Atlas Care Services Ltd

Atlas Care Services Ltd Wisbech

Inspection report

Office 22, 1 Harbour Square
Wisbech
PE13 3BH

Tel: 01945660809
Website: www.atlascare.co.uk

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11 April 2019
07 May 2019
20 May 2019

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

About the service: Atlas Care Services Ltd Wisbech is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older and younger adults. At time of the inspection a service was being provided to 149 people.

People's experience of using this service:

Risks to some people were not always managed safely. Risk assessments did not always identify what the risk was, or the action staff should take to reduce the risk. Risks to people were also increased because not everyone using the service had a care plan and for those who did, they were not always accurate.

People did not always receive visits from the care staff at the correct time. Some visits were late, and some did not happen at all. The provider had systems in place to prevent late and missed calls, but the management of the systems were not effective. This placed people's health and safety at risk.

People's medicines were not always managed safely. Not all medication administration records (MARs) had been completed accurately. Audits had not identified all issues with the MARs and where issues had been identified action had not always been taken in a timely manner. People were at risk of not receiving their medicines as prescribed.

Staff received an induction and shadowed a more experienced staff member when they started their employment. Staff lacked direction because they were not fully supported or supervised. Not all staff had a good understanding of the principles of the Mental Capacity Act 2005. This meant that staff may make decisions on people's behalf (when they lacked capacity to do so) without following the correct procedures.

Care plans provided by the local authority were in place. However Atlas Care Services Ltd Wisbech had not always completed their own care plans or reviewed the local authority care plans or their own to ensure they contained accurate information and reflected people's preferences. This meant that there was a risk that people were not receiving care in the way they wanted and in a consistent manner.

There was a lack of managerial oversight at the service and the governance systems in place were not always managed effectively. Where issues were identified, there was a lack of action to address them in a timely manner and these continued.

Recruitment procedures were followed to ensure the right people for the job were employed. Staff were aware of what action to take if they thought any one had suffered any harm. Staff were aware of the procedures to follow to prevent and control infection.

Rating at last inspection: This was the first inspection since the service was registered on 9 May 2018.

Why we inspected: This was a comprehensive inspection and had been planned to start in May 2019. However, due to receiving serious concerns from people using the service and other stakeholders this inspection was brought forward.

Enforcement: Refer to the end of the full report for action we told provider to take.

Follow up: 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 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 and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures which may lead to begin the process of preventing the provider from operating this service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led

Details are in our Well-Led findings below.

Inadequate

Atlas Care Services Ltd Wisbech

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
This comprehensive inspection was brought forward in response to information of concern that we received from a number of people using the service.

Inspection team:
Two inspectors visited people that used the service and spent time at the office. Another inspector made calls to staff to gather their opinions of the service. An expert by experience spent two days making calls to people who used the service to gather their views of the care they received from Atlas Care Services Ltd Wisbech. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector and one inspection manager returned to the office at the end of the inspection to feedback the findings to the providers representative and the manager.

Service and service type:
This service is a domiciliary care agency. It provides personal care to people living in their own homes. Not everyone using Atlas Care Services Ltd Wisbech receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager had not worked in the service since December 2018.

Notice of inspection:
We gave the service 2 days' notice of the inspection site visit in order for visits to people who used the service to be arranged and also to ensure that the manager was present when we visited the office.

Inspection site visit activity started on 15 March 2019 and ended on 20 May 2019. We visited the office location on 15 March and 07 May and 20 May 2019 to see the manager, provider's representative and office staff; and to review care records and policies and procedures and to feedback and discuss our findings.

What we did:
Before the inspection we reviewed and analysed information we had received about the service since it was registered. This included details about incidents that the provider must notify us about. We also assessed the information we require providers to send us at least annually, to give some key information about the service, what the service does well and the improvements that they plan to make. We used all this information to plan our inspection.

During the inspection we spoke with 12 people using the service and three of their relatives. We also spoke with 11 staff members, a field care supervisor, the quality assurance officer, the branch manager (the person managing the service in the absence of the registered manager) and the provider's representative.

We received feedback from Lincolnshire County Council as they fund some of the people who use the service.

We looked at records in relation to people who used the service including care plans, risk assessments and medication records. We looked at records relating to training, activities, meals provided, complaints and systems for monitoring quality. We looked at feedback provided by people using the service and staff.

After our inspection we asked the provider for further information and this was received within the requested timescale. This was reviewed and included as part of the inspection.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Using medicines safely
•Risk assessments were not always accurate, individualised or identified what the actual risk was. Although dates for review were included in the assessments, the reviews had not always occurred. This meant that staff did not always have the information they required to reduce risks to people's health and safety.
•One person had been assessed as being at very high of risk of developing pressure areas. Their risk assessments only contained general information about skin care and not how to reduce the risks of them developing pressure areas. The risk assessments did not include important information such as, where prescribed creams to reduce the risk of pressure areas developing, should be applied.
• Staff received training in medicines administration and had their competency checked to ensure their practice was safe. However, one member of staff was concerned that although they had attended the medication administration training they had not been shadowed by an experienced member of staff when administering medication to people to ensure they were following the correct procedures.
•Although there was a system in place to review completed medication administration charts they were often not reviewed in a timely manner. This meant that any mistakes or issues could carry on for long periods of time.
•MAR charts were not consistently signed by staff when they administered people's prescribed medicines. This suggested that people did not always received the medicines as prescribed. For example, the MAR for one person`s prescribed cream was left blank and not signed for a whole month. The manager was not aware of this and had no explanation or any evidence that actions were taken to address these issues. We found that one MAR chart had a hand-written entry on it for an additional medication to be administered. There was no signature of who had added the extra medication or explanation as to why.

The lack of robust risk assessments and failure to have an effective system to review medication records placed people's health and safety at risk. The above concerns demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment).

•Following receipt of the draft report the provider has stated that action has been taken to update all care plans and risk assessments. Any improvements made following the inspection will be assessed and reported on at the next inspection.

•One person told us, "I do feel safe. They (the staff) help me to shower and dress and I feel safe with them. They also come at lunchtime to check on me. One family member said, "The care is definitely safe. [Family Member] now has three carers which is a big improvement. The improvement since they moved to Wisbech is noticeable." Another person told us, "I feel safe, but I get different carers all the time."

Staffing and recruitment

•The majority of People spoke positively about having regular carers who knew them well. However this was not the case for everyone and some people felt they would benefit from having regular care staff. One person who said they did not receive regular staff told us that "Staff are often late or do not arrive at all."The provider stated after the inspection that they aimed to provide 90% of people's care by a regular group of carers. They also stated that they had audited six people's care in April and it showed that they were only meeting their aim of 90% in 66% of those audited. This meant that people did not always have continuity of care.
•Staff told us that when they received their rota of care calls the timings were not scheduled correctly which meant they were expected to be in more than one place at the same time. One member of staff told us, "I was expected to be in four places at the same time." This person went on to say that travel time between people was not allocated. We looked at the staff rota's and found for some staff this was the case. The representative of the provider stated that as a result of our feedback the rostering system had been changed so that calls did not overlap, and travel time was accounted for.
•People told us that they had experienced some, "missed calls" when staff had either not turned up at all or had been very late attending. The manager acknowledged that this had happened and stated that systems were already in place to monitor calls but further monitoring was being introduced at the service which should further ensure that calls are not missed in the future, as staff in the office will be alerted.
•Missed calls meant that people had remained in bed for long periods of time, had not received their medication on time and had not had food and drink prepared for them. This put people's health and safety at risk. Several people told us about the impact of receiving either a late call or missed call. One person told us, "They (staff) do turn up but they can be very late. My evening call is 8.15pm and they can be as late as 10pm at times." Another person told us, "On two occasions in the last two months I have had to ring them (the agency) as no one turned up. This is a problem for me as I am diabetic." Another person told us, I feel safe and secure with staff. I do have a minor concern about the continual turnover of personnel. They do turn up for call but can be up to 40 minutes late, though they do inform me. It is difficult to have any continuity with so many different staff. The provider stated after the inspection that calls are not considered late until they are 45 minutes past their scheduled time.
•Staff told us that when they were expected to work in pairs the second staff member was not always available. This meant that they had to rely on people's family members to be the second person to help them carry out tasks such as personal care or moving a person. The manager was aware that this had happened and stated that if some staff were absent at short notice they had to prioritise where staff went.

Failure to provide staff at the agreed times to people places their health and safety at risk. The above concerns demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

•Recruitment systems were effective and ensured suitable people of good character were employed to work at the service
•The provider stated after the inspection that systems have been updated to ensure that staff are allocated the correct duration for each visit and adequate travel time between visits is included. Any improvements will be assessed and reported on at the next inspection.
•The provider stated after the inspection that all care plans have been reviewed and updated. Any improvements will be assessed and reported on at the next inspection.

Learning lessons when things go wrong

•The provider had a lessons learnt log that was shared with the registered managers of all the branches.

Although there had been poor practice issues raised with the manager from the local authority the learning from these had not added anything to the provider's lessons learnt log. The manager stated that they had discussed lessons learnt with the care coordinator, but they had not recorded this.

Systems and processes to safeguard people from the risk of abuse
•People told us they felt safe when they were receiving care. One person told us, "Yes I do feel safe. They help me to shower and dress and I feel safe with them." Another person told us, I feel safe and secure with staff."
•Staff had received safeguarding training and they knew what to do if they have any concerns about the safety and welfare of the people using the service. They told us they would report any concerns immediately.

Preventing and controlling infection
•Staff received training in infection control and safe infection control procedures were followed.
•Staff were able to explain infection control methods and the use of personal protective equipment. We saw staff put on gloves and aprons before providing personal care to people.

Requires Improvement

Is the service effective?

Our findings

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience.
•Staff did not always receive adequate training or support to enable them to carry out their duties effectively and safely. Not all staff had attended their refresher training as required by the service for moving and positioning people, basic life support, infection control and food hygiene. This meant that there was a risk that staff were not aware of current best practice guidelines when supporting people in their own homes. The provider stated that their process was to book staff onto the next available course when refresher training was due. However this process had not always been followed.The provider stated that the training is kept under review and is changed in line with best practice.
•The provider's policy stated that staff should receive a supervision twice a year. Records showed that staff were not always receiving two supervisions a year. One staff member had started working in November 2018 and had not received a supervision but had received a phone call to check how they were.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
•As the service being offered was sometimes on very short notice from the local authority there was not always an opportunity for a full assessment to be undertaken by staff before the first care call started. However, an assessment was completed and supplied by the local authority so that staff could be aware of people's needs.
•Staff had a limited understanding of how some health conditions affected people in their day to day living. One person told us they didn't think that the staff understood their long - term health condition and how it affected them. Staff confirmed that they didn't know much about the persons health condition.

Ensuring consent to care and treatment in line with law and guidance.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

•Staff had received training in MCA. However, not all staff had a good understanding of the principles of the MCA or how it should be applied.
•Although staff worked with people living with dementia they could not explain how this condition may impact on people`s decision making and were unaware of mental capacity assessments or best interest decision making principles.

•One care plan stated that the person did not have mental capacity. This was not established by completing a decision specific mental capacity assessment. The manager was not aware that best interest decisions should be about specific questions. However, later on in the care plan the person had been asked to sign to say they consented to their personal care. The manager agreed that this contradicted the earlier information in the care plan.
•Some staff explained to us how they prompted people to make choices. One member of staff told us, "They still have the right to make choices and we cannot force them to help with choices. You ask people or show them (visual prompts). For example, what they would like to eat."

Supporting people to eat and drink enough to maintain a balanced diet.
•People told us that staff provided them with food and drink. One person told us, "They warm meals up for me, although they don't always ask me what I would like."
•One person told us that because the staff did not always arrive on time this affected their health condition as they needed to eat at regular times.
•Staff told us they were aware of what people liked to eat and drink and always checked the dates on food before serving it.
•Staff had received training in food hygiene.

Staff working with other agencies to provide consistent, effective, timely care.
•The manager stated that they had a no refusal contract with Lincolnshire County Council (LCC). This meant that they sometimes had to care for new people at short notice. They said that this sometimes caused logistical problems. The representative of the provider and manager met regularly with the LCC to discuss any issues and identify any improvements needed.

Supporting people to live healthier lives, access healthcare services and support.
•People we spoke with made their own health care appointments or had family who supported them to arrange these.
•Staff monitored people's wellbeing, such as their general health, and informed families or referred people to health care professionals if they identified any concerns.
•One person told us, "Since I've come out of hospital they have helped me to progress."

Requires Improvement

Is the service caring?

Our findings

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

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence.
•We received positive comments from people about how the staff treated them. People were positive and said that staff treated them with respect and promoted their privacy, dignity and independence. One family member told us, "They (the staff) certainly treat us with respect. They encourage [family member] with what they can do and help them with things they can't. They have got to know us well.
•A healthcare professional told us that a person raised concerns with them about confidentiality after hearing two staff talking about other people they provided care to. The manager was not aware of the issue and said they would discuss it with all staff to ensure it didn't happen again.
•A healthcare professional told us that a person had raised concerns with them about staff talking to them in an inappropriate manner and as if they were talking to a child. The manager was not aware of the issue and said they would discuss it with all staff to ensure it didn't happen again.

Supporting people to express their views and be involved in making decisions about their care.
•People told us that when they had regular staff they got to know them well and involved them in decision making. One person told us, "A lady came earlier this week and we did discuss some changes to my care which will be implemented soon." Another person told us, "They (office staff) come from time to time to do reviews and they ring up quite often too."
•The manager said that at present no -one had an independent advocate, but they would support people to access one if they needed assistance with making decisions.
•People had been asked their views on the service. However, timely action was not always taken in response to any concerns raised.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
•Care plans provided by the local authority were in place. However Atlas Care Services Ltd Wisbech had not always completed their own care plans or reviewed the local authority care plans or their own.
This meant that staff did not always have the information they needed to support people in the way they preferred. One person told us, "I don't know of any care plan. I never see anyone from the office." A second person told us, "Nobody has been to see me to review my care."
•Some care plans were missing important information which meant that staff did not know how people's health conditions affected them. For example, one person was living with dementia but there was no information in their care plan to explain the support needed from staff to meet their needs. The same person had a medication assessment which stated they sometimes had pain in their hands so would at times "Struggle." There was no explanation in the care plan about what support the person might need when experiencing pain in their hand.
•One person's daily notes showed that they had an area of sore skin. However, there was no information in their care plan about how this should be cared for.
•A healthcare professional raised concerns with us about one person not having a care plan or risk assessments in place. The manager confirmed that there was no care plan in place completed by the service. One person we visited as part of the inspection did not have a care plan in their home.
•For another person the care plan we looked at had been reviewed in June 2018 and changes in their needs were identified however these had not been added to the care plan. Although the care plan was due to be reviewed again in December 2018 this had not been undertaken. The manager stated that they were aware not all care plan reviews were up to date. The provider told us that of the 149 people the Wisbech branch provided a service to, 52 of the care plans were either not in place or needed updating to ensure they were an accurate reflection of people's needs and preferences.

Failure to ensure care plans were up to date meant that people`s needs may not have been met in a safe way or the way that they preferred. The above concerns demonstrate a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person Centred Care.)

When we met with the representative of the provider to feedback our findings of the inspection they informed us that they were planning to review and transfer all care plans to their new electronic system by August 2019. They stated that this would ensure that information was up to date, accurate and reviewed as necessary.

Improving care quality in response to complaints or concerns
•The provider had a complaints policy in place although this was not always being followed.
•There was no record of how some complaints had been investigated or what the outcome was.

•The local authority had raised "Poor practice issues" with the manager however, these had not been treated as complaints or used as opportunities to improve. Duty of candour had not always been followed to ensure that when needed people were told of the outcome of an investigation and when needed apologised to. The manager stated that they thought the local authority had provided this feedback to the individuals.
•The complaints procedure also states that all office staff would receive training regarding the complaints procedure. However, the office staff told us, they had not received training about dealing with complaints.
• One person told us, "I do phone them sometimes, but I don't feel they are listening to me. I'm never entirely happy with their response and answers when I speak to them.

Failure to operate an effective complaint procedure means that complaints may not be investigated thoroughly, or the necessary action taken to make improvements or ensure it does not occur again. The above evidence demonstrates a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Receiving and acting on complaints).

•End of life care and support
•The manager stated that the agency did not provide end of life care at present but if they considered it in the future they would ensure staff received the appropriate training.

Inadequate

Is the service well-led?

Our findings

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

•The providers policies and systems had not always been followed by the staff employed at the time of the inspection to ensure that people received their care calls at the time they were expected. The provider stated after the inspection that action had been taken to make the required improvements. Care and support were not in line with best practice and staff training and development was not always carried out in a timely manner.
•The provider did not keep the day to day culture of the service under review.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements ; Continuous learning and improving care. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

•Although there were processes in place to monitor and assess the quality of the service these were not being followed at the Wisbech branch. The failure to follow the processes had not been identified by the provider before the inspection. The provider has stated after the inspection that they have taken action to ensure the required improvements are made.
•The manager was not clear about their role and told us he had not had a formal induction into the role. The manager had not received any formal supervision since starting in their role. However, they had attended regular meetings with managers from other branches and staff in the operational team and regularly met with the directors of the provider. The manager told us that he had not identified areas for improvements and the action needed. He told us that he was waiting the outcome of the inspection before putting an action plan in place. The provider informed us that they had an action plan for the service. However the manager told us he was not aware of this.
•Although some quality audits had been completed with people who used the service, where concerns had been raised these had not been responded to.
•The provider had a lessons learnt log but no information had been added from the Wisbech branch.
•The manager had failed to carry out audits on a regular basis and therefore had not identified where lapses had occurred, such as inaccurate care plans and assessment and management of risks. Where audits had been completed and shortfalls identified, action had not been taken to address them. For example, although a person had raised a concern about missed and late calls this had not been investigated. The provider had not carried out checks to ensure that the quality assurance systems were being managed effectively. Following the inspection the provider stated that they have taken action to ensure the quality

assurance systems were managed effectively.
•Analysis of audits, complaints and poor practice records had not been carried out. This did not support continuous improvement or learning.
•The company policy was to have a staff meeting quarterly. However there had been no staff meetings since December 2018.

Failure to follow the effective governance systems in place has meant that the areas for improvement have not always been identified or the action needed to make improvements has not been taken in a timely manner. The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance).

•Following receipt of the draft report the provider stated that they complete audits six monthly and where trends emerge changes and actions are agreed. The provider stated that an audit commenced in April 2019 had produced a majority of positive scores.

Working in partnership with others

•The provider was meeting regularly with the local authority to discuss any issues they had about the service being provided.

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 9 HSCA RA Regulations 2014 Person-centred care Failure to ensure care plans are up to date means that people needs may not be met in safe way or the way that they prefer.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The lack of robust risk assessments places people health and safety at risk. Failure to ensure records are completed could mean that people do not always receive their medication as prescribed.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Failure to operate an effective complaints procedure means that complaints may not be investigated thoroughly or the necessary action taken to make improvements or prevent reoccurrence.

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 Failure to operative effective governance systems has meant that the areas for improvement have not always been identified or the action needed to make improvements has not been taken in a timely manner.

The enforcement action we took:

(1)□The registered provider must not provide personal care to any new service user without the prior written agreement of the Care Quality Commission.

(2)□On the first Monday of each month the registered provider must send to the Care Quality Commission a report detailing any missed or late visits to service users. This report must include details of what immediate action was taken to ensure service users' safety and what actions have been taken to improve the systems currently in place.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to provide staff at the agreed times to people places their health and safety at risk. Failure to ensure that staff have the knowledge and support they require to meet people's needs places people's health and safety at risk.

The enforcement action we took:

(1)□The registered provider must not provide personal care to any new service user without the prior written agreement of the Care Quality Commission.

(2)□On the first Monday of each month the registered provider must send to the Care Quality Commission a report detailing any missed or late visits to service users. This report must include details of what immediate action was taken to ensure service users' safety and what actions have been taken to improve the systems currently in place.