

# Spectrum (Devon and Cornwall Autistic Community Trust)

## East Wheal Rose

### Inspection report

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### Ratings

#### Overall rating for this service

Requires Improvement ●

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

# Summary of findings

## Overall summary

### About the service

East Wheal Rose is a residential care home that provides care and accommodation for up to three autistic people. It is part of the Spectrum group who have several similar services in Cornwall. They are providers of care for autistic people and/or people with learning disabilities. At the time of the inspection two people were living at the service.

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.

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

People's needs were not always met because the service was short staffed. Although there was a core staff team who had worked at the service for several years the service was short staffed. An agency staff worker had been allocated to the service who routinely worked long hours. They had left the service without notice and this had resulted in the service running on 'emergency minimum' staff numbers in the week running up to the inspection.

People were not consistently supported to have maximum choice and control of their lives and staff did not always 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. For example, one person did not have access to a kitchen. This decision had not been regularly reviewed. Due to the breakdown of one of the two vehicles people were not always able to go out when they wanted to. The provider had not taken action to resolve the problem in a timely manner.

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:

The service did not support people to have maximum choice, control and independence.

The service did not always support people in a safe, clean, well equipped, well-furnished and well-maintained environment that met people's sensory and physical needs. Part of the premises, which were originally set up to enable one person to access it safely, were no longer arranged to meet their needs. This meant people were not able to work towards identified goals.

Staff shortages impacted on people's opportunities to go on planned trips out and take part in pastimes and activities in the service.

When they were able to go out, people were supported by staff to take part in activities in their local area. People had exclusive possession of their own bedrooms and living spaces.

#### Right care:

Safeguarding concerns were investigated. Staff knew how to recognise and report abuse.

Staff promoted equality and diversity in their support for people. They understood people's cultural needs and provided culturally appropriate care. For example, people were supported to have access to films and music which were relevant to their culture.

Where appropriate, staff encouraged and enabled people to take positive risks. Staff were enthusiastic and motivated in encouraging and supporting people to take part in hobbies and experiences that interested them.

#### Right culture:

People's dignity was not consistently respected. Action to improve people's experiences were not taken in a timely manner.

The core staff team had worked at the service for a long time, knew people well and had a good understanding of their needs.

Staff communicated with families regularly. People had access to independent advocates to help represent their wishes.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection

The last rating for this service was good (published 17 April 2019).

#### Why we inspected

The inspection was prompted in part due to concerns received about staffing. A decision was made for us to inspect and examine those risks. We also undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for East Wheal Rose on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### 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 monitor the service and will take further action if needed.

We have identified breaches in relation to staffing levels, upkeep of the premises, supporting people with dignity and oversight of the service. Following the inspection managers told us about actions they had taken to mitigate risk. We have made a recommendation about ensuring consent to care is in line with best practice.

#### Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not entirely safe.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

**Requires Improvement** ●

### Is the service caring?

The service was not always caring.

**Requires Improvement** ●

### Is the service responsive?

The service was not always responsive.

**Requires Improvement** ●

### Is the service well-led?

The service was not well-led.

**Requires Improvement** ●

# East Wheal Rose

## 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 two inspectors.

#### Service and service type

East Wheal Rose is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is required to have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. Due to an administrative error the manager had cancelled their registration. They were reapplying for registration.

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

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

#### During the inspection

We met people living at East Wheal Rose and observed their interactions with staff. We spoke with three

members of staff including the manager, deputy manager and a care worker. We reviewed a range of records. This included people's care records and one person's medicine records. We looked at rotas, incident reports and daily records. A variety of records relating to the management of the service were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at records we had requested from the service. We contacted two relatives of people using the service and one external professional. We spoke with three staff members.

# Is the service safe?

## Our findings

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

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

### Staffing and recruitment

- The service did not have enough staff for people to take part in activities and visits how and when they wanted. Due to difficulties recruiting permanent staff locally, Spectrum had recruited agency staff to work at the service.
- An agency staff worker had been working long hours at East Wheal Rose which meant it was difficult to fill gaps in the rota if they took unplanned leave. Rotas showed they were scheduled to work between 69 and 78 hours a week during February. The weekend before the inspection they had left the service without giving notice. This had put immediate pressure on staffing levels in the service.
- One person required support from three members of staff, and the other person had support from two members of staff for seven hours each day and one member of staff for the rest of the day. The service emergency contingency plan stated; "In extreme emergency situations..... the emergency minimum [staff numbers] for East Wheal Rose would be three." And; "In these extreme circumstances the service users must remain in the unit.... There would be no tasking of service users at all."
- On the day of the inspection there were only two members of staff on duty. The regional manager had come in to support them. We asked if there were any plans for the day and were told; "They [people living at East Wheal Rose] are not able to go out today as there are not enough staff."
- Rotas and sign in books showed for the five days preceding the inspection the service had operated at 'the emergency minimum' numbers for all or some of the day. This meant people's opportunities to leave the service, or take part in activities in the service, were severely limited.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Permanent staff were recruited safely with the appropriate checks completed before they started work. The agency used by the provider completed background checks for any agency staff employed.

### Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of harm because staff had received training in how to recognise potential abuse and the action they should take if they suspected abuse.
- Any allegations of abuse had been investigated and all appropriate action taken.
- Sometimes people became distressed or anxious which could lead to them putting themselves and staff at risk of harm. Staff understood how to support people when they were distressed to minimise the associated risks.



- The service looked after people's personal monies. Any expenditures were recorded and receipts kept. We checked the money held and records and identified no concerns.

#### Assessing risk, safety monitoring and management

- Risks associated with how people acted when distressed had been identified. Risk assessments were in place to guide staff on how to recognise indicators of risk and take action to mitigate the risk.
- Fire checks were completed regularly. A recent fire risk assessment had highlighted actions to complete and these had been completed.
- People had Personal Emergency Evacuation Plans in place so staff and first responders would know how to support people to leave the building in an emergency.

#### Using medicines safely

- There were systems in place to help ensure people received their medicines safely and as prescribed. Staff received training in how to support people with medicines.
- If people needed 'as required' medicines such as pain killers, staff had to check with a manager before administering it.
- Medicine administration records were completed clearly, and staff had signed to indicate when people had received their medicines.
- The provider was introducing an electronic medicine recording system across all their services. The deputy manager was due to complete training in using the system to ensure they had the necessary confidence and skills to use the system.

#### Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- People were able to have visitors in line with government guidance. During an outbreak of COVID-19 relatives had been encouraged to maintain contact using technology and regular telephone calls.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

### Learning lessons when things go wrong

- Accidents and incidents were recorded. This included any incidents when people had become distressed. Staff recorded what the likely trigger had been and how they had supported the person. The information was shared with the organisations behavioural team who sometimes commented on how things could have been done differently.

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

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

- The premises did not support people's independence. One person had a kitchen which had originally been developed for their use. At previous inspections we found the person was using the kitchen, with staff support, for basic food preparation. The person found it difficult to focus on food preparation if there were distractions in the environment. A lockable pantry meant food items could be locked away without restricting the persons access to the kitchen. At this inspection we found the person was no longer being supported to use the kitchen. The pantry and kitchen cupboards were unlocked and the area was chaotic. A member of staff confirmed the person used to be supported to access the kitchen. They commented; "It all fell away, I don't really know why. It would be good to reinstate it."
- A document called 'What I want to achieve' stated the person wanted to 'Access my kitchen to prepare meals with utensils, food and other items in place. Increasing all independent living skills.' The way in which the kitchen was set up meant the person was unlikely to be able to work towards this outcome.
- We discussed the use of the kitchen with the deputy manager. They told us that the experience had ceased to be a positive one for the person as they easily became distracted by checking the contents of cupboards. However, no consideration had been given to how the room could be set up differently to better suit the person's needs.
- Areas of the service were in need of repair and/or redecoration. For example, one person's bedroom door was badly damaged, skirting boards had rotted away and flooring needed replacing. Staff told us the defects had been reported and had been ongoing since before Christmas.
- The outside of the building and the garden had been neglected. The garden was untidy and overgrown. The front porch was full of cobwebs and a window had been boarded up. The driveway was full of potholes and the area around the house was generally uneven.

This was a breach of Regulation 15 (Premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Following the inspection, the deputy manager contacted us to inform us repairs and improvements to the environment, inside and outside, were being completed, or were on the list to be completed.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Some restrictive practices were in place to help ensure people's safety. There was no evidence to show these were being regularly reviewed to check they remained relevant and the least restrictive option.

We recommend the provider seek advice and guidance from a reputable source, about systems for reviewing and recording restrictive practices.

- DoLS authorisations had been submitted appropriately. Mental capacity assessments were completed prior to submitting DoLS applications.
- One person had medicines given to them hidden in food. The decision had been made following best interest processes and included in their DoLS application. This decision was revisited at care plan reviews to ensure it remained proportionate and relevant.

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

- People's needs had been assessed and were regularly reviewed. Care records included information about people's communication and sensory needs.
- Goals and aspirations had been identified for people, including skills teaching. However, there were no clear pathways to support people to achieve those goals.

Staff support: induction, training, skills and experience

- Newly employed permanent staff completed an induction before starting work at the service. Agency staff completed a day's induction which covered basic training needs. This was followed up by a day reading care plans and completing a house induction in their assigned service.
- Staff had received mandatory training. This was regularly refreshed in line with guidance.
- Staff received regular supervisions with a manager.

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

- People were supported to eat and drink enough to maintain a balanced diet. People's preferences were recorded in care plans and known by staff. Staff ensured people had access to regular drinks.
- Mealtimes were flexible to meet people's needs and to avoid them rushing meals. Staff supported people to choose what they wanted to eat and be involved in basic food preparation.

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

- People were supported to see their GP, dentists and attend other health appointments regularly.
- If people found health appointments stressful, arrangements were put in place to help alleviate this. For example, professionals visited people at the service or in an environment where they felt safe.
- Hospital passports had been developed to give hospital staff an overview of people's needs if they needed to be admitted.
- Key workers had oversight of individual's care plans and appointments. These were staff who knew people

well and had a good understanding of their needs.

# Is the service caring?

## Our findings

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

At our last inspection we rated this key question good. The rating for this key question has changed to 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

- People were not consistently treated with dignity and respect. One person sometimes became agitated and staff needed to monitor them to ensure they were coping with their emotions and not at risk of harm. The deputy manager told us staff sometimes observed the person without their knowledge to give the person privacy while ensuring they were safe. They said this practice had been in place for many years. There was no evidence the decision to check the person covertly had been discussed in a best interest process or was regularly reviewed to ensure it remained the least restrictive option. This put the person's privacy and dignity at risk.
- On the day of the inspection the kitchen was being used to store staff coats and bags. Staff told us they always did this as there was nowhere else for them to keep their things. Washing up had been left on worktops and the area was untidy. This was not respectful of the person's space and meant it was difficult for them to use without becoming distracted.

This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The premises had been split into two distinct living areas with separate entrances and outdoor space. This meant people were able to have privacy and their needs did not impact negatively on each other.

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

- People's cultural backgrounds were known and respected. Staff encouraged people to have access to food, films and music which reflected their cultural background.
- Staff were respectful when discussing people's needs. They recognised people sometimes struggled with their anxieties and supported them to develop ways of managing this.
- An external professional gave positive feedback in relation to the staff team. They commented; "Staff have a real willingness."
- We observed staff were able to support a person to be calm and reassured so they were more settled.
- A relative told us; "[Name's] keyworker is always ringing, you can see their enthusiasm for [Name]."

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

- People's opinions of the service were gathered. Systems had been developed to gather people's views of the service on a regular basis. Questionnaires had been created using pictures and symbols, so they were

meaningful to people.

- Staff were able to describe how people communicated and how they were able to recognise when people were becoming anxious or distressed.
- When necessary managers had worked with advocacy services to help ensure people's voices were included in decision making processes.

# Is the service responsive?

## Our findings

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

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

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not able to make choices about what they did and when. They did not have the freedom to go out when they wanted. Resources to enable people to leave the service had not been made available. It was important to both people living at East Wheal Rose, that they were able to go out when they wanted and spontaneously. They did not spend time together and went out separately, each having access to a vehicle. One of the vehicles had not been operational since December 2021 and therefore people had to share one vehicle. This restricted their opportunities to go out. The providers 2021 achievement record, as shown on their website, refers to a delivery of a fleet of 16 new vehicles in November 2021. However, this resource had not been used to improve the experience of people living at East Wheal Rose.
- Following the inspection, the deputy manager told us a vehicle was being adapted to enable the person to use it safely whilst the other was being repaired. However, this had not been completed in a timely manner and had impacted on people's opportunities.
- An external professional commented; "It is imperative [name] has their vehicle. They don't always want to go out but when they do, they need to go."
- A member of staff described a recent occasion when one person had seen the vehicle ready to leave and had wrongly assumed they were going out. They told us; "I checked when we got back and was told [name] was not very happy."

This contributed to the breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Following the inspection the provider contacted us to inform us the person did not receive sufficient funding to cover the cost of a vehicle. However, they had made arrangements to replace the vehicle and were expecting delivery of it in May 2022.
- When people were able to go out they took part in pastimes and hobbies that were meaningful to them. People had opportunities to try new things and revisit experiences they had tried in the past.

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

- Care plans were personalised and contained information across a wide range of areas. One-page profiles contained basic information and provided a quick and accessible overview outlining what was important to and for people.
- Daily notes recorded what people had done during the day and what had worked well.
- Staff were knowledgeable about people's needs. They were able to describe how they supported people



both in and out of the service, including when they were distressed or heightened.

#### Meeting people's communication needs

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

- Easy read information had been developed to help people understand the possible impact of COVID-19.
- One person used some simple sign language called Makaton, to support their communication. Staff had received training about it and there was guidance available in the service.

#### Improving care quality in response to complaints or concerns

- Managers told us there were no complaints at the time of the inspection. There was a satisfactory complaints policy in place.

# Is the service well-led?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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's culture was not always person-centred and empowering. Shortcomings at the service had impacted on people's opportunities and experiences. There had been a failure to continue to support people with day to day independent living skills. This meant there was a risk they would lose those skills and staff expectations for people had been lowered. The provider had not identified that people's experiences had been negatively impacted by the poor practice.
- Arrangements for staffing at the service had not been effective. An agency worker had been allocated to the service and was working 70 hours a week plus two sleep-in shifts. This meant their hours were difficult to cover when they became unavailable without notice. This had not been foreseen or planned for and had left people without the correct level of support.
- The provider had been made aware of defects in the environment and the breakdown of one of the service vehicles. Action to remedy these issues had not been taken in a timely manner.
- Managers had not communicated with relatives in line with the principles of the Duty of Candour. A relative told us they had been made aware of concerns about their family members well-being. They did not feel the service or provider had kept them updated about actions taken.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We contacted the Nominated Individual who told us they would ensure the relative was updated about action taken following the concerns being raised.

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

- The manager was also a regional manager for the provider, and had oversight of six other services. This meant their time at the service was limited.
- Whole service audits were carried out to identify any areas for improvement. The last one had been completed 27 July 2021. At this time no areas for improvement were identified and therefore there was no plan to drive forward improvements at the service.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated

- The manager was supported by a deputy manager who worked full time at the service.

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

- Regular staff meetings were held to share any relevant information with the staff team.
- When supporting people to make choices staff used communication tools such as pictures and sequence strips, according to people's needs.
- One relative told us the manager and key workers communicated well with them and kept them updated about their family members wellbeing.

Continuous learning and improving care

- When people tried any new activities learning logs were used to record what worked well and what could be done differently.
- The provider kept up to date with national policy and guidance such as closed cultures guidance. Any changes or developments were shared with managers at manager meetings.

Working in partnership with others

- An external professional told us staff were motivated and had people's interests at heart. They said the managers and staff provided any information requested.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care  People's care and treatment was not always appropriate and did not always meet their needs or reflect their preferences.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect  People were not always treated with dignity and respect and their privacy was not always ensured.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment  Premises were not properly maintained.

This section is primarily information for the provider

## Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems or processes were either not established or operated effectively to ensure compliance with the regulations.</p> <p>Systems or processes did not enable the registered person to assess, monitor and improve the quality and safety of people. provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); Systems or processes did not enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk.</p>

### The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff.</p>

### The enforcement action we took:

We issued a warning notice