Canterbury Oast Trust

Community Support Services

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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 the Care Quality Commission (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.

About the service
Community Support Services is a domiciliary care agency which provides care and support to people living in their own homes. 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. The new manager was unable to confirm the number of people in receipt of personal care. At the time of the inspection 34 people were being supported with approximately a third of people being supported with prompting and / or supervision relating to personal care. People being provided with support lived with a learning disability and autistic spectrum disorders. People were living independently and had tenancy agreements with a housing provider.

People's experience of using this service and what we found
People were not always protected from abuse, discrimination and harm. Staff had not kept their skills and knowledge up to date. Risks to people's health, safety and welfare were not robustly assessed and measures to mitigate risks were not clearly recorded. People were not supported to have their prescribed medicines safely.

There was not always enough staff to provide people with the support they should have. The provider failed to monitor the one to one hours people needed to ensure they were able to spend time doing the things they enjoyed.

People were not encouraged and empowered to live their lives as independently as they could. People were not actively supported to take care of their homes and gardens.

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.

Checks and audits, to monitor the quality and safety of the service, were not regularly completed or recorded. The new manager had implemented audits and checks prior to the inspection; however, these were yet to be completed and embedded into day to day staff practice.

People were supported by staff who had been recruited safely. People, relatives and staff provided mixed feedback about the quality and safety of the service.

An interim chief executive officer (CEO) had been contracted by the provider to provide support whilst a permanent CEO was recruited. The interim CEO, who has a background of working with people living with learning disabilities and autistic spectrum disorders, had identified shortfalls in the service delivery before the inspection. Action was being taken and they were working with multi-disciplinary health care professionals to drive improvements.

Why we inspected
The inspection was prompted in part due to concerns received about people's finances, people not being appropriately supported to see health care professionals and low staff levels. A decision was made for us to inspect and examine those risks.

We assessed if the service was applying the principles of Right support right care right culture.

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 statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe and well-led:
The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support
Staff did not provide effective support to identify people's aspirations and goals and assist people to plan how these would be met. Staff did not always focus on people's strengths and promote what they could do. There was an inconsistent approach to supporting people to learn new skills. Staff did not consistently enable people to access health and social care support in the community.

Right care
Staff did not consistently promote equality and diversity in their support for people. People could communicate with staff as staff understood their individual communication. Staff did not fully understand how to protect people from poor care and abuse. People were not empowered to take part in activities of their choice. People were supported to keep in touch with people who were important to them.

Right culture
The service had not fully enabled people and those important to them to work with staff to develop the service. Feedback had not been requested from people, relatives or health care professionals for several years. Staff had not always ensured the quality and safety of the service had been fully assessed to ensure people were safe. Safe recruitment practices were followed. Staff knew and understood people well.

We have found evidence that the provider needs to make improvements. Please see the safe 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 report.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to people's safety and welfare, management of medicines, staff deployment and good governance.

We took action to impose further conditions on the providers registration following the inspection.

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
he 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Community Support Services

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 one inspector.

Service and service type
The service is a domiciliary agency. However, Community Support Services provides care and support to people living in several 'supported living' settings so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager
The service did not have a manager registered with CQC. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There was a new manager overseeing the service and they had submitted an application to register with CQC.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 12 May 2022 and ended on 26 May 2022. We visited the office location on 12 and 13 May 2022.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We spoke with two professionals who regularly visit the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service and five relatives about their experience of the care and support provided.

We spoke with eight members of staff including the new manager, a manager from another of the provider's services and the interim chief executive officer.

We were unable to speak with the nominated individual as they were away from the service at the time of the inspection. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff 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. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people's health, safety and welfare were not adequately assessed, monitored and managed. Care plans and risk assessments were not regularly reviewed.
- People's risk assessments did not provide enough guidance for staff to keep people safe. For example, when a person was at risk of choking, there was information in a risk assessment about how to support the person with their meals. However, there was no detail about what action to take should the person begin to choke. This risk assessment was noted as being written in January 2019. There was no evidence this had been reviewed since that date. The service regularly used agency staff to provide support. Only four staff out of 23 had up to date first aid training. Three staff had not completed any first aid training. There was a risk staff may not know how to support this person should they begin to choke.
- When a person was living with epilepsy, there was no information in their care plan about how they presented when they had a seizure. Seven staff had not completed epilepsy training to ensure they were up to date with best practice and make sure they provided the right support. There was a risk people may not be supported safely.
- Records noting a person's seizures were unclear and contradictory. The 'seizure diary' showed a mixture of dates of seizures in 2021 and 2022 with only one noted with an asterisk in April 2022. Another record noted the person had had two seizures in 2022. There was a risk staff would not be able to convey accurate information to health care professionals when needed.
- Aspects of people's home environments were not assessed to ensure the provider could deliver support safely to people. For example, when a person was living with epilepsy potential environmental risks, should they have a seizure, had not been considered. Although the provider was not responsible for people's homes, they had not taken any action to alert external professionals or encourage and support people to get the necessary help to make their homes safe.

The provider failed to assess the risks to the health and safety of service users. This is a breach of Regulation 12(1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they felt safe having support from staff. They said, "I feel safe with the staff supporting me when I need it" and, "Sometimes the staff need to remind me about keeping myself safe when I go out. Most of them are pretty good."
- Other risks, such as supporting people to stay safe when they went out, were completed. These included important details, such as making sure mobile telephones were fully charged and ensuring people had emergency contact details.
- Feedback from relatives was mixed. Relatives said, "[My loved one] is absolutely safe", "[Our loved one] has a set routine. The staff know them really well. I think they are well cared for and safe. Sometimes it is

about getting the balance between independence and dependence", "[Our loved one is really happy. Their place is ideal. I firmly believe their needs are met" and, "[Our loved one] has not always been safe."

Using medicines safely

● People were not always supported to have their medicines safely and as prescribed. Community Support Services was commissioned, by funding authorities, to provide some people with support with their medicines. Levels of support included administering some people's medicines or checking each day and counting medicines to make sure people had taken their medicines correctly. There had been several medicines errors.

● One person, who administered their own medicine, was supported by staff to check they had taken their medicines when they should. Staff also arranged for new prescriptions and collected the person's medicines. In December 2021, staff failed to collect the person's medicine on time. The person did not have their epilepsy medicine for several days and this resulted in the person having a seizure. Following this incident, a risk assessment was completed. Whilst this noted staff must order the person's medicines on time, there was no detail regarding collecting medicines. The risk of medicines not being collected remained.

● A relative said, "[Our loved one] needs someone to oversee their medicines. Staff did not collect their prescription and they missed their medicine. Their medicines were clearly not monitored."

● There continued to be medicines errors. There had been two medicines incidents recorded in February 2022, one in March 2022 and a further three in April 2022. For example, staff assisted a person with their medicines on 20 April 2022 and found one of their medicines, used to treat high blood pressure, had not been given the previous evening. Staff contacted health care professionals to seek advice.

● People's medicines administration records (MAR) were not consistently accurately completed. For example, one person's MAR had no medication signed as administered on 10 May 2022. However, the number of medicines remaining in stock indicated these medicines had been administered.

● When people had prescribed creams to help keep their skin healthy, there was no body map to make sure staff knew where the cream needed to be applied. Staff did not consistently sign the MAR to note the cream had been applied as prescribed. For example, one person's MAR had not been signed on seven occasions. A member of staff commented, "We don't always sign the MAR for creams". The deputy manager confirmed the application of prescribed creams should always be noted on the MAR.

The provider failed to ensure the proper and safe management of medicines. This is a breach of Regulation 12(1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from the risks of abuse, discrimination and harm. Staff had not kept their safeguarding training up to date. Following the inspection, the new manager confirmed staff had enrolled to refresh their training. Whilst staff understood how to report concerns, they had not recognised the potential signs of financial abuse or that failing to provide people with the right support to manage their medicines constituted neglect.

● People were not supported and empowered to manage their finances. Community Support Services were commissioned, by funding authorities, to provide some people with support around their finances. Staff did not check to make sure people were managing their monies to see if they needed any additional support.

● Concerns had been raised with CQC regarding people being in debt because they had not been efficiently supported by staff to ensure payments were made promptly. The new manager told us this was due to the provider, Canterbury Oast Trust, offices being closed during the COVID-19 pandemic. There had been no thought around finding a solution to ensure people were able to manage their finances effectively. When people were supported to go out, in the provider's vehicles, they were charged a mileage fee. When people

shared the vehicle, the cost was not reduced to reflect this. A relative commented, "We have been raising for years about the mileage charges to [Canterbury Oast Trust] and it has fallen on deaf ears."
● During the inspection we asked the new manager, since the monetary concerns had been raised, what checks had been completed on people's other finances, such as utility bills, to make sure they were not getting behind with bills. No financial audits had been completed. Following the inspection, the provider employed a finance lead who was reviewing processes and implementing new procedures.

The provider failed to ensure systems and processes were established and operated to prevent abuse of service users. This is a breach of Regulation 13(1) safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment
● The provider did not consistently have enough staff to ensure people were able to have one to one support where they were funded to, in order to take part in activities of their choice when they wanted to. The service did not have a systematic approach to determine the numbers of staff needed to meet people's health and social care needs. Staff told us there were not enough staff to support people to go out when they wanted.
● During the inspection a local GP surgery rang to ask why a person had not been supported to an appointment, that day, with a nurse. There was an entry in the staff diary which noted, 'Leg review [person] at 14:00.' A member of staff rearranged the appointment for later that day and the person was supported to attend. The member of staff told us they had been busy supporting a person with their shopping. Staff had not prioritised what support people needed throughout the day to ensure their needs were met.
● The provider did not monitor the level of support people received. When people should have received a certain number of hours of one to one support, this was not scheduled on a rota to make sure they received this support. The new manager was not able to provide evidence that one to one hours had been provided in line with the hours commissioned by people's funding authorities. Concerns regarding this had been raised by health care professionals, prior to the inspection. Following the inspection, specific rotas for people's one to one hours of support were introduced to make sure people received the support they should have.
● Relatives told us, "[My loved one] gets one to one support" and, "[Our loved one] is supposed to have one to one time to support them with cooking and activities. At every review we bring up about the one to one time they don't get as they should."
● The new manager had identified staff training was not up to date and that staff had not had one to one supervision for two years. Plans had been implemented to address this. Staff had begun to refresh their knowledge and staff supervision meetings had begun.

The provider failed to ensure sufficient numbers of qualified, competent, skilled and experienced persons were deployed to meet people's needs. This is a breach of regulation 18(1) staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff who had been safely recruited. References were obtained and a full employment history was recorded with an explanation of any gaps in employment. Checks with the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong
● Accidents and incidents were not consistently monitored and analysed to identify any patterns and trends

to make sure any action needed was taken. We were informed this was usually controlled by the nominated individual. There was no system in place to ensure this was completed in the absence of the nominated individual. The management team were unable to locate any checks, audits or overviews completed by the nominated individual.

● The new manager had reviewed the accident forms, in the absence of the nominated individual, and had noticed an emerging concern with a person's medicines management. Action had been taken to provide additional support and seek medical advice.

● During the inspection, a person missed their medical appointment, because efficient deployment of staff was not in place. Staff did not follow their process to report this to the new manager at the time. The inspector informed the manager. On the second day of the inspection we saw this incident had been recorded in the provider's accident process.

● Following the inspection, a new process was implemented to ensure all incidents, accidents and near misses were closely monitored to ensure the correct action was taken to reduce the risks of them happening again.

Preventing and controlling infection

● Most people were supported to keep their homes clean and hygienic. However, when a person needed additional support to help them keep their bedroom clean, staff had not explored how this could best be managed. Staff had not spent time with the person to empower them and encourage them to do so. The person told us they would accept some additional support from staff to help them.

● People told us staff wore a face mask and they understood why this was important. Staff completed infection prevention and control training.

● Staff carried out regular COVID-19 testing. Staff wore personal protective equipment (PPE) effectively and safely. Staff told us there was plenty of stock of PPE. They understood what PPE to wear and when, and how to dispose of this safely.

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 the last inspection this key question was rated as good. At this inspection this key question has now changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There had not been effective oversight of the service. There had not been a registered manager overseeing the service since 2020. The nominated individual was leading the service, and this had not been effective. The new manager had submitted an application to the Care Quality Commission to register.
- Regular checks and audits of the service had not been completed to ensure people received the support they needed and to monitor the quality and safety of the service. The new manager told us they were not able to find any completed checks and audits. They said the nominated individual and previous manager should have been completing the audits. The new manager had identified some shortfalls in the service provided and created an action plan. However, whilst they took immediate steps to action some of these, they told us they had not recorded the checks completed, in line with good practice.
- The new manager began overseeing the service in December 2021. They did not have a clear understanding of people's needs or full oversight of the service. For example, the new manager did not know how many people were supported with the regulated activity of personal care. The had not received support from the nominated individual.
- The provider had ineffective system to monitor and ensure people had support to attended health appointment where needed. Some people had attended planned appointments with support but other people, who would not be able to attend without staff prompt and support, had missed their planned appointments. This meant people had not received the right support when it was needed.
- There were no regular checks of people's home environments to ensure people could be supported to maintain their homes and gardens or to ensure that environments were safe. Although the provider was not responsible for people's homes, they had not taken any action to encourage and support people to maintain their homes and gardens or alert external professionals where people may need additional support. Relatives told us their loved ones were not supported with this.
- Care plans had not been regularly reviewed and updated as people's needs changed. For example, a person who was living with epilepsy last had their care plan reviewed in June 2019. There was no specific epilepsy plan to guide staff about how the person presented or how to provide the right support. Another person's care plan was undated and not up to date. It contained an emergency manager's contact details for a registered manager who left the service in March 2020. There was no evidence this care plan had been reviewed. People's care and support needs had need been regularly reviewed to ensure their needs were met. Care plans had not been completed with people's life history.
- The new manager and deputy manager had not heard of 'Right support, right care, right culture' which is the statutory guidance which supports CQC to make assessments and judgements about services providing

support to people with a learning disability and/or autistic people. Neither were aware of the 'Learning from deaths mortality review' programme (LeDeR). LeDeR reviews deaths to identify areas of learning and examples of good practice. The information gained is used to improve services for people living with learning disabilities and autistic people.

● The new manager and staff did not know about the principles of STOMP (stopping over-medication of people with a learning disability, autism or both).

● Staff did not have a good understanding of the provider's vision and values. The values of 'respect and recognition, professionalism and quality, teamworking, integrity and honesty and equality and fairness' were not being actively promoted. Staff told us, "I am not sure what the [provider's] values are" and, "I can see a vision of how the service should be."

The provider failed to establish and operate systems and processes to assess, monitor and improve the quality and safety of the service provided. This is a breach of Regulation 17(1) 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

● The provider had not established and promoted a positive culture. Staff were not empowering and encouraging people to develop their independent living skills. People said, "Some of the staff are good and will help me to keep my home tidy and others just don't seem to care", "[Staff member] has helped me learn to cook meals from scratch but some don't want to help me with that" and, "[The new manager] is good. They have been very helpful to me when I have been worried and anxious".

● People were living in their own homes with tenancy agreements and support from staff for a number of hours each day. Support for people was for things, such as their personal hygiene, cooking, cleaning and activities. People were not consistently supported with these. For example, one person's care plan noted, they liked to batch cook. Their relative told us, "We have provided all the ingredients for [our loved one] to be supported to cook and staff have made excuses and not done it. [Our loved one] enjoys cooking. We bought a slow cooker a few years ago and staff have never supported them to use it."

● People's choice about how they spent their day and where they went was limited and generally revolved around places owned and run by the provider, such as a farm or the woods. People were not spoken with about the things they would like to do, goals and aspirations or places they would like to go. Staff did not deliver good quality support consistently.

● People were not empowered to be as independent as possible and were not encouraged to be active within the local community. Staff said, "I have tried, within [Canterbury Oast Trust] to encourage the empowering of people but have not got anywhere", "I am really passionate about tenant's health, well-being and mental health. I am keyworker for a tenant who really wanted to get a bike. I spoke to their relative who arranged it. We have been trying to go out regularly. Sometimes I take the tenant out in my own time" and "Tenants don't really get much opportunity to go out, other than [Canterbury Oast Trust] places."

● There was no consideration given to, or guidance for staff to follow about how to enter people's homes when they arrived to provide personal care or other support for people. For example, if people had key safes or if staff needed to ring a doorbell.

● Relatives feedback was mixed. They told us, "[My loved one] has had good help to do the things they enjoy", "Some things have gone a bit since COVID-19. [Our loved one] used to go to concerts with staff support but those stopped in the pandemic" and, "Parents have put in a lot of support with gardening over the years. We all had a go at a family meeting about the garden of [our loved one's house]. Staff have just not supported people to maintain the garden. They gave up."

● The interim CEO had identified, prior to the inspection, that staff needed upskilling to be able to provide people with the support they deserved. Arrangements were in progress for training about person-centred

active support. This training is due to be rolled out, initially to all support staff, and then to ancillary staff and the provider's trustees.

The provider had not created an open culture where people were listened to and improvements made as a result. This is a breach of Regulation 17(1) good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The new manager understood their responsibilities to be open and transparent in accordance with the duty of candour guidelines.
- During the inspection it was clear the nominated individual and previous senior management team had not followed this practice. A relative told us they had emailed the chairman of the trustees and had not received a reply.
- We liaised with the local authority commissioning team and safeguarding authority. Several concerns had been raised about the quality and safety of the service provided. The interim CEO and new manager were working with social care professionals to drive improvements.

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

- People, staff and health care professionals had not been asked to provide feedback about the service. Following the inspection surveys were sent to people to obtain feedback on their support, goals and aspirations and their health and well-being. The new manager will review and analyse the responses to identify good practice and areas for improvement. Further surveys were scheduled to be sent to relatives and health care professionals.
- The new manager did not know when the last tenants' meetings had been held. They were unable to access information which may have been held by the nominated individual regarding this. A review of records indicated there was a meeting in June 2019. Meetings had been scheduled to make sure people's voices were heard.
- There had not been any staff meetings for two years. The new manager had identified this shortfall and re-introduced these. Staff said, "[The new manager's] door is always open. I feel supported. The staff team know who to call for advice" and, "Things are slowly improving now that [the new manager] is here."

The provider had not created an open culture where people were listened to and improvements made as a result. This is a breach of Regulation 17(1) good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The interim CEO shared a detailed action plan prior to the inspection and has continued to provide regular updates on actions planned and taken.
- Relatives commented, "[The new manager] is very good. They get on top of things straight away. We had a review with [our loved one] a couple of weeks ago. I am completely happy, because [my loved one] is happy. I couldn't wish for anything better. I think [my loved one] has achieved more than we ever thought would be possible" and, "[The new manager] and [senior] are on the ball and working their socks off to improve things."

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems and processes were established and operated to prevent abuse of service users.

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 failed to assess the risks to the health and safety of service users. The provider failed to ensure the proper and safe management of medicines.

The enforcement action we took:

We took enforcement action against the provider

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate systems and processes to assess, monitor and improve the quality and safety of the service provided. The provider had not created an open culture where people were listened to and improvements made as a result.

The enforcement action we took:

We took enforcement action against the provider

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of qualified, competent, skilled and experienced persons were deployed to meet people's needs.

The enforcement action we took:

We took enforcement action against the provider