Atlas Care Services Ltd

Atlas Care Services Ltd Lincolnshire

Inspection report

Tate Business Park, Dozens Bank,
Pode Hole
Spalding
Lincolnshire
PE11 3LX

Tel: 01775660189

Date of inspection visit:
01 June 2017

Date of publication:
02 August 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Atlas Care Services Ltd Lincolnshire is registered to provide personal care to people living in their own home. Most of the people using the service are over the age of 65 and live in the Holbeach, Spalding and Long Sutton areas of Lincolnshire.

We carried out an announced comprehensive inspection of the service on 12 and 13 September 2016. At this inspection we found four breaches of legal requirements. This was because there were significant shortfalls in the organisation of staffing resources; the monitoring of service quality and the assessment and mitigation of risks to people's safety; the notification of significant incidents and the response to people's concerns and complaints.

Following this inspection, the registered provider ('the provider') wrote to us to tell us what they would do to address these breaches. We undertook this focused, follow-up inspection on 1 and 2 June 2017 to check that they had followed their plan and to ascertain that legal requirements were now being met. We also took the opportunity to review medicines management in the service in the light of two recent incidents involving people's medicines which had been investigated under the local authority's safeguarding procedures. At the time of our inspection approximately 350 people were receiving a personal care service from the provider

This report only covers our findings in relation to these issues. You can read the report from our previous comprehensive inspection by entering 'Atlas Care Services Ltd Lincolnshire' into the search engine on our website at www.cqc.org.uk.

On this inspection we found that the provider had not addressed two of the four breaches of legal requirements we identified in September 2016.

There was a continuing failure to organise staffing resources consistently and effectively to meet people's needs and expectations. There was also a continuing failure to effectively monitor the quality of service delivery and to fully assess and mitigate risks to people's safety.

We have taken action against the registered provider to ensure that they make the necessary improvements to become compliant with legal requirements. You can see what action we have taken at the end of the full version of this report.

We found that the provider had made changes to the way any concerns and complaints were handled and legal requirements in this area were now met.

We also found that the provider had introduced a new system to ensure CQC was notified of any significant incidents relating to the service and that, as a result, legal requirements in this area were now met.

There were systems in place to ensure people received any medicines they required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We found that the provider had taken insufficient action to improve the safety of the service.

There was a continuing failure to organise staffing resources consistently and effectively to meet people's needs and expectations.

This meant that the provider remained in breach of legal requirements.

There were systems in place to ensure people received any medicines they required.

Is the service responsive?

Requires Improvement

We found that the provider had taken sufficient action to ensure the service was responsive.

Improvements had been made in the response to people's concerns or complaints.

This meant that the provider was now meeting legal requirements in this area.

Whilst improvements had been made, we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice.

Is the service well-led?

Requires Improvement

We found that the provider had taken insufficient action to ensure the service was well-led.

There was a continuing failure to effectively monitor the quality of service delivery and to fully assess and mitigate risks to people's safety.

This meant that the provider remained in breach of legal requirements in this area.

Action had been taken to ensure CQC was notified of significant incidents involving people using the service.

This meant that the provider was now meeting legal requirements in this area.

Atlas Care Services Ltd Lincolnshire

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 was 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.

We undertook a focused, follow-up inspection of Atlas Care Services Ltd – Lincolnshire on 1 and 2 June 2017. This was to check that the provider had addressed four breaches of legal requirements we had identified at our comprehensive inspection of 12 and 13 September 2016. We also reviewed medicines management in the light of two recent incidents involving people's medicines.

The inspection was announced. The registered provider was given advance notice because the location provides a domiciliary care service. We did this because senior staff are sometimes out of the office supporting front line care staff or visiting people who use the service. We needed to be sure that they would be available to contribute to the inspection.

We inspected the service against three of the five questions we ask about services: 'Is the service safe?', 'Is the service responsive' and 'Is the service well-led?'. This is because the service was not meeting legal requirements in relation to each of these questions.

The inspection team consisted of one inspector and an expert 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. On 1 and 2 June 2017 our expert by experience telephoned people who used the service to seek their views about how well the service was meeting their needs. Our inspector visited the administration office of the service on 1 June 2017.

Before our inspection we reviewed the information we held about the service. This included the information

the provider had sent us following our inspection in September 2016, setting out the action they would take to meet legal requirements. We also considered notifications received (events which happened in the service that the provider is required to tell us about) and information that had been sent to us by other agencies.

As part of our inspection we spoke with eleven people who used the service, three relatives, the branch manager, the quality auditor, two care workers, and one of the directors of the registered provider. The registered manager was on holiday at the time of our inspection although we had email contact with him on his return. We looked at a variety of documents and written records including medication administration records, call scheduling analysis and information relating to the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

When we conducted our comprehensive inspection of the service in September 2016, we found that the provider had failed to ensure the safe and effective deployment of staffing resources and scheduling of care calls. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to this breach, the provider told us that they would increase the number of care coordinators employed in the service to ensure there were sufficient resources to schedule people's care calls and roster staff effectively. The action plan submitted by the provider at that time stated, "[A] fourth Care Coordinator has been recruited and is due to start in Dec 2016. [The] full team will then be in place." The action plan also stated that by 31 January 2017, 90% of all care calls would be 'templated' (allocated to a team of regular staff) to provide people with "an acceptable level … [of staffing] continuity."

However, during our follow up inspection of 1 and 2 June 2017, the majority of the people who spoke to us about this issue told us of their continuing concerns about the scheduling of their care calls, particularly the late arrival of staff. For example, talking to our expert by experience on the first day of our inspection, one person's relative said, "Well they should be here at 11.00am and it is now 11.50am. It is really frustrating." Another person told us, "They need to sort their times out. They are sometimes really late. It should be 5pm and it is sometimes 6.30pm. They don't let me know." Another person's relative recounted, "We had a carer booked for 10.00pm because we were going out for the evening. She had not arrived by 10.45pm so I had to call our daughter to help me put [name] to bed. It was very embarrassing for me [and] we never got an explanation." Talking specifically about the scheduling of evening visits, one person told us, "Some are not very punctual. It's a bit worrying for me when they are late for the night call. They don't let me know."

As additional confirmation that further action was required to improve the timeliness of people's care calls, when we reviewed the overall percentage of late calls (defined as late by 20 minutes or more), we saw that this had increased significantly since our last inspection – 10.5% of all calls in April 2017 compared to 4.3% in September 2016. This meant that, in April 2017 alone, 3510 calls were 20 minutes late or more.

People we spoke with had mixed views about the issue of staffing continuity. Some people told us this had improved since our last inspection. For example, one person's relative said, "We generally have the same [staff] now." Another person said, "[I] generally [have the same staff]. It helps to get to know them when you have the same ones all the time." However, other people told us that this remained an issue of significant concern that left them feeling frustrated and insecure. One relative commented, "[The care staff] change all the time. We never know who is coming. We would like to know especially for the evening call. We would feel more secure." One person said, "They never let me know who is coming. It annoys me so much and is very frustrating."

When we discussed these issues with the branch manager, she acknowledged that the provider's plan to improve call scheduling by recruiting a full team of care coordinators by December 2016 had not been achieved. She said, "We have never really had consistency with the care coordinators. We have only had two

or three to cover a four person job. [They] should have 800 hours each [to schedule every week] … [but] … some have had 1300 hours. It's only since 30 May (two days before our inspection) that we have had four coordinators. We have been running with one or two down since the last inspection. I feel some of the problems stem from that. [They have been] struggling and struggling to get the calls covered." At the time of our inspection, the newly recruited fourth care coordinator was undertaking their induction and the branch manager advised us that it would be "a few weeks" before they were fully operational within the team.

The branch manager also confirmed that the plan to improve staffing continuity by 'templating' 90% of care calls had not been achieved. She said, "At the moment [around] 70% of calls are templated. It's 90% in the action plan [but] the care coordinators are saying this is unrealistic. I have put it down to 80% to achieve it." Following our inspection visit, the registered manager confirmed that the total percentage of templated calls in the week beginning 19 June 2017 was 75.47%.

Almost nine months on from our previous inspection, it was clear that the provider had still not yet fully achieved the action plan they had drawn up to ensure the improvements required in the timing of care calls and continuity of staffing.

The provider's on-going failure to organise staffing resources consistently and effectively to meet people's needs and expectations was a continued breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this inspection we also took the opportunity to review the management of medicines within the service. This followed two recent incidents involving people's medicines which had been investigated under the local authority's safeguarding procedures. Everyone we spoke with during the inspection told us they were happy with the support they received from staff in this area. For example one person said, "The carers always prompt me to take them." Where staff assisted people to take their medicines they noted this on a medicines administration record (MAR) sheet. We reviewed some people's completed MAR sheets. These were generally completed correctly although the branch manager agreed to review the format of the sheet to make it easier to identify why people had not taken medicines that had been prescribed for occasional use. The provider conducted regular audits of the MAR sheets to ensure people were receiving their medicines correctly. We saw any issues identified as a result of these audits had been followed up with the staff member(s) concerned.

Requires Improvement

Is the service responsive?

Our findings

When we conducted our comprehensive inspection of the service in September 2016, we found that the provider had failed to ensure people's concerns and complaints were handled in a responsive and effective way. This was a breach of Regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to this breach, the provider told us that they would improve the monitoring of any concerns that were raised, to ensure they were either resolved or escalated to senior staff in a timely way.

On our follow-up inspection of 1 and 2 June 2017, the branch manager outlined the steps the provider had taken to ensure an improved response to any concerns raised. She explained that one member of staff had been given responsibility for monitoring the 'task list' that was used to track any concerns until they were fully resolved. The branch manager told us that giving this lead role to one person was proving effective in ensuring a more timely response to any issues raised. She also told us that the provider had adopted a similar approach to the logging and tracking of any formal complaints. We reviewed the provider's handling of recent complaints to the service and saw that these had been managed effectively in line with the requirements of the provider's policy.

Reflecting these changes, almost everyone we spoke with told us that they were satisfied with the provider's approach to managing any concerns or complaints. For example, one person said, "If I have any problems I speak to the manager and get my concerns across." Another person's relative told us, "I would contact the manager if I had to [but] I usually just speak to the carers." Talking positively about the provider's response to a specific complaint they had raised, another person said, "I complained about a carer fibbing. It was dealt with okay."

At our previous inspection, people had told us they were unhappy with the handling of any telephone calls they made to the office. On this inspection, although two people told us they sometimes experienced difficulty in getting through to the office, most people we spoke with said they were happy with this aspect of the service. For example, one person said, "If you leave a message they will always get back to you." Another person's relative commented, "We get through okay." Describing the attitude of the staff who handled calls to the office, one person said, "They always try to help." Another person told us, "They are helpful if I have to cancel because of hospital appointments."

Although further work was needed to ensure people's calls to the office were always answered promptly, we found that the provider had taken sufficient action to address the breach of Regulation 16(2). However, whilst improvements had been made, we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice.

Requires Improvement

Is the service well-led?

Our findings

When we conducted our comprehensive inspection in September 2016 we found that the provider had failed to effectively monitor the quality of service delivery and to fully assess and mitigate risks to people's safety. This was a breach of Regulation 17(2a and 2b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to this breach, the provider told us that they had revised and amended the system used to survey customer satisfaction, to improve the monitoring of service delivery.

On our follow up inspection of 1 and 2 June 2017 we reviewed the provider's revised approach to surveying customer satisfaction. We saw that a new questionnaire had been designed which gave people the opportunity to rate their experience of using the service against the five key questions used by CQC in our inspections. Senior staff used the questionnaire to survey people's views through home visits and telephone interviews and to capture the details of follow up action taken to address any individual concerns expressed.

However, the provider had not yet consolidated the feedback from these individual questionnaires to pull out overall themes and trends and identify priorities for service improvement. When we spoke to the provider's quality auditor she told us she had very recently developed a system which consolidated data from the individual questionnaires and highlighted the key feedback themes but was waiting for the registered manager to review and agree this new approach before it was implemented within the service. We reviewed the data that the quality auditor had gathered in developing the new system and saw that the issues of greatest concern to the people surveyed included continuity of staffing and timeliness of care calls. As reported elsewhere in this report, these were the same issues of concern that people expressed to us when we spoke to them as part of our inspection.

Almost nine months on from our previous inspection, it was clear the provider had still not fully implemented systems to identity and address people's feedback about the service they received. Reflecting this on-going failure to effectively monitor service quality, we found senior staff lacked insight into the continuing problems experienced by people using the service. For example, on the first day of our inspection, when we asked the branch manager what she thought people would tell us about service quality when we telephoned them, she said, "Hopefully people will say it's good. [I've] not heard anything else. I assume if there were any big problems they would have come through to me."

During our inspection we found further instances of the provider's continuing failure to effectively monitor the quality of service delivery. For example, we reviewed the log of formal complaints received. As described elsewhere in this report, each of these complaints had been investigated and a response provided to the complainant. However, there was no evidence that the provider had completed any analysis of themes or trends. This was despite the provisions of the provider's complaints policy which stated complaints would be, "Monitored and analysed to enable trends to be identified and acted upon." Given that the overwhelming majority of recent complaints related to late or missed care calls or a lack of staffing

continuity, another opportunity had been missed to gain an understanding of the reality of people's experience of using the service.

In response to the breach of Regulation 17(2a and 2b) we identified at our previous inspection, the provider also told us that they would take action to improve the systems used to review significant incidents and identify any action that could be taken to reduce the risk of something similar happening again. The action plan submitted by the provider at that time stated, "If future incidents occur, staff will be informed … to reduce future risk or repeat. All appropriate communication systems will be utilised to warn of identified risks and sent to all staff affected. For all future incidents, training course content will be considered as part of systems review as appropriate."

However, when we reviewed this issue as part of our follow up inspection, we found that the provider's approach remained inconsistent and still did not fully mitigate potential risks to people's safety. For example, in response to one recent serious incident involving a person who used the service, we saw that the provider had alerted all frontline care staff about the incident and provided them with guidance to reduce the risk of a repeat occurrence. However, despite the commitment given following our previous inspection, to review and update the content of staff training in the light of each serious incident, we found no evidence that this had been done in this case. When we reviewed the provider's response to another recent incident, there was no evidence that staff had been alerted or provided with any guidance to reduce the risk of it happening again. Again, there was also no evidence that the relevant training course had been reviewed to reflect the learning from this case.

Similarly, when we reviewed the provider's log of accidents and incidents involving staff or people who used the service, in 50% of the most recent cases, we found no record of any follow up action having been taken to reduce the risk of something similar happening again. This was despite there being a specific section on the provider's incident form which prompted staff to detail any follow up action. Neither was there evidence of any analysis of recent accidents and incidents to identify trends or themes which could have been used to reduce risks to people and staff in the future.

Taken together, the provider's on-going failure to effectively monitor the quality of service delivery and to fully assess and mitigate risks to people's safety was a continuing breach of Regulation 17(2a and 2b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On our previous inspection in September 2016, we found that the provider had failed to notify us of several allegations of abuse involving people using the service which had been considered by the local authority under its adult safeguarding procedures. This was a breach of Regulation 18(2)(e) of the Care Quality Commission (Registration) Regulations 2009.

In response to this breach, the provider told us that they had introduced a new 'safeguarding tracking and recording system' to ensure the necessary notifications were submitted to CQC in the future.

In preparation for our follow up inspection of 1 and 2 June 2017, we identified that there had been several cases in the previous nine months when allegations of abuse concerning people using the service had been considered by the local authority under its adult safeguarding procedures. We were pleased to see that, on each occasion, the provider had notified us of these allegations, as required by the law. We found therefore that the provider had taken sufficient action to address the breach of Regulation 18(2)(e).

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 17 HSCA RA Regulations 2014 Good governance There was a continuing failure to effectively monitor the quality of service delivery and to fully assess and mitigate risks to people's safety

The enforcement action we took:

A Warning Notice was issued requiring compliance in this area by 31 October 2017.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a continuing failure to organise staffing resources consistently and effectively to meet people's needs and expectations.

The enforcement action we took:

A Warning Notice was issued requiring compliance in this area by 31 October 2017.