversity and human rights. However this did not always translate into their everyday practices and documentation. For example, lack of mental capacity assessments meant it was difficult to see how human rights had been fully considered.

●People's differences in relation to areas such as religious beliefs, race and ethnicity were respected. For example, one person needed to use a wheelchair for their mobility. They had been unable to access all areas of the house due to the layout and narrow doorways of the building. The manager had liaised with the landlord to change the layout of the building to ensure they could access all areas and go where they pleased.

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

●People were offered some choices in their day to day lives. For example, meal choices and activities. For others, there appeared to be a lack of planning and training to ensure staff understood how to fully involve people in their own decision-making processes.

●On one visit, we saw people getting up at different times and having their breakfast of choice. They were supported by staff who left them to eat at their own pace but regularly checked if they needed anything.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- The service had a complaints policy and procedure, but we did not see this accessible in a suitable format for people to read.
- Complaints were managed at local level and the provider did not always have oversight of the complaints. The manager told us the complaints file was not up to date and no records had been kept for "a long time". One relative told us they had complained on several occasions regarding the care of their family but that their complaint was not resolved. Their family member had now moved to an alternative care provider following the concerns raised.
- Complaints were not always documented, and this was confirmed by staff. This meant there was no evidence that complaints had been addressed in line with the provider's complaints policy or any action taken to resolve them.

The lack of evidence to show how complaints were managed appropriately is a breach of Regulation 16 (Complaints) of the Health and Social Care 2008 (Regulated Activities) 2014.

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

- People who were able to speak with us said they had control over their lives. For example, deciding on meal choices, what they did during the day, where they liked to go and how they decorated their rooms. One person said "I have my room how I like it, lots of rabbits. We decide on what menus we would like."
- Care and support was planned but not consistently reviewed in a timely way to ensure it remained up to date. For example, one person's plan had not been reviewed in 12 months. Another care plan detailed a place that someone enjoyed going but this had been closed prior to the pandemic which was over 12 months ago.
- Plans gave staff clear instructions about how best to support individuals with mental health anxieties and recognise triggers that may raise the anxieties. There were clear positive support plans with details of how best to support people in the least restrictive way. However, these plans had not been updated in 12 months and therefore it was not clear if there had been any changes in their health care.
- One person's care record had four different support plans in the file. It was not clear which of these plans were being used. When we spoke with the manager of the house, they were unsure of the plans and what was contained within them. Staff told us they completed daily records but did not routinely look at support plans.
- This risk of outdated information was mitigated to some degree as experienced staff knew people well and most people were able to voice their preferences. However, due to the high turnover of staff and the employment of new staff, this was still a risk.

●We received some information of concern about staff not always acting and treating people in a way which ensured they had choice and control over their lives. The examples were of someone being denied their own belongings and cigarettes by some staff. This did not promote the ethos of Right care, right support, right culture. We asked the provider to investigate these allegations further.

We recommend the provider ensures best practice is followed in reviewing people's personalised support plans and updating them accordingly.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
●People's communication needs were known and understood by staff. Communication support was provided if needed.
●There were posters and charts which were in versions people could read.
●People's support plans were not always written in a way they could understand them. The manager said they were reviewing these documents to make an easy read version and was part of their action plan in moving the service forward.

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
●Prior to the lockdown of care services in line with the Covid-19 pandemic, people undertook a variety of activities which were individual to them. However, these had been somewhat restricted for the past year when social interests were not able to be followed. These included visiting day centres, clubs, discos, pubs and restaurants. A relative said, "The first lockdown was very difficult … they can go out with staff now socially distanced and with masks. They (staff) have got the right balance now."
●Staff at the service had purchased more equipment to use in-house and in the garden. This enabled people to be engaged in different activities and learn new skills. For example, garden equipment so people could spend time in the garden when the weather was good.
●Staff had been inventive with some activities. For example, people in two different houses, which were next to each other, played games with each other over the garden wall.
●One house had a blackboard which detailed the group activities for the week and these had been chosen to suit people's individual preferences.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- There had been widespread and significant shortfalls in the way the service was led and an inconsistency in management, both at local level and at provider level. This had led to staff feeling destabilised, unsupported and undervalued as they saw managers come and go. One staff member said, "Staff morale has been down as it has been a struggle without a manager".
- Since the service registered with CQC in 2019, there had been several changes in the management of the service at local level. This included the CQC registered manager and the CQC nominated individual (a nominated individual is a person who is responsible for supervising the management of the service). This inconsistency of leadership meant some areas of quality performance had not been completed, to ensure the quality and safety of the service.
- In December 2020 a change in director of the organisation led to further organisational and management changes at head office. This impacted on management at local level, causing further unrest and unsettlement for the staff working at Iverna North.
- At the start of this inspection in January 2021, there were some signs of improvement under the management structure at that time. Staff felt more settled and had confidence and trust in the new interim manager and operations manager. Comments included, "I feel well supported by (manager) who works tirelessly but she cannot do it all" and "(Manager) is fantastic and supports and listens to all staff". A care professional said, "The most recent change in management has led to improved communication."
- During the inspection, the operations manager was made redundant and the interim manager resigned. This again undermined staff confidence in the management of the service. Several staff handed in their notice and other staff were looking for alternative employment. Staff comments included, "Over the past 12 months we've had four managers … it's a ship with no direction", "Staff morale has been down and a struggle … things are not great" and "It's like rats leaving a sinking ship".
- A staff consultation was in progress looking at proposed changes to staff's rates of pay and working practices. Some changes had already taken place, for example a reduction in the payment of night staff. Head office had employed a senior manager to handle the consultation along with the quality assurance director. This led to staff feeling further destabilised.
- Since the start of the inspection CQC had received a further 15 allegations from staff working at the service. The most common themes were around the attitude of the senior management team, moving people with no best interest decisions made, staff not being paid and bullying practices. These allegations are being investigated and judgements have not yet been made.
- During the inspection, the service moved location to share premises with another service which did not

require to be registered with CQC. As part of the agreement, the manager of Iverna North was required to provide seven hours direct management support to the manager of the other service. This meant there was a reduction in seven hours management per week of Iverna North.

●When the move to new premises occurred, the service was left without internet provision for two weeks and a working telephone line was not available. This meant relatives, professionals and visitors could not get in touch with the service if they needed and this caused stress in managing the service during this time.

●There had been a lack of consistent oversight and management of the service from head office. The provider had failed to recognise the quality of the service had deteriorated. They did not have adequate systems in place to monitor and review the quality of care and ensure the service was meeting people's needs safely and effectively. There had been very few monitoring visits carried out from head office during the last six months.

●The service had a service improvement plan (SIP) which was out of date. After the inspection we received the updated SIP which had been sent to the local authority quality assurance and improvement team (QAIT). The SIP contained information about how the service would move forward by future planning and improvements.

●The local management team had been working independently to improve the service and had hoped to introduce a quality assurance system to check on the quality of the service move it forward. The need to improve the service had also been identified by health and social care professionals. One care professional commented, "… is a recognition that internal systems need constantly reviewing and updating in order to achieve better outcomes for clients." This had not been followed up as those managers were no longer in post.

●There was no registered manager in post. The provider had failed to complete the appropriate statutory notifications required by CQC. These related to a change of premises, a lack of registered manager and notifiable incidents.

Due to the lack of governance and oversight of the service, this is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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 service was unable to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. There were examples of people's tenancy rights not being upheld; one staff member told us they had been instructed to "persuade" one named person to move to a different room by head office staff because they wanted to facilitate this move. There were examples of people's finances not being managed in a way which gave individuals maximum choice and where restrictive practice had been used inappropriately. This did not promote a positive culture for people.

●The culture of the service was closed and not transparent. Staff felt isolated within their roles and did not have the opportunities to meet colleagues and discuss best practice. Staff did not feel engaged, empowered or valued.

●Staff also expressed concern they did not feel that they could trust head office management staff and that they had told them to do things they considered 'not right' or 'illegal'. For example, one staff member said they had been told not to use agency staff to plug shortfalls in staffing levels. Another staff member was told "it was their fault" for the deterioration of the service and the safeguarding issues.

●Before the inspection, staff were reluctant to report unsafe or inappropriate practice due to them feeling there may be recriminations against them. During and after the inspection we received 27 concerns about

the running of the service, the culture and staffing feeling they were not being listened to.

●Staff did not always understand the houses were individual people's homes with tenancy agreements. The provider did not promote a positive culture between the homes and promote people's rights. For example, some staff 'dropped' into people's homes for a chat with another staff member.

●Regular staff meetings for all staff had not been regularly held. However, staff meetings for the managers of each home took place weekly and these were used to discuss individual people and any changes in working practice. Agenda items included topics such as audits, confidentiality and safeguarding.

●Decisions made by the provider had left staff feeling the service was unsafe and not treating people properly. This included the quality of the care and support, low staffing numbers, staff not wearing personal protective equipment properly and decisions being made by management which were not in people's best interests. For example, moving people to different rooms without taking the appropriate steps to do this.

●Despite a high turnover of the management of the service and the number of support staff leaving, exit interviews were not routinely carried out. This meant the provider was not able to use the information about why staff were leaving to improve the quality of care.

●Investigations were not always carried out fully and there was no evidence that improvements had been embedded in practice.

●Complaints were not always investigated and recorded. A staff member said, "We haven't recorded any complaints for ages".

Due to a lack of an open and transparent culture, this is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

●During our inspection, a whole service safeguarding enquiry was started by the local authority. The local authority had put a block on funding new admissions.

●The provider was engaging with CQC and the local authority safeguarding team and quality assurance and improvement team (QAIT) to improve the management of the service.

●The provider confirmed they were committed to employing a new manager. They had deployed several managers from other services to complete specific pieces of work.

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
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not record, investigate and respond to failures identified by the complainant (1) (2)

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the proper and safe management of medicines 2 (g) The provider did not ensure effective control measures in relation to infection prevention and control were in place 2 (h)

The enforcement action we took:

imposed condition of registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure people were safe from abuse and improper treatment (1) (2) (3) (4)

The enforcement action we took:

imposed condition of registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure there was continuous oversight and quality monitoring of the service (1) (2) The provider did not ensure lessons were learnt when rings went wrong (1) (2)

The enforcement action we took:

impose condition of registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not employ suitably trained staff were employed and properly trained to do their jobs and keep people safe (1) (2)

The enforcement action we took:

imposed conditions of registration