Carewatch Care Services Limited

Carewatch (Poole)

Inspection report

26 Parkstone Road
Poole
Dorset
BH15 2PG

Date of inspection visit:
08 September 2016
09 September 2016
13 September 2016

Date of publication:
10 February 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was announced and took place on 8, 9 and 13 September 2016. We told the provider 24 hours before our visit that we would be coming to ensure that the people we needed to talk to would be available.

Carewatch West Dorset provides personal care and support to people who live in their own homes. At the time of our inspection they were providing personal care to more than 100 people.

Carewatch West Dorset has a registered manager in post. 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.

This inspection was brought forward from the planned date due to a number of notifications from the service that calls to people had not been completed and safeguarding enquiries from the local authority about missed visits and concerns with medicines administration and concerns about one person who had had a serious accident whilst staff were present. At our last inspection in November 2015 we found breaches in the regulations relating the provision of person centred care and to the management of medicines. The provider submitted an action plan which stated that the service would meet these regulations by July 2016. This inspection was also carried out to check that the provider had taken the required action.

At this inspection we found that the registered manager had been temporarily seconded to another branch for over eight weeks with one day a week at the Poole branch, in addition to regular communication with staff in Poole. The deputy manager told us that they had spent a number of days at the same branch and also spent time supporting the branch from the office in Poole. We found that there were repeated breaches in the regulations relating the provision of person centred care and to the management of medicines. We also found additional breaches in three other regulations.

People we spoke with gave us positive feedback about the staff. They said the staff were kind and caring and they felt confident that the staff were knowledgeable about their role. Staff understood how to maintain people's dignity and treated people with respect. However, people's rights were not always protected because the service was not acting in accordance with the Mental Capacity Act 2005. This

shortfall was a new breach of the regulations.

Some people were still not always protected against the risks associated with the unsafe management and use of medicines. Medicine records for four people were checked. Errors and omissions were identified in each record and these had not been identified through the audit process that was in place. This was a repeated breach of the regulations.

Areas of risk in relation to matters such as leaving out medicines for one person and the use of equipment had not been identified by staff for three people and therefore suitable plans had not been put in place to reduce and manage possible risks. Other risks had been identified but the assessments had not been reviewed and updated following significant events or changes in people's needs. This shortfall was a new breach within this regulation.

Staff were recruited safely but the service had experienced a period of staff shortages and existing staff were working long hours to try to ensure that they provided a service to the people the service worked for. Some staff were not receiving regular supervision and support. Seven staff files were reviewed. One staff member had left and another was on long term absence. One staff member had not had any form of supervision since 20 January 2016, another since 5 August 2016. One person had received a number of spot checks and supervisions during their probation. None of the issues that were raised in these meetings were discussed at the probation review where they were taken on as permanent staff. Two further staff members had not received further supervision following disciplinary action being taken. Three other staff supervision records were picked at random. The most recent dates for either an appraisal, office supervision or spot check were December 2015, January 2016 and May 2016. Therefore staff were not receiving regular and effective supervision and support. This shortfall was a new breach of the regulations.

All of the people whose care records we examined were at risk of their needs not being fully met, because care plans and assessments were not up to date and lacked specific information about people's needs and how they should be met. This was a repeated breach of the regulations.

Quality monitoring systems were not effective and had not identified any of the issues found during this inspection. Some records contained errors and omissions and some were illegible: two care plans were not dated or signed, hand written records for the investigation of a complaint were illegible, 15 entries in daily records for one person were checked and there were no entries for three visits, 13 entries in daily records for another person were checked and two entries were illegible, 18 entries daily records for another person were checked and there were not records for two visits. This meant that staff may not always have important information available to them. This shortfall was a new breach of the regulations.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to

varying the terms of their registration.

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

You can see what action we told the provider to take at the back of the full version of the report.

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.

People were not always protected against the risks associated with the unsafe management and use of medicines.

The risks to people's health and safety whilst receiving care had not always been properly assessed, and for three people , action had not been taken to mitigate any such risks.

Systems were in place to protect people from harm and abuse. Staff knew how to recognise and report any concerns.

Staff were recruited safely but there was not always enough staff to make sure people had the care and support they needed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always receiving the supervision and support they needed. From the records we looked at, four of the five staff currently at work had not received regular supervision, and there were no systems in place to ensure that follow up actions were taken when issues with staff performance were identified.

People's rights were not always protected because the service was not acting in with the Mental Capacity Act 2005.

People were supported to have access to healthcare as necessary.

Is the service caring?

Good

The service was caring.

People received support from staff who were kind and caring.

Staff understood how to support people to maintain their dignity and treated people with respect.

Is the service responsive?

Inadequate

The service was not responsive.

Some people had not had their needs met and other people were at risk of their needs remaining unmet because care plans and assessments were not up to date and lacked specific information about people's needs and how they should be met.

The service had a complaints policy and complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not well-led.

The registered manager had not been available, in a full time capacity, to manage the service.

Quality monitoring systems were not effective and record keeping required improvements.

Carewatch (Poole)

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 checked 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 8, 9 and 13 September 2016. Two inspectors undertook the inspection. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff would be available.

Before the inspection we reviewed the information we held about the service; this included incidents they had notified us about. We also contacted the local authority safeguarding and contract monitoring teams to obtain their views. A Provider Information Return (PIR) had not been requested from the provider on this occasion. The 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.

We made telephone calls to people using the service, their relatives and staff. We spoke with 10 people or their relatives and six staff. We also spoke with the registered manager and four staff in the office who were involved in supporting people who used the service. We looked at seven people's care and medicine records. We saw records about how the service was managed. This included eight staff recruitment and monitoring records, staff schedules, audits and quality assurance records as well as a wide range of the provider's policies, procedures and records that related to the management of the service.

Inadequate

Our findings

People told us they were happy with the staff that looked after them and were confident that they were competent to provide the care and support they needed.

During the inspection in November 2015 a number of shortfalls in the management and administration of medicines were identified. The registered manager submitted an action plan following our inspection which identified the work that was needed to be done and confirmed that the service would meet this regulation by July 2016. At this inspection we found that any improvements which had been made had not been sustained and further issues were also identified.

Four of the people whose care records we examined had skin conditions and had been prescribed topical creams to treat this. One person had a care plan that stated that topical creams were to be administered at every visit. There was no information in the care plans for the other three people. The Medicines Administration Record's (MAR) for each person stated which area of the body each cream was to be applied to. However, there was no guidance in place either in a care plan or on the MAR to ensure staff applied the correct amount or followed other requirements such as leaving on the skin or rubbing into the skin. One person was receiving five visits per day. They were prescribed five different topical creams. It was difficult to determine how often two of the creams were to be applied but these had only been signed for once a day on the MAR. The other three creams had been signed for on the MAR at four different times of day; morning, lunch time, tea time and bed time. The care plan stated that creams should be administered at every visit and staff entries in the log book at every visit said that creams had been administered. However, there were only four times a day on the MAR and not the five that should have been present if staff were recording this medicine correctly. This meant that people may not have received some of their medicines as prescribed.

MAR (Medicines Administration Record) charts were created from care records held in the office which were printed and sent to each person's home in time for staff to use from the beginning of each month. Office staff checked and signed the MAR's before they were sent. Some of the records we checked showed that people had been prescribed additional medicines part way through the month. In this situation, staff had handwritten the new medicine onto the MAR chart. We found that they had not fully recorded the names of the medicines, strength of the medicines or the times it should be administered and that entries had not been checked and signed by a second member of staff to ensure that the correct instructions were being followed. We found that one medicine had been prescribed to be taken twice a day. The MAR only identified for staff to give this once a day, in the morning. Nobody had recognised that it was incorrect and therefore the person was not receiving the dose that had been prescribed for them.

There were occasions where staff took medicines out of the original container and left them in a container for the person to take at a time when staff were not there. This had not been risk assessed. In some instances, staff were signing the MAR to say that all medicines had been taken when they had not witnessed this to be the case.

One person had been prescribed medicines which must be taken at specific times. There was no recognition of this in a care plan. Daily records showed that out of 15 calls made, four were made within the 15 minute period before or after the stated the arrival time for the call. There were eleven occasions when staff visits were either too early or too late for them to support the person with taking their medicine at the correct time.

Staff had been trained in the administration of medicines and records showed that their competency to administer medicines safely had been checked regularly. They were regularly "spot checked" by a more senior member of staff whilst providing care to ensure that they were following the correct instructions for medicines and keeping suitable records. However, during their spot checks none of the shortfalls identified during this inspection had been highlighted. A spot check is an unannounced check on the staff member to observe their competence.

One person was prescribed an item to be taken in a variable quantity. Where items were prescribed in variable quantities, the actual amount administered was not clearly recorded on the MAR and there was no information about the maximum amount to be administered within a given period of time.

Completed MAR's were returned to the office at the end of each month and all of them were audited. The audit checked that staff had signed for any medicines given, had used the correct codes when medicines were not given and whether there were any omissions. The system of checking the MAR did not always ensure that handwritten additions to the MAR were properly recorded, signed and counter signed. Where issues were identified there was a record of contact with staff to explore the issue. However, there was not always a record of the outcome of the investigation.

This meant that people may not have received some of their medicines as prescribed.

This was a repeated breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected against the risks associated with the unsafe management and use of medicines.

There were systems in place to manage risk but these were not always operating effectively. Three people had items of equipment such as bedrails in place. The service had not carried out a risk assessment to ensure that the equipment was fitted and worked safely and that any risks either to the person or staff were identified and managed correctly.

An accident record showed that a person had fallen whilst on a trip with a member of staff. Their falls risk assessment had not been reviewed and updated following the incident.

These shortfalls were a breach of Regulation 12(2)(a) and 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the risks to people's health and safety whilst receiving care had not been properly assessed, and action had not been taken to mitigate any such risks.

This inspection was brought forward from the planned date due to a number of notifications from the

service that calls to people had not been completed and safeguarding alerts from the local authority about missed visits and concerns with medicines administration and concerns about one person who had had a serious accident whilst staff were present.. The registered manager told us that there were enough staff employed to provide care for everyone they looked after. However, they also confirmed that staff were working more hours, outside of their usual availability, because they were trying to cover for staff absences and recent difficulties in recruiting suitable staff. This meant that staff did not have regular rounds and people were receiving a number of different staff who did not always know them rather than a few regular staff which was the registered manager's aim. They also stated that, until the week of the first day of the inspection, they had not been able to recruit the number of staff required in the office to plan visits and arrange staff rotas. Two staff said that they were very tired and were afraid that they may make mistakes because of this.

We looked at the circumstances surrounding all of the missed visits and found that these were all except one were due to late changes in the rota, poor communication between office staff and care staff or care staff misreading their rota. A relative told us, "They always come on time. Over the summer they sometimes missed [a call], but that was due to being short staffed, people on holiday and sick and that but it was only for three or four weeks and they told me in plenty of time". Another relative told us, "[I] receive a weekly rota telling me who will be coming and when. Often the person and the times get changed with no notice. For example, both this morning and yesterday morning a different person arrived." This was an area for improvement.

The service had a satisfactory system in place to ensure that recruitment practices were safe. Records for four people who had been recruited to work as staff were checked. We found that procedures had been followed; each person's file contained proof of identity including a recent photograph, a Disclosure and Barring Service check and evidence of people's good character and satisfactory conduct in previous employment. They had also completed fitness to work questionnaires and provided evidence of their right to work in the United Kingdom where necessary. This made sure that people were protected as far as possible from individuals who were known to be unsuitable.

The service had satisfactory policies and procedures in place to protect people from abuse. Staff received regular training in safeguarding and whistleblowing and information about this was included in the staff handbook which was given to all staff. Staff knew the different signs and symptoms of abuse and told us they were confident about how to report any concerns they might have. The registered manager had made notifications to CQC of any concerns that they had reported to the local authority and discussed with us the lessons that had been learned from previous safeguarding investigations.

Requires Improvement

Our findings

People said that staff were kind, caring and understood their needs. One person commented, "The carers are all excellent. They know what to do and if there is a new person I tell them how I like things, like in the bathroom, and they do it".

At the last inspection we found that staff had received regular supervision either through spot checks, informal and planned meetings in the office and an annual appraisal. At this inspection we found that these were not always up to date because the registered manager and deputy manager had not been working full time at the branch. Some staff had acted up as senior carers and undertaken spot checks. Existing senior staff had carried out some one to one supervisions with staff. We looked at 10 spot check records for five staff. Six spot check records showed that issues and concerns had been identified. However, where staff had then received supervision, the issues had not been addressed and followed up. There was no system in place to review the spot checks and supervisions and identify where there were performance issues. Three staff had received warnings due to incidents that had occurred. We found that, these had occurred whilst the two of the staff were working through their induction period but the incidents had not been discussed or evaluated before their permanent employment had been confirmed.

This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff were not supported by effective supervision to ensure that their competence was maintained.

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 make decisions for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when required. 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.

At the last inspection we found that the service did not always follow the required processes when caring for people who may lack capacity to consent to receiving care. The registered manager and staff had completed update training since the last inspection. Examination of records and discussions with staff highlighted that there was still not always a sufficient understanding of the processes to assess capacity, make decisions in people's best interests where necessary and to accept that people have the right to make unwise decisions. At this inspection we identified that there were five people who may have lacked capacity receiving care from the agency but no assessments, best interests decisions or care plans had been

completed to ensure people were protected.

This was a breach of Regulation 11(1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the agency was not acting in accordance with the Mental Capacity Act 2005.

People and relatives confirmed that staff always checked with the person before providing care and gained their consent to provide the care needed. Care plans contained consent forms and these had been signed by the people receiving care.

People were supported to maintain good health. People gave us examples of health professionals such as occupational therapists; GP's and district nurses being contacted by staff on their behalf when they requested it or when their care worker identified a concern.

People told us that they were supported to have enough to eat and drink. They said that, where preparing food and drinks was part of their care package, staff would offer them choices and ensure that they had any necessary support to eat their meals.

Good

Our findings

People and relatives told us they received a caring and personal service from Carewatch Poole. They said that there was a core group of staff that they felt they knew and who knew them.

Discussions with the registered manager and other senior staff showed that they were aware of people's preferences, likes and dislikes, although assessments and care plans did not always reflect the detail which the staff were aware of. This meant that not all staff would be able to provide the same level of care because they did not have sufficient information in the care plans. This was an area for improvement.

Everyone said they felt that their privacy and dignity was preserved at all times when receiving personal care. One person told us how staff kept them covered with a towel as much as possible when helping with personal care.

All of the people and relatives that we spoke with confirmed that they had been consulted about their care plans and were involved in making decisions about their care. They also said their needs were met by the staff that visited them.

Staff confirmed that they knew about requirements to keep people's personal information confidential. People confirmed that staff did not share private information about other people with them.

Inadequate

Our findings

People told us that staff asked them how they liked their care to be provided and that, if they wanted their care completed in a particular way, staff would listen to them and respect their preferences.

Five people also raised concerns that their rota's were often changed with little or no notice or that staff arrived late with no communication from the service that they were coming but would be late.

At the last inspection we found that people's care needs were not always fully assessed and planned for. For example, people with conditions such as diabetes, dementia, Parkinson's disease and multiple sclerosis did not have care plans outlining what the condition meant to the person, how it affected them, how it may progress and any risks or possible complications that may occur. Information leaflets about some conditions were included in people's care plans but these were not specific to the person and did not cover all aspects of some conditions. The registered manager submitted an action plan following our inspection which identified the work that was needed to be done and confirmed that the service would meet this regulation by July 2016. However, we found that people's assessments and care plans still did not fully detail all of their needs and how they should be met.

At the last inspection, the care plan for a person with diabetes stated they were at risk of hypo or hyper glycaemia but there was no information about the signs or symptoms of these, the action to take if this occurred, or any other risks associated with diabetes. There was also no information about the medicines the person took to manage their condition or how the timing of their meals affected their condition. The person also told us that they needed their tea time call within a certain time frame to ensure they ate within a suitable period to manage their diabetes. Visit records showed a variation in the times the staff arrived for the tea time call. The person told us they often made their own meal, although this was very difficult for them to do, because the rota showed that staff would not arrive in time and they were worried about becoming ill if they did not eat on time.

At this inspection we found that brief notes had been added to the care plan that stated which type of diabetes the person lived with and that they self-administered their medicines. There was no information in the care plan indicating that the times of the visits were important to ensure the person was able to eat and take their medicines at specific times. A risk assessment stated that the risk to the person from their diabetes was low. However, the assessment did not take into account the effect of not eating and taking medicines at the correct intervals could have on the person.
In addition, a person living with Parkinson's Disease and related health needs did not have a care plan to

inform staff about how this affected them, signs to look for regarding the progression of the disease and the importance of taking medicines at specific times. Daily records showed that the service did not always arrive at the correct time to administer the person's medicines. In addition the person had suffered illness requiring attention from the emergency services and a fall. The care plans and risk assessments had not been reviewed following these incidents. This meant that the person's needs were not being fully met.

Another person was very poorly and staff told us they were in the end stage of their life. Staff told us that the person was being cared for in bed, unable to move without experiencing high levels of pain. Whilst some staff had the experience and knowledge to give the person pain relief medicines before providing necessary personal care, there was no information in the care plan to ensure that all staff did. This meant that the person's needs were not always fully met because care plans and assessments were not robust.

The agency had started to provide a package of care for a person a month before the start of the inspection. We found that the service had relied upon assessment and care needs information from the local authority and had not carried out an assessment and put in place a care plan ready for the start of the package. This meant that staff did not have adequate information to follow, the person's wishes and preferences had not been ascertained and included in the plan of care and the person's needs may not be fully met because care plans and assessments were not available for staff.

This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

There was a complaints policy and procedure that was given to people when they began receiving a service from the agency. People told us they knew how to complain and were confident that they would be listened to should the need to complain arise. The registered manager told us that they tried to work closely with people to try to resolve any issues and explained how they used any concerns or complaints that arose as an opportunity to learn and improve the service as well as to try to prevent further occurrences. There was a clear system for receiving, investigating and responding to complaints. We looked at four recent complaints and found that they had been responded to appropriately although the recording of the investigation, outcome and actions taken, for all of the complaints, was not always clear. This was an area for improvement.

Requires Improvement

Our findings

People and relatives gave us positive feedback about the staff and the care they received. However, they also told us that the service they received had been affected recently by staff sickness and shortages and that communication with staff and the office was poor. Staff were caring and motivated to provide a good service but felt that they could not always do this due to the perceived pressure to work more hours to cover colleagues and not having their branch manager available to ensure that the service ran smoothly and effectively.

A review of the history of this service showed that when the registered manager was working full time at the branch, the service ran well with very few missed calls, complaints or safeguarding enquiries. Prior to the inspection in October 2015, the registered manager had been temporarily seconded to help out at another Carewatch branch. They had only just returned to their own branch at the last inspection where we found two breaches of the regulations and advised that improvements should be made in two other areas.

At this inspection we found that the registered manager had been temporarily seconded to another branch for over eight weeks with one day a week at the Poole branch, in addition to regular communication with staff in Poole.. This inspection was brought forward from the planned date due to a number of notifications from the service that calls to people had not been completed and safeguarding enquiries from the local authority about missed visits and concerns with medicines administration and concerns about one person who had had a serious accident whilst staff were present.

Also, during this period, there were changes to the branch structure. The registered manager was not at the service to properly implement the changes, recruit staff to new roles and ensure that staff were working effectively.

We asked to see records of supervision and support that the registered manager had received from their line manager. The provider was unable to provide records for this

At this inspection we have found repeated breaches of two regulations and new breaches in three other regulations. The provider had not ensured that there was suitable leadership of the service whilst the registered manager and deputy manager were supporting another location.

There were arrangements in place to monitor the quality and safety of the service provided. However, these were not always effective. There were audits of various areas including medication, infection prevention

and control, accidents and incidents, care plans, complaints and health and safety. The audits completed had not always identified the shortfalls that have been found at this inspection. For example, audits of care planning and medicines had not highlighted that the requirements made at the last inspection had not been met.

Systems to assess, monitor and mitigate risks to the health, safety and welfare of service users and others who may be at risk from carrying on the service were not always effective. Accident records showed that a member of staff had suffered a needle stick injury from a needle for a prescribed medicine in a person's home. There was no information in the person's care plan about why there may be medical needles in the home or any support they may require to ensure that needles were stored and disposed of safely. Following the incident the care plan had not been reviewed and a risk assessment had not been completed.

During this inspection a number of different records were examined. These included care plans, daily records, medicines and staff records. Some records contained errors and omissions and some were illegible: two care plans were not dated or signed, hand written records for the investigation of a complaint were illegible, 15 entries in daily records for one person were checked and there were no entries for three visits, 13 entries in daily records for another person were checked and two entries were illegible, 18 entries in daily records for another person were checked and there were no records for two visits. This meant that staff may not be able to read important information or know who to ask if they had queries about the entries that had been made. We raised this issue with the registered manager at the previous inspection who advised us that this had been identified and action was being taken. Any improvements that had been made had not been sustained.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

Following this inspection the local authority visited the agency to monitor compliance with their contract to provide services to local people. The local authority confirmed that the registered manager had started to take action to address the shortfalls.

All of the staff we spoke to knew how to raise concerns and whistle blow. They told us that they had regular reminders in meetings and training about the whistleblowing policy and their rights under it. They were confident that any issues they raised would be addressed.

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 11 HSCA RA Regulations 2014 Need for consent Staff were not acting in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not supported by effective supervision to ensure that their competence was maintained.

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

The enforcement action we took:

issue a warning notice

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risks associated with the unsafe management and use of medicines. The risks to people's health and safety whilst receiving care had not been properly assessed, and action had not been taken to mitigate any such risks.

The enforcement action we took:

issue a warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

The enforcement action we took:

issue a warning notice