Iverna (Central) Devon Limited

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Inspection report

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Ratings

Overall rating for this service	Insufficient evidence to rate

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

Summary of findings

Overall summary

About the service
Iverna (Central) Devon is a supported living service providing personal care to people with a learning disability in shared housing. The service provides care to people living in their own homes in and around Okehampton, Crediton, Hatherleigh and Mid Devon. Iverna is a subsidiary of Esto Care Ltd. People have tenancies and the landlord, Larch, is a separate company to Iverna.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is defined as support 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 36 people were receiving personal care.

People's experience of using this service and what we found
The lack of quality assurance systems meant we could not be assured people were receiving safe and effective care. The provider did not have adequate quality monitoring systems in place. Staff and relatives told us they were concerned about the provider's management of the service. Staff told us they were afraid to speak out for fear of losing their jobs. The views of relatives and professionals had not been sought by the provider to check on the quality of the service and ensure improvements were made where necessary.

People could not be confident that money paid into shared house accounts for items such as food and cleaning cost had been carefully managed or used appropriately. The provider made assurances, following a whole service safeguarding process which initially began on 4 June 2020. They said the accounts would be audited, and any money overpaid would be refunded. At the time of this inspection the concerns had not been addressed.

People were not always supported by sufficient staff with the knowledge or skills to meet their needs safely. Proposals to change staff's pay and conditions meant there was a risk some vacant shifts may not be covered. A number of experienced staff and managers had recently left the service. The provider had failed to ensure new staff completed induction training. Staff had not always completed ongoing training on essential topics, or topics relevant to people's needs. We were not fully assured that people were supported by staff who had been safely recruited. Records of staff recruited in recent months did not provide enough evidence that adequate checks and references had been taken up before new staff began working with people.

We were not fully assured that people were protected from the risk of contracting Covid-19. We saw some staff not wearing the correct personal protective equipment (PPE), and staff not following current government advice on safe infection control procedures. Staff had not received sufficient training, support, policies or procedures to ensure safe infection control practices were followed at all times.

Following our inspection, the provider told us about actions and improvements they had made and planned

to make to address the issues we found.

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.

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.

This service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.
Right Support
• The model of care and setting did not fully maximise people's choice, control and independence Support given to people to help them manage their finances and day-to-day expenses were not personalised. People were expected to pay a set amount into a 'house account' to pay for food and household expenses. People were not given a choice about this.
• Shared houses were managed and staffed in an institutionalised manner. Records were held at each house instead of the main office. Notices displayed on walls gave houses an institutional appearance. Staff worked in one team based in a single house. People were not supported to choose their own team of staff with the skills and interests to meet their individual needs.
Right care:
• We were not fully assured that care was person-centred or that it promoted people's dignity, privacy and human rights. We received concerns that several staff had recently left the organisation and that other staff were considering leaving. There was a risk that people may not be supported by experienced staff who knew them well and understood their individual support needs.
Right culture:
• The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services led confident, inclusive and empowered lives. There was a closed culture; the provider had failed to communicate adequately with people, staff and relatives. We received concerns from the majority of staff about low morale, and a bullying culture. Staff and relatives expressed distrust in the provider's ability to manage the service well.

There had been a lack of consideration for meeting the Right support, right care, right culture which had resulted in people receiving care based on the model of residential care rather than promoting personalised individual support.

All of the people we spoke with told us they were very happy with the support they received. Comments included, "It's great. The people are wonderful. The staff are great. They are so kind and understanding", and "The staff are alright". We observed staff supporting people in a range of activities such as games, supporting people with household tasks, and sitting and chatting to people and looking at photographs. People were relaxed and smiling.

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 under the current provider. 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.
The last rating under the previous provider, Lyndridge Care and Support, was Good published on 15 May 2018

Why we inspected
Before this inspection took place, we received a high number of concerns and complaints from staff, relatives and from other professionals. The service had been the subject of a whole service safeguarding investigation since June 2020.
Concerns included, high numbers of staff leaving or planning to leave the service, low staff morale, a lack of trust in the provider's ability to manage the service, a culture of bullying, low reporting of accidents, incidents and abuse. Staff told us they had been instructed not to contact CQC or the local authority about concerns or abuse.

We have found evidence that the provider needs to make improvement. 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 full report.

Following our inspection, the provider told us about a range of actions they had taken, or were planning to take, to address the issues we found. However, it is too early to be confident that their actions are sufficient to fully address all of the issues.

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: safe care and treatment, safeguarding, good governance, notifications of other incidents, and staffing

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.

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.

Iverna (Central) 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
This inspection was carried out by three inspectors.

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

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we wanted to make sure key members of staff would be available, and we needed to seek permission to visit people in their own homes and speak with them.

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 visited seven shared houses where people who used the service lived. We also visited the main office in Okehampton. We spoke with 18 people who used the service and we received e mails and telephone calls from nine relatives about their experience of the care provided. We spoke with 25 members of staff. We also spoke with the nominated individual and a consultant who had been employed by the provider to look at the management of the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Immediately before, and during the inspection, we received 27 e mails from staff who raised concerns about the management of the service.

We reviewed a range of records. This included 12 people's care records and their medication records. We looked at five staff files in relation to recruitment, training and supervision. We also looked at a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with professionals in the local authority care management, safeguarding and commissioning teams who had recent knowledge of the service. We also continued to receive e mails from relatives about their concerns.

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

- Before our inspection we received a large number of concerns from whistle blowers. Staff told us they had been instructed not to raise concerns or safeguarding issues with the local authority safeguarding team or with the Care Quality Commission and instead they must raise the concerns through their line managers. Comments included, "We have also been warned heavily and asked not to whistle blow on any concerns we have about the people in our care".
- During our inspection we looked at the minutes of a meeting held 3 March 2021 with house managers and the nominated individual. The minutes said "[Nominated individual] wasn't happy to hear staff had been whistleblowing via DCC/CQC without going through the internal process first. The whistleblowing has been very damaging to the company and all concerns should have been raised within the company before seeking outside intervention so we can support the staff and manage any concerns". This was not in line with national guidance and practice. Staff should be enabled to make their concerns known outside of the service if they wish.
- Following the meeting the provider had sent out new instructions to staff along with copies of their safeguarding policies and procedures which indicated staff may choose to contact external agencies if they wished. However, some staff told us they still did not trust the company to respect their rights to whistle blow.
- Many staff who contacted us said they felt there was a culture of bullying. This had affected staff morale. Comments included, "There is a bullying culture from head office, and we are scared".
- Some aspects of people's finances were not handled safely. In June 2020 the whole service safeguarding investigation looked at concerns relating to the use of house accounts. Each person was expected to pay a set amount into the house accounts to pay for food and household expenses. There was a lack of clarity about the use of these accounts and concerns were raised that some people may have paid too much into these accounts. The provider agreed to take actions to investigate the concerns and refund any monies overpaid by people who used the service.
- We were unable to check house accounts at the time of our inspection. We were assured these had been passed to the provider's head office to be audited. After the inspection the provider told us the audits had taken place. We have asked for evidence that these audits have been completed and that any money incorrectly charged to people, and any excess amounts held in the accounts have been repaid

Failure to ensure people were safe from abuse and improper treatment is a breach of Regulation 13 (Safeguarding) of the Health and Safety Act 2008 (Regulated activities) Regulations 2014

- All of the people we spoke with told us they were very happy with the support they received. Comments included, "It's great. The people are wonderful. The staff are great. They are so kind and understanding", and "The staff are alright". We observed staff supporting people in activities such as games, household tasks, and

sitting and chatting.

Assessing risk, safety monitoring and management
● People could not always be confident they would be supported by staff who had the training or experience to meet their needs safely.
● Due to the number of staff who had recently left the service there were insufficient staff with the competence and training to carry out an invasive procedure. After our visit to we were given assurances that training had been organised as a matter of urgency. The provider told us the training was provided by community nurses who needed time to plan this training.
● Staff were not trained in using Makaton meaning some people would not be able to communicate with staff.
● People with epilepsy were not supported by staff who had received training on this topic. This meant there was a risk that staff may not recognise the signs of an epileptic seizure or know what actions to take.
● A member of staff told us about a person who had frequently grabbed them by the hair. The member of staff had not received training on how to support people who may display behaviours that challenged staff. They felt they did not have the knowledge or skills to support the person safely and told their manager they no longer wished to support the person.
● Where staff had recently left, we were not assured that new and remaining staff had the right skills and training to meet people's needs safely. New staff had not received an induction or completed a qualification known as the Care Certificate. A member of staff told us, "I feel the training is inadequate and I am aware of a vast amount of staff who still haven't even had inductions into the company (11 months in)". We saw one record showing a staff member who started in January 2021 had still not completed their induction.
● Relatives told us they were very worried that staff working in some houses had enough experience or training in topics specific to people's health needs. Comments included, "Iverna has not provided junior staff with requisite training in infection control, learning difficulties, epilepsy, medication control, professional boundaries, communication etc".
● After the inspection the provider told us that training had been booked prior to the pandemic. However, alternative training was not arranged when face to face training was cancelled.

Failure to ensure people were supported by staff with the competence, skills and knowledge necessary to manage risks to their health and welfare is a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Each person had a detailed support plan in place covering all aspects of their support needs and associated risks. In those houses where there were stable teams of experienced staff, they were able to demonstrate a good understanding each person's support needs and any risks to their health and safety.
● Following our inspection, we heard from staff and the provider about plans to ensure staff completed all overdue training. We also heard about future plans for the range of training to be improved.

Staffing and recruitment
● People could not always be confident there were enough numbers of staff to meet their agreed support needs due to high numbers of staff leaving the service. In one group of houses a number of staff had recently left and some staff were about to leave or considering leaving.
● Relatives told us they were concerned that agreed one-to-one hours were not always fulfilled. We found staff rotas did not always provide evidence to show how staff were deployed to fulfil the one-to-one hours. A relative told us that when they had asked how the person's individual support needs were being met, they were not fully satisfied with the responses.

Failure to ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of people using the service is a breach of Regulation 18 (Staffing) of the Health and Social Care 2008 (Regulated Activities) 2014

● The provider and senior managers assured us that, while a number of staff had recently left the service, some staff were due to return from furlough or from sick leave. They were also in the process of recruiting new staff.

● Staff were not always recruited safely or given adequate supervision and induction training at the start of their employment. We found recruitment records were incomplete and did not always provide evidence of sufficient pre-employment checks being taken up. For example, recruitment records did not always provide evidence of the staff members' start date, some interview notes were missing, missing or insufficient references, and evidence of previous training was not always recorded. The records also contained insufficient evidence of induction training or records of supervision during their induction period.

Failure to follow safe recruitment procedures is a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care 2008 (Regulated Activities) 2014

Preventing and controlling infection

● We were not fully assured that staff had received adequate training or instructions on the risk of catching or spreading COVID-19, or the procedures they must follow to keep themselves and others safe from infection. Staff had received written policies and procedures on how to prevent infection from Covid-19. However, some staff were not following current government guidance, for example by wearing cloth masks. In two houses we saw a member of staff continually removing and replacing their mask. We had previously alerted the nominated individual to the government guidance on personal protective equipment (PPE) during our inspection of another service operated by the provider.

● The provider had failed to promptly access testing for people, visitors and staff. Staff in one house told us they were concerned about the lack of lateral flow tests. After our visit we spoke with health professionals who told us they had previously given the provider information and resources to obtain these tests and to train staff on their use.

● A relative told us they were concerned about the lack of training given to staff on how to complete a lateral flow test. They described a test carried out by a member of staff on a person using the service, saying, "The technique used was completely wrong. She had obviously not read the instructions, so the test was and is completely pointless".

● After our inspection we wrote to the provider to ask them to provide a detailed improvement plan explaining how they planned to address the risks we found relating to COVID-19. They told us 43% of staff had received computer based-training on COVID-19. They planned to ensure all staff complete this training by the end of April 2021. They also told us that a risk assessment had been completed for staff who were unable to wear face masks. However, they did not provide any supporting evidence to show how the risk assessment had been carried out or how they planned to ensure all staff followed safe procedures before and after this training was implemented.

Failure to ensure staff received adequate training and instruction in line with current government guidance on the use of PPE and preventative measures 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.

Learning lessons when things go wrong

● We were not assured that the service had learnt lessons when things went wrong. Staff gave us examples of concerns they had raised and incidents that had occurred. They were not satisfied that these matters had been investigated fully, actions taken, or that lessons had been learnt. For example, following a person's death in 2020 staff said the incident leading to their death had not been adequately investigated by the provider. Staff had received no communication from a senior member of staff to discuss the incident, or to help them understand what happened and what they could do differently in future. A member of staff told us, "They did not see the risk. I was shocked. I did not sleep for weeks".

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.

Using medicines safely

● Concerns raised in 2020 included concerns regarding medication errors. These were investigated within the whole service safeguarding process. The registered manager had worked closely with the local commissioning teams to identify the causes of the errors. They had taken a range of actions to improve the safety of medication administration including further training and competency checks for staff, improved recording systems and better monitoring and auditing systems. This had resulted in lower levels of medication errors.

● At this inspection we found medicines management had improved. Systems were in place to check stocks and ensure medicine administration was correct. Despite this some relatives told us they continued to have concerns about the safe management of medicines. For example, a relative told us about two recent incidents where the person had not received prescribed medicines. We spoke with a member of staff about this and they were able to give a satisfactory explanation for the incidents and the actions they had taken.

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

- The provider has failed to ensure that people received a satisfactory quality of service in accordance with regulatory requirements. There was a lack of consistency in the management of the service. Before this inspection the registered manager and several senior managers had left. Staff told us they were concerned about who was in charge. It did not provide the level of assurance we would expect for this service.
- . In December 2020 there had been a change in director of the organisation resulting in management changes at head office
- The provider failed to ensure systems were in place to protect people and staff from the risks of COVID-19. Their monitoring systems failed to identify that staff had received insufficient training, guidance, policies and procedures on COVID-19. They had failed to identify where staff were not following current government guidance.
- The provider's quality assurance systems failed to identify issues relating to poor recruitment procedures, inadequate induction training, and staff not completing essential training and updates.
- The provider has failed to fully investigate concerns relating to the management and use of house accounts in a timely way.
- The provider's quality monitoring systems did not include systems to monitor care reviews or ensure support plans had been regularly reviewed and kept up to date. There were no monitoring systems in place to look at accidents, falls, incidents, complaints, one to one provision or safeguarding concerns.
- Whilst some staff in some of the houses had systems in place to review and audit documents, this was inconsistent and not overseen by the provider.
- There were inconsistencies in respect of how staff felt in terms of support from the organisation. For example, a member of staff told us, "I have only had three supervisions with [line manager] in her two years working for the company".
- In February 2021 an operations consultant employed by Esto Care took over the role of Nominated Individual. They told us about actions they had taken, or planned to take, to improve the service including the recruitment of new staff and managers. At the time of this inspection proposed changes and improvements had not been fully implemented or embedded and therefore were cannot be certain these will be effective.

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

- People were not supported by an organisation that was open, inclusive or empowering. Staff and relatives

were concerned about the providers' management of the service. Staff described a culture of bullying, low staff morale, and high numbers of staff leaving the service or considering leaving. Comments included, "There is a bullying culture from head office, and we are scared".

● Staff told us they had received little or no contact from the provider or senior management team until recently. Comments included, "Not once were we contacted by anyone other than our area manager from Iverna. We all continued to work without any guidance, only ever criticised never praised or thanked", and "Staff are not kept up to date with things. We hear about things through the grapevine. Would be nicer to hear from them".

●The provider was unable to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. People lived in houses that were managed and staffed in an institutional manner. For example, notice boards containing messages for staff around the people's homes.

● The provider failed to ensure that people, staff and relatives felt safe or able to raise concerns and complaints. Information initially conveyed to staff regarding whistle blowing and raising concerns had damaged staff morale and some staff told us they continued to feel mistrust in the provider.

● The provider has failed to ensure all staff were kept informed about important changes in the service or in people's support needs. This was because the provider communicated via emails. Only senior staff had access to e mails and computer equipment. For example, a communication from a GP about a change of treatment was not implemented because staff could not always access emails. A member of staff said, "We had a medication error where we weren't using both creams because we didn't see the email as staff were off. Staff have no work email".

● Staff rotas were paper documents held in each house. There were no provisions for these documents to be shared with senior managers or staff based at the agency office in Okehampton. The provider and senior managers were unable to check staff rotas unless they visited each house.

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

● Relatives expressed concerns about the lack of communication they had received from the provider since taking over the service in 2019. A relative told us, "They are seriously devoid of even the most basic principles of care, and are run, if you can call it that, by a succession of consultants who have not communicated with us and have stone-walled all enquiries". Another relative said, "Contact from Iverna above the 'house' team has been virtually non-existent, they did not even write to introduce themselves when they took over. Perhaps an indication of their level of care".

● The provider told us they had undertaken a survey of staff and people who used the service between October 2019 and December 2020. This did not include seeking the views of relatives or professionals.

Continuous learning and improving care

● The provider did not have systems in place to ensure all staff had access to a range of learning resources to ensure people received good quality support in line with current best practice.

● Staff were expected to complete computer-based training on essential topics. However, there had been no systems to monitor the training, or to ensure staff had completed the training within expected timescales.

● Staff were not supported to gain relevant qualifications in care.

Working in partnership with others

● In the last year the service has been supported by health and social professionals including the local safeguarding team, quality assurance team, and health specialists to help them implement changes and improvements. Some improvements had been effective, for example medicine administration procedures. However, the improvements were implemented too slowly and were not fully effective, and this meant the

service had remained in a whole service safeguarding
● The provider has failed to support people to address issues relating to the safety and security of their accommodation. This included the safety of furniture and equipment, and problems with heating and sewerage systems.

Failure to maintain good governance and to assess, monitor and improve the quality and safety of the service is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● While most staff we spoke with were unhappy with the management of the service by the provider, we also heard from a small number of staff who were entirely happy in their jobs. For example, "I'd just like to say I'm extremely happy with the house I am working at and have no problems at all with what the staff and management team are doing. The company are making improvements to the house which will benefit all of the people we support".

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
● In 2020 there was a concern that some incidents had not been properly reported to the local safeguarding team or to the Care Quality Commission (CQC). The local authority worked closely with the person who was at that time the registered manager of the service. We were assured that the concerns were being addressed and incidents were being reported. However, recent changes in the management of the service have resulted in a lack of clarity about who is responsible for submitting notifications to the CQC or the local safeguarding authority about accidents or incidents of potential abuse or neglect.
● During this inspection we found some incidents had occurred in recent weeks that had not been notified to the CQC. For example, a person had been admitted to hospital following a possible choking incident. We did not receive a notification about this incident. At the time of writing this inspection report, the most recent notification from the service was received on 4 January 2021. A notification has subsequently been submitted on 5 May 2021. This incident occurred on 20 March 2021.

Failure to submit notifications of incidents or possible abuse is a breach of Regulation 18 Registration Regulations 2009 (Notifications of other incidents)

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 18 Registration Regulations 2009 Notifications of other incidents The provider has failed to submit notifications of incidents or possible abuse when these have occurred.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider has failed to ensure new staff are recruited following safe procedures.

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 People who use the service and others were not protected against the risks associated with unsafe care or treatment. The provider has failed to ensure people were supported by staff with the competence, skills and knowledge necessary to manage risks to their health and welfare

The enforcement action we took:

We have imposed a condition

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment

The enforcement action we took:

We have imposed a condition

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to maintain good governance and to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We have imposed a condition

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who use the service cannot be confident they will receive support from sufficient numbers of suitably qualified, competent, skilled and experienced staff.

The enforcement action we took:

We have imposed a condition