Carewatch Care Services Limited

Carewatch (Windsor)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection visits took place on 13, 14 and 15 June 2018 and were announced. Subsequent to the inspection, we received concerns from three separate sources. We have incorporated evidence arising from these concerns in this report.

We gave the provider 5 days' notice as we wanted to make sure someone would be there to assist with locating documents and to arrange visits to people's homes. This is the first inspection since the service moved to this location.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and specialist housing. It provides a service to older adults and younger disabled adults. At the time of our inspection the service was supporting 196 people.

The service requires a registered manager to manage the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection a registered manager was managing the service.

We received information following our inspection that the registered manager and deputy manager left the service on 23rd August 2018. The interim arrangements were that the area manager would be responsible for managing the service.

Medicines were not always managed safely. For example, we saw that staff had not always signed for medicines they had given and incorrect codes were used on some medicine records. We saw that staff were signing medicine records for one person's insulin which would indicate that they had administered the insulin. However, the person administered their own insulin and only required prompting. We discussed this with the management team during feedback. We were told this would be addressed. We received concerns about the poor management of medicines following our inspection.

During our inspection we visited one person in their home and found a risk assessment was not in place for the person's bedrails and their overhead hoist.

The provider did not have robust systems to monitor the quality and safety of the service. Systems did not enable the provider to identify that safety of people using the service was compromised. Spot checks were carried out by senior staff but did not highlight the concerns we found. Systems for identifying risks and issues were ineffective.

Safe recruitment procedures were carried out. Files we saw contained relevant documentation required to

ensure only suitable staff were appointed. Staff received appropriate induction, training and support. Mandatory training was completed by new staff before they could support people. Following completing of training senior staff carried out spot checks to ensure staff were competent in their role. However, spot checks did not identify issues we found following our inspection. Following our inspection, we received a whistle blowing concern raised to the local authority about a member of staff not having a Disclosure and Barring Service check completed prior to them joining the service. We were aware the provider agreed to complete an investigation into the concern raised.

At our inspection we found that complaints were responded to and used as a way of improving the quality of the service. However, following our inspection we received additional information that concerns and complaints had not been responded to or acknowledged.

We received mixed views about the service from relatives and people we spoke with. Relatives told us, "I think [my family member] is safer with them now, it was quite bad before, but I still check on everything", "Well the regular carers are very good it's when we get random others that it is not so good", "I am sure [family member] is safe with them, "I suppose I have to say it has got better in the last few weeks", "The regular girls in the week are alright but at the weekend it's all strange faces and [family member] doesn't like it, well who would." People told us, "Well its usually the same carers but sometimes they are different, they do my medicines fine", "They just come once a week to take me shopping, it's the same lady, I do feel very safe with her", "I am happy with the staff."

Professionals we spoke with told us they had seen improvements in the service provided.

Staff received training in safeguarding. They told us they would not hesitate to report any concerns they had. Staff could contact the office or the on-call system if they wanted to discuss anything.

Staff told us they felt supported and they had regular supervisions. Records confirmed supervisions took place. One member of staff told us, "Yes definitely supported, you couldn't want for more."

People had access to healthcare services to maintain good health. People were supported to attend healthcare appointments when required. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Information we received following our inspection showed this was not always the case. We were aware one person specifically stated their preference to have female staff only supporting them. However, the service did not respect the person's wishes which led to care and support being rejected by the person.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any 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.

Medicines were not always managed safely. People were at risk of not receiving their medicines as the prescriber intended.

Risk assessments were not always in place.

Safe recruitment checks were not always in place to ensure only suitable staff were appointed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always received relevant training to carry out their role safely.

Staff acted in accordance with the Mental Capacity Act 2005

Staff had supervisions to support them in their role.

People had access to healthcare services to maintain good health.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always maintained.

People were not supported with their identified needs.

Relatives told us staff were caring.

People were not supported with their agreed preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and support in the way they preferred.

People knew how to make a complaint and had information in a format they understood when they first joined the service.

Complaints were not responded to in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager and deputy manager had left the service. We were not informed about their departure.

Robust systems were not in place to monitor the service.

People who used the service did not always receive support at a time agreed by them and the provider.

Staff told us the service had improved and was well managed.

Carewatch (Windsor)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13, 14 and 15 of June 2018 and was announced. This inspection was extended due to further evidence we received after our inspection.

We gave the service five days' notice of the inspection site visit because some of the people using it could not consent to a home visit from an inspector, which meant that we had to arrange for a 'best interests' decision about this. The inspection site visit activity started on 13 June 2018 and ended on 5 July 2018. It included a visit to the office location on 13 and 14 June 2018 to see the manager and office staff; and to review care records and policies and procedures. On 15 June we visited people in their homes and on 5 July we spoke with staff by telephone.

The inspection was carried out by one inspector and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was older people's care.

Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect the service or the people using it.

The provider had submitted a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we visited five people in their home. We also spoke with 10 relatives and nine

people who used the service by phone. We spoke with the registered manager, three quality officers and six members of staff. We received information from a professional who was involved in the service.

In addition, we looked at four recruitment files, nine care plans, nine medication records, quality audits, accident and incident records and other documents relating to the management of the service. We received additional information following our inspection which involved concerns raised by three family members.

Inadequate

Is the service safe?

Our findings

We received mixed views about the service from relatives and people we spoke with. Relatives told us, "I think [my family member] is safer with them now, it was quite bad before, but I still check on everything", "Well the regular carers are very good it's when we get random others that it is not so good", "I am sure [family member] is safe with them, "I suppose I have to say it has got better in the last few weeks", "The regular girls in the week are alright but at the weekend it's all strange faces and [family member] doesn't like it, well who would." People told us, "Well its usually the same carers but sometimes they are different, they do my medicines fine", "They just come once a week to take me shopping, it's the same lady, I do feel very safe with her", "I am happy with the staff."

Safe recruitment procedures were not always carried out. Following our inspection, we received a whistle blowing concern raised to the local authority about a member of staff not having a Disclosure and Barring Service check completed prior to them joining the service. We were aware the provider agreed to complete an investigation into the concern raised. In addition, the member of staff had not received any training before they supported people with medicines and carrying out manual handling procedures. This put people at risk of receiving care from unsuitable untrained staff.

However, files we saw during our inspection contained relevant documentation required to ensure only suitable staff were appointed. Staff received appropriate induction, training and support. Mandatory training was completed by new staff before they could support people. Following completing of training senior staff carried out spot checks to ensure staff were competent in their role.

In addition, following our inspection we received further concerns regarding unsafe care and poor practice. We received information that one person was left in his chair overnight and not transferred to bed. The person's family found their relative slumped in their chair in a poor state.

We also received information following our inspection relating to the competence of agency staff. One relative told us how their family member was not hoisted onto the commode but was 'man handled'. We noted that the deputy manager confirmed agency staff had not used the hoist and had not followed manual handling procedures. This put the person at risk of falls and serious injuries.

Risk assessments were carried out during the initial assessment which included an environmental risk assessment. However, one person we visited had bedrails in place, we did not see a risk assessment in relation to this in the person's care plan. In addition, we saw the person had an overhead hoist in their home which was used to manoeuvre the person from their bed. A risk assessment had not been completed for the use of this equipment or any information in relation to how to use the hoist. We spoke with the two members of staff who were present at the persons home at the time of our visit. They told us they knew how to use the hoist so did not think this would be necessary. We pointed this out to the senior managers during our feedback. They told us this would be addressed.

Medicines were not always managed safely. For example, we saw that staff had not always signed for medicines they had given and incorrect codes were used on some medicine records. We saw that staff signed one person's medicine record indicating that they had administered insulin when this was not the case as the person only required prompting to administer their insulin. We discussed this with the management team during feedback. They said they will address with staff the importance of recording the correct codes on medicine charts.

Subsequent to our inspection we received further information in relation to the safe management of medicines. People's medicines were not available in the quantities required at all times to prevent the risks associated with medicines that are not administered as prescribed. We found one person had been without their medicines for one month. The medicines were to treat high blood pressure, stroke, dementia and prostate cancer. This meant the person would experience complications in relation to not receiving their medicines. For example, raised blood pressure which could lead to further strokes, dementia symptoms worsening and related symptoms in relation to the person's cancer.

We found another person had not received their medicine to treat Alzheimer's disease, the person's family member told us the medicines were found on the floor. The person had previously suffered two strokes which meant they were on a variety of medicines one of them being a drug to manage mental health issues.

Following our inspection, we were told staff had left used incontinence products on a kitchen worktop and had left an unemptied commode next to a person for several hours. This demonstrated that people were at risk because hygiene practice was not followed and people's health was at risk as a result. These practices also demonstrated a lack of respect for the person's dignity.

People's risks from infections was compromised because staff did not follow correct procedures for infection control. Staff told us they were provided with personal protective equipment such as gloves and aprons. One person told us, "They do wear their gloves and aprons but sometimes an odd one comes and don't have any with them, but I do have them in the house so then they use them"

This was a breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood their responsibilities to raise concerns and record incidents and accidents. We saw that accidents and incidents were responded to appropriately and were recorded with actions taken as appropriate. For example, informing the GP and significant others.

Policies in relation to safeguarding and whistle blowing reflected local procedures and relevant contact information. Staff demonstrated a good understanding of the procedure in reporting abuse. Staff could contact the office or the on-call system if they wanted to discuss anything.

Requires Improvement

Is the service effective?

Our findings

People did not always receive effective care from staff who had skills to carry out their role. For example, when we visited one person in their home we saw staff were testing the person's blood glucose levels. However, the person's care plan referred to 'please prompt me to check my blood glucose levels'. We discussed this with the member of staff and they told us the person was unable to use the new blood testing monitor. We asked the member of staff if they had received relevant training in this area and they told us they had not. We were told that no staff had received training in this area. This meant the person may have been at risk of receiving inappropriate intervention in relation to their condition. This showed that, in conjunction with the evidence presented in the Safe domain about medication administration training, in some instances, staff had not received the required training to be able to ensure that people received their medicines safely and as prescribed.

Staff performance in relation to agency staff was not monitored adequately by the service and people were likely to be at risk as a result. We could not be assured training had been completed to sufficient standards to ensure people's safety. We noted following our inspection the provider has requested evidence of training for agency staff. Comments we received from relatives were, "The training is a bit hit and miss, one or two are excellent but there are a lot of new ones and they do things differently" and "The odd ones that come are not so well trained as my regulars are." The provider had not assured itself that training had taken place to ensure people's safety.

We received information following our inspection in relation to ensuring people received adequate food and fluids to maintain good health. For example, we were aware one person may have spent 18 hours without food on one occasion and on another occasion, was not given any food in the evening. Furthermore, we were told staff arrived at 15.44 for a lunch time call which meant lunch was not provided for the person until that time leaving the person for several hours without food. We were aware the person was frail and in poor health and suffered with severe anaemia and low weight. Another relative reported they overheard care staff saying they could not 'be bothered' to prepare a meal for their family member and had on more than one occasion just given a piece of fruit instead. This evidence showed people were at risk of poor diet which may have impacted on their health over time.

One relative told us their family member had slurred speech during the extreme hot weather due to dehydration. In addition, another relative told us their family member had not received adequate fluids and was admitted to hospital with dehydration. We were aware the person had received intravenous fluids during their hospital stay to replace fluids. Following their hospital stay the person made a full recovery and we were not aware this had a lasting impact on their health.

People were supported to maintain a balanced diet. Staff supported people to shop and cook meals of their choice. People commented, "They make my breakfast and a cup of tea, they do cook as well", "They make me microwave meals but at the weekend half the time the dinner is cold, I do tell them but they are in a rush", "My [relative] leaves a bit of mashed potato and they heat that up with something or do a sandwich, you don't want a lot to eat at my age." Relatives told us, "They do give [my relative] food but they (relative)

eat very little now, just yogurt or simple things like spaghetti hoops", "Yes they do microwave meals or a sandwich, there are always eggs they can do, but there are meals on wheels or they go out for a main meal." The service supported people who required specific diets. We saw that one person we visited required a soft diet due to their condition. The person told us "They (staff) are brilliant I don't know what I'd do without them."

Records showed that staff received induction, training and on-going support. A 12-week programme was in place to monitor new staff. Staff told us the training was good and enabled them to provide quality care. Records confirmed staff were up to date with their mandatory training and were booked to attend refresher courses when required.

Records confirmed that supervisions were carried out by the management team. Staff told us they were supported and could always speak to someone either formally or informally. Staff told us, "I have been with [name of manager] from day one and I can always speak with them" and "Generally I will phone the office if I am worried about something."

People and their relatives gave mixed feedback on whether there were enough staff to meet their support needs. Relatives told us, "We have kept a private carer for the morning as the first call is so important. But they (Carewatch) come lunch time and evening, we don't know who is coming, we haven't had a rota for a year and it's all different people", "They are supposed to stay for 30 minutes but they are rushing and sometimes the call only lasts 10 minutes", "It can be all over the place at weekends, [my relative] rang me last weekend because it was twenty past one and they had not come." One person told us, "They come four times a day they are pretty much on time, it's just weekends when its agency staff that it all goes to pot."

The provider used agency staff when required to ensure the service could meet people's needs. Staff told us there were enough staff and that the quality officers would always go out and attend visits when required. At the time of our inspection we were told the provider was carrying out a recruitment drive and that recruitment was ongoing.

We received comments from three relatives following our inspection who said they didn't always know who was coming and at what time. One relative commented sometimes their relative goes for prolonged periods without support with food or fluids as the staff do not turn up at the allocated time.

The service worked with other healthcare professionals to enable specialist support to be provided. We saw input from various healthcare professionals when required such as Parkinson's nurses and community occupational therapists. This meant that people were supported to receive on going healthcare support to maintain their well-being.

People told us that staff checked with them before providing care. Staff could describe how they promoted choice and responded appropriately if people refused care. We were told how one person consistently refused support during a bath. One member of staff said, "We try to encourage as much as we can but in the end, it's their choice."

Staff had knowledge of the key requirements of the Mental Capacity Act 2005. They put these into practice to ensure people's human rights were respected. We saw consent to care had been sought in line with legislation. Five people using the service had given another person authority to take decisions about the service provided. In instances where people lacked capacity to make decisions relevant significant others were involved in the process. There were five people who had a deputy appointed by the Court of Protection with powers to take decisions about the service provided.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack capacity to do so for themselves. The Act requires 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 interest and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when it is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). This service required a different process which is not covered by the DoLS team. Applications were made directly to the Court of Protection if the service felt someone was being deprived of their liberty.

Requires Improvement

Is the service caring?

Our findings

Relatives and people we spoke with told us they were mainly satisfied with the service. They told us staff were patient and kind. People told us, "They cheer me up in the morning and we have a laugh and they pull my leg, its lovely. I can't fault my regular carers, it's just the agency ones, I can't fault the care, the girls are lovely, it's just the week ends" and "I am happy with the care, but the staff vary." Relatives commented, "The regular carers are very good, we have two regular ones who are marvellous, above and beyond I would say, [my relative] has dementia and they are so good with her and having regular people helps" and "The few regulars we have left are fantastic, so good, but we get so few of them now, we don't know who is coming."

Subsequent to our inspection we found concerns raised by family members. This was in relation to one relatives' family member not receiving care and support from female staff only. This was part of the agreed plan with the provider as the person was extremely shy in the company of men. The care plan strictly advised that the person would only be assisted by female staff due to the person being a spinster for over 54 years. However, male staff were sent to support the person which resulted in them (person) refusing to bath or change their clothes. We were told the person stayed in the same cloths for days as they were frightened of men assisting them to dress. This resulted in the person developing a urine infection which put them at further risk in relation to their condition. People's preferences were not considered staff did not respond to people's discomfort and distress.

Another relative told us their family member's personal care was not carried out on several occasions. The relative also stated that due to personal care not being delivered on one occasion, their relative was found with their hand covered in their own excrement. The family member told us their relative tried to use the commode themselves and the care staff had not supported the person to do this. This demonstrated staff did not understand the importance of dignity and human rights.

Staff told us about examples of ensuring they maintained people's privacy and dignity. Examples included closing doors and making sure people were adequately covered during personal care.

People were supported to express their views and staff were skilled in anticipating people's needs. We saw that one person we visited was unable to communicate effectively due to their condition. The two members of staff were able to instinctively know what the person wanted. They told us, "We have been coming here for so long we just know."

The service enabled people to receive support to help them understand and be involved in their care and support. The service made referrals to other agencies such as advocacy services when necessary. The service maintained regular contact with people through courtesy calls, questionnaires and arranged visits. One relative commented, "I can get hold of the office easy enough and if I leave a message they do get back to me." One person said, "They do come and see me from the office."

People could negotiate and make changes to their routine. The service was flexible to respond to people's

changing needs. Reviews took place regularly or according to any changes to confirm the service could continue to meet people's needs. We received comments such as, "We have asked for a review as we will need more care soon", "I have had a review in the last year, I have to say if you have to cancel, they are alright about it", "There was a lady out last Friday to do a review and ask me questions."

Care plans identified people's support needs and preferred way of communicating. The service had an equality and diversity policy in place and staff had received training in this area. Staff respected people's preferences and needs under the Equality Act. For example, age, disability, religion and culture. The service told us they had supported one person who had shared openly their sexuality. They had devised a care plan specific to his needs which referred to choices and preferences.

Requires Improvement

Is the service responsive?

Our findings

We saw the service had a formal process to manage complaints. People could make a complaint by telephone, in person, in writing or via email. On receipt of a complaint a log would be made and responded to according to the services policy and procedure. We saw 17 complaints had been made in the previous 12 months and 16 of these were resolved. We spoke with the registered manager about the 'open' complaint. They told us a meeting had been arranged with the family to discuss the issues.

We received further information following our inspection in relation to complaints. One family member told us they had raised concerns and complaints with the provider since the onset of the service being delivered. However, none of the concerns had been addressed or responded to. For example, the relative was promised a call back on Monday 19th August 2018 from the provider and never received the call back. When the relative phoned the service on the 23rd August 2018 the provider said they had no idea of any issues or the phone call made. Another family member told us they had put an official complaint in to the service on 12/08/2018 and had not received a response as of 12/09/2018.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans reflected people's physical, mental and social needs. These included personal history, individual preferences, interests and aspirations. These were understood by staff so people had as much choice and control as possible. One relative told us, "[My relative] is in hospital at the moment. But before that we had two visits each week, it was always the same man, [my relative] said he preferred a man and that is what usually came." This demonstrated the service acknowledged people's individual preferences and enabled people to choose the way they received support.

Reviews were used as a way of monitoring the service. We saw positive comments from people during reviews which included, "Very good care workers they give me a choice", "Office team are helpful when I ring", "The care is good but variable, [he] does get people that have not been to him before. On the whole [he] is happy with his care." However, some comments were not so positive. One person said the office never return calls and communication is poor. But everything else they were happy with.

The service supported people to access the community. One person we visited told us they go on shopping trips every week… "I like to look in the shops and sometimes I buy some clothes." The person went on to say that sometimes they decided not to go as their mobility was not as good as it was. We saw the person received input from a specialist nurse to help and support them with their condition.

The service used advocates to interpret where needed. Staff had use of the service's mobile phones which were used as a way of monitoring visits. In addition, the service translated care plans and services user guides in another language when required..

The service ensured that people had access to the information they need in a way they could understand it

and were complying with the Accessible Information Standard (AIS). The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can understand information they are given. We saw where people were unable to communicate effectively, alternative communication aids were used. For example, one person used a light-writer and staff understood how this worked. In addition, different fonts, languages or braille were available to enable understanding where needed.

The service was able to support people at the end of their life. We were told there was no one receiving end of life care at the time of our visit. Do not attempt cardiopulmonary resuscitation (DNACPR) orders were in place in some care plans we viewed.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have robust systems to monitor the quality and safety of the service. Systems did not enable the provider to identify that safety of people using the service was compromised. Spot checks were carried out by senior staff but did not highlight the concerns we found. These included the serious issues outlined in the Safe domain of this report. Systems for identifying risks and issues were ineffective. The service put people at risk because of poor monitoring and management of food and fluid intake.

We received further information following our inspection in relation to the management of the service. We received information that the registered manager was no longer working at the service.

Following our inspection, we requested further information from the provider. They requested more time to provide the information we requested. We gave the provider more time as requested. However, we did not receive this within our specified timeframe. We reviewed this action plan and found it addressed some of the issues we found, however we remained concerned about people's safety in relation to medicines management. We also remained concerned about the level of oversight and governance because the plan was not specific in how learning would be shared and embedded across the organisation.

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

Staff told us they had seen improvements in the service. One member of staff said, "I 've worked here before, I can definitely see a difference now." Another member of staff told us, "We 've improved definitely." Staff spoke about the service being a good place to work. They told us they received regular supervisions and had access to training opportunities.

A relative commented, "Well I have to say it has improved over the last year but it was awful before so it's not saying much."

Spot checks were carried out by management to ensure staff were competent in their role and to identify any training needs. However, monitoring did not identify issues we found. We could not be assured that people's safety was protected. Following our inspection, we were made aware the provider had not acted in an open and transparent way with relevant persons in relation to care and treatment provided.

The service had access to care records as well as carrying out spot checks to ensure staff were competent in their role and care being delivered was a high standard. The service engaged with people using the service on a regular basis. This could be either formal meetings, following feedback, when carrying out spot checks or during telephone contacts.

The service worked in partnership with other agencies. We received positive comments from professionals involved with the service. The service shared appropriate information with other organisations for the benefit of people using the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate effectively an accessible system for identifying, receiving, recording and responding to complaints.

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 Sufficient quantities of medicines were not available to ensure the safety of service users and to meet their needs.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not enable the provider to identify where quality and safety were being compromised and respond appropriately without delay.

The enforcement action we took:

Warning notice