Atlas Care Services Ltd

Atlas Care Services Ltd Lincolnshire

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
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. The registered provider set up the service in 2015 to take on a major new contract awarded by Lincolnshire County Council following a reorganisation of homecare services in the county. Under this contract, a large number of people who had previously received care from other agencies started to receive their care from Atlas Care Services Ltd Lincolnshire.

We inspected the service on 12 and 13 September 2016. The inspection was announced. At the time of our inspection approximately 380 people were receiving a personal care service from the provider.

The service did not have a registered manager. The service was being managed by the managing director of the registered provider ("the managing director") and a recently appointed assistant manager. Shortly before our inspection visit the managing director had applied to CQC to become the registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers ('the provider'), 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.

CQC is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and to report on what we find. Staff had received training in this area and demonstrated their understanding of how to support people who lacked the capacity to make some decisions for themselves.

During our inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to the deployment of staffing, the handling of complaints and concerns and the monitoring of service delivery. We also found a breach of the Care Quality Commission (Registration) Regulations 2009. This was because the provider had failed to notify us of significant incidents relating to the service.

You can see what action we told the registered person to take in respect of these four issues at the end of the full version of this report.

We also identified the need for improvements in staff training to ensure people who used the service, and staff from other agencies, had full confidence in the ability of staff to support people safely and effectively.

In other areas, the provider was meeting people's needs.

Staff had warm relationships with people they supported and cared for them in a kind and person-centred way. Staff knew people as individuals and supported them to have as much choice and control over their lives as possible. People were treated with dignity and respect.

People's care plans were very detailed and were understood and followed by staff. The provider had systems in place to ensure people's plans were reviewed and updated on a regular basis.

People were supported to eat and drink whenever this was required. Staff also assisted people to access local health and social care services if they needed specialist advice or treatment. Staff supported people to take their medicines in accordance with the guidance set out in their care plan.

Staff worked together in a friendly and supportive way and were provided with regular supervision, including direct observation of their care practice. Senior staff demonstrated a supportive and non-hierarchical style of leadership which was appreciated by staff at all levels in the service.

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

The service was not consistently safe.

The deployment of staffing resources and the scheduling of care calls were not managed safely and effectively.

Staff knew how to recognise and report any concerns to keep people safe from harm.

The provider assessed potential risks to people and staff and put preventive measures in place where these were required.

Staff administered people's medicines in accordance with the guidance provided.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some staff required further training, particularly in the use of certain items of equipment.

Staff understood how to support people who lacked the capacity to make some decisions for themselves.

Staff assisted people to eat and drink whenever this was required.

Staff worked closely with a range of local health and social care services to help people access specialist care and treatment if this was required.

Is the service caring?

Good

The service was caring.

Staff supported people in kind and caring ways that took account of their personal needs and preferences.

Staff knew people as individuals and supported them to have as much choice and control over their lives as possible.

Staff treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provider did not respond effectively to people's concerns and complaints about the service they received.

People had detailed care plans which were understood and followed by staff.

Senior staff reviewed people's care plans on a regular basis to ensure they remained up to date.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had failed to monitor service delivery effectively and act responsively to issues of concern.

The provider had failed to respond fully to a serious incident involving a person using the service.

The provider had failed to notify us of several allegations of abuse which had been considered by the local authority under its adult safeguarding procedures.

Senior staff had an open and non-hierarchical leadership style that was valued by their colleagues.

Staff worked together in a friendly and supportive way.

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 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.

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

The inspection team consisted of one inspector, a member of the CQC medicines team 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. Our inspector visited the administration office of the service on 12 and 13 September 2016. On 12 September the member of our medicines team visited the administration office and also spent time with people in their own home to observe staff supporting them to take their medicines. On 12 September the expert by experience telephoned people who used the service to seek their views about how well the service was meeting their needs.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report. We also reviewed other information that we held about the service as notifications (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, including the local authority.

As part of our inspection we spoke with 13 people who used the service, four relatives, the managing

director of the registered provider, the assistant manager, the medication coordinator and two care workers. We also spoke to a local healthcare professional who had regular contact with the service. We looked at a range of documents and written records including two people's care files, staff recruitment files, training records, medicine administration records and information relating to the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

Without exception, everyone we spoke with was extremely unhappy with the way in which the provider organised its staffing resources to cover their scheduled care calls. One person told us, "I told the agency it was important that I knew when my carers were coming. It started out alright but over the last few months it's got to the point that my morning call can sometimes only be half an hour before the next carer is due to make my lunch. That can't be right, can it?" Another person said, "I wish I [saw] the same carers every time. With the last agency that's exactly what happened but since Atlas took over the contract I have seen so many carers. It makes my life so much harder having to explain all the time what it is I need help with." Another person said, "I remember one missed visit about three months ago. Although there would probably be more if it weren't for the fact that I just sit on the phone to the office when the carers are running late, which happens most of the time." One person's relative told us his wife had a medical condition that meant she was unable to move independently. Expressing his frustration at the scheduling of care calls he told us, "She is supposed to go to bed at 9pm but they often come at 7pm. It's too long for her to be in bed. It really isn't good enough." Reflecting these comments, a member of staff told us, "Rostering is not brilliant. Weekends is awful. We haven't got enough staff to do it."

People told us that the problems with call scheduling sometimes made them feel unsafe and vulnerable in their own home. One person told us, "I can't really say that I do [feel safe] because you never know from one day to the next what service you are going to get." Another person said, "I only see my regular carers for half the week, if not less. Other than that I never know who is going to be coming through the door next. It's not very reassuring." Echoing these concerns, a member of staff said, "Sometimes people will ask me who they have got coming tomorrow. I have to say, "Sorry sweetheart, I don't know." They [shouldn't] have to ring the office to find out who is coming. You want to know who is coming into your home." At lunchtime on the first day of our inspection, the same member of staff told us that she had still to receive the following day's rota.

Some people also expressed their concern that poor call scheduling meant they weren't always able to take their medicines at the time specified on the prescription. One person said, "My tablets don't really get evenly spaced out because of the timings of my visits from carers." Another person told us, "I really need help putting my eye drops in at regular times morning and night. But it can be very difficult when the carers arrive at all different times."

We discussed these issues with the managing director and assistant manager who acknowledged people's concerns about missed and late calls and poor continuity of staffing. They told us that the scheduling and coordination of care calls was "in crisis" and described the action that was in hand to try to address the problem. However, the clear and powerful feedback given to us by people using the service indicated that the provider was still failing to deploy staffing resources safely and effectively to ensure people received the service they were entitled to expect.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other than the problems with call scheduling and the impact this had on the times they received their medicines, people who were assisted by staff to take their medicines said they were satisfied with the support they received in this area. One person told us, "Once they are here, I never have any problems having my tablets."

We looked at people's care plans and saw that senior staff had discussed people's medicines with them before they started using the service. They had also assessed and recorded the level of support needed. Care staff were given clear instructions on how to administer each person's medicines and they recorded when this had been done. We observed a staff member give one person their lunchtime medicine and saw that they did this correctly in accordance with the guidance provided. The provider's medicine policy was available to staff electronically in the staff handbook, although the provider acknowledged that this was overdue for review. Staff received training in medicines as part of their induction to the service and had also recently received refresher training in this area. Senior staff reviewed the completed medicine administration record sheets. This review process had identified that the sheet currently in use in the service was not easy for care staff to use and a new version was being developed. The provider also had systems in place to record and investigate any medicines errors, with additional training or supervision provided to staff as required.

Before someone started receiving a service, a senior member of staff normally met with them to agree a care plan to address their personal needs and wishes. As part of this process, a range of possible risks to each person's wellbeing was considered and assessed, for example risks relating to mobility or nutrition. We saw that each person's care record detailed the action staff were expected to take to address any risks that had been identified. For example, one person had been assessed as being at risk of developing skin damage and staff were asked to check the person's skin carefully every time they provided the person with personal care. Staff were aware of the assessed risks and management plans within people's care records and used this information to guide them in their work. One member of staff told us, "[The care plan] tells us step by step what we need to do."

When completing each person's care plan, the provider also assessed the person's home environment to identify any possible risks to staff, many of whom worked on their own. For example, if any additional equipment was needed to ensure the safety of the person or staff. Staff also had 24-hour access to a senior member of staff if emergency advice or assistance were required.

Staff told us how they ensured the safety of people who used the service. They were clear about to whom they would report any concerns and were confident that any allegations would be investigated fully by the provider. Staff said that, where required, they would escalate concerns to external organisations. This included the local authority safeguarding team, the police and the Care Quality Commission (CQC). Staff had received training in how to keep people safe and there were policies and procedures in place to guide staff in this area. Advice to people and their relatives about how to raise any concerns was provided in the information booklet that was given to people when they first started using the service.

The provider had safe recruitment processes in place. We examined three staff personnel files and saw that references had been obtained and other pre-employment screening completed. Security checks had also been carried out to ensure that staff employed were suitable to work with the people using the service.

Requires Improvement

Is the service effective?

Our findings

New members of staff participated in a four day classroom based induction programme followed by a period of shadowing experienced colleagues before starting work as a full member of the team. Commenting on their own experience of joining the service, one member of staff said, "[My induction] was helpful. Particularly learning to use the medicine recording sheets." The managing director was aware of the national Care Certificate which sets out common induction standards for social care staff and told us that work was in hand to build this into the staff induction programme in the future.

The provider maintained a record of staff training requirements and organised a programme of regular training events to meet these needs. Discussing their experience of a recent training event, one member of staff said, "The training wasn't too bad. It refreshes your memory a bit." The provider also encouraged staff to study for nationally recognised qualifications. The managing director told us, "We expect all staff to be at least NVQ2 and automatically enrol people when we can."

However, despite the provider's structured approach to staff induction and training, people had mixed views about the ability of some staff to meet their needs effectively. One person told us, "Most of the carers know what they are doing." However, another person said, "The newer carers will often just stand around not knowing what to do." Another person's relative told us, "The carers who have been with the agency for a long time all know what they are doing. But some of the [newer] carers are sent out to clients before they are ready. My mum will only let her two main carers bath her and will sometimes go a week and a half between baths because she doesn't think the [newer] carers know how to use the bath lift properly." This concern about the effectiveness of training in the use of people's equipment was confirmed by a local healthcare professional who had regular with service and told us that some staff needed more training in this area. Although the provider said that all staff had up-to-date training in this area, in the light of the feedback we received, further action was clearly needed to ensure every member of staff had the all the skills necessary to inspire confidence in the people they supported and the professionals they worked alongside.

Care staff received regular one-to-one supervision from senior staff. Some supervision sessions were in the office whilst others involved direct 'spot check' supervision of the staff member's care practice in a person's home. Describing their experience of the spot check process, one member of staff said, "It can be helpful. Sometimes you get feedback, such as the need to write more in the [daily communication log]. I've had two with Atlas and I think they were happy with me!" Reflecting on their last office-based supervision which had taken place the previous week, another member of staff told us, "It was good. You can raise any issues or problems."

Care staff demonstrated their understanding of the Mental Capacity Act 2005 (MCA). This 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. Staff confirmed they understood the importance of obtaining consent before providing care or support. For example, one staff member told us,

"When I am helping someone to get dressed I always ask them what they fancy wearing that day. It's important to give people choice."

We also discussed the MCA with the managing director and the assistant manager. They told us that they had not initiated, or been involved in, any 'best interests' decision-making processes for anyone who used the service. The assistant manager acknowledged that this was an area in which she lacked recent experience. She agreed she needed to take action to update her knowledge, in case she needed get involved in any best interest decision-making processes in the future.

Staff assisted people to eat and drink whenever this was required. Each person's care plan detailed any particular preferences and these were understood and respected by staff. For example, one person's care plan instructed staff on a tea time visit to make the person an evening meal of their choice and refill their drink. Staff told us that they tried to offer people as much choice as possible in what they had to eat and drink. One staff member said, "If someone has frozen ready meals I will bring a selection out and say, 'Today's selection is…!' It's not a brilliant choice, but at least it's a choice." Confirming this approach, one person told us, "My carer makes me breakfast, lunch and dinner. She will always ask me what I would like to eat." The provider had assessed any risks relating to people's nutrition and, where necessary, clear guidance was set out in the person's care plan for staff to follow. For example, one person had been identified as being at risk of malnutrition and staff were instructed to prepare them a meal on every visit. Staff were also alert to the risk of dehydration in older people. Reflecting on their approach in this area, one staff member said, "I always leave a drink out on the side [before I go]. Just to make sure they don't get dehydrated."

Staff worked alongside a range of local health and social care professionals including community nurses, GPs and occupational therapists to help people access any specialist care and treatment they required. Staff told us of occasions when they had been concerned about a person's health and had contacted the district nurse or GP to ensure the person received the treatment they required.

Good

Is the service caring?

Our findings

People told us that the care staff were caring and kind. One person said, "My carers are my lifeline because I only see [my family] occasionally." Another person's relative told us, "The two main carers who look after my mum are lovely and she gets on really well with them. I just hope they stay with the agency."

People also told us that staff knew them as individuals and often used this knowledge to help them in ways that reflected their personal needs and wishes. For example, one person said, "They will usually put my towel on the heater so I have it ready once I get out of the shower. It's only a small thing but it does make a difference." Another person told us, "They make sure the water is nice and warm for my bath as they I know I don't like it cold." Talking about a person she supported on a regular basis, one staff member said, "The other day [she] asked me if I could bring her some chips. I brought her some from the chip shop and I have never seen her eat so quickly. She loved it!"

Staff were committed to helping people to maintain their independence and exercise as much control over their lives as possible. For example, one member of staff told us, "One lady always tells me to leave the pots [after a meal]. Even though it's part of my duties it makes her feel better doing it herself." Another member of staff said, "It's important not to mother people too much. I encourage [her] to walk on her own [but] with my hand gently on her back." Confirming the approach of staff in this area, one person told us, "I can look after myself perfectly well once my carer gives me my food. [But] she will always make my hot drinks for me as the kettle is a bit too heavy to lift these days."

People told us that staff supported them in ways that maintained their privacy and dignity. One person said, "They will always make sure the curtains are drawn at night before they start helping me to undress." Another person told us, "They always ring the doorbell before they open the door so that I don't worry about who is coming in." Describing their approach to providing people with personal care, one staff member said, "I always put a towel over their legs and close the door and curtains."

The provider had systems in place to maintain confidentiality in relation to people's personal information. For example, people's personal files were stored securely in the administration office and computers were password protected.

The assistant manager was aware of local advocacy services. She told us that she had not been asked to help someone secure the support of an advocate but would not hesitate to make contact with local services if necessary. Advocates are people who are independent of a service and who support people to make and communicate their wishes. The managing director agreed to add details of advocacy services to the information booklet that was given to people when they first started using the service.

Requires Improvement

Is the service responsive?

Our findings

The provider's 'customer charter' was included in the information booklet that was given to people when they first started using the service. In this document it was stated that, "As part of our approach to service delivery and customer care the following … values and behaviours… are critical to the success and future of the company." We noted that two of these 'values and behaviours' were to ensure people using the service were "dealt with promptly and efficiently" and had "recourse to an effective complaints system should [they] be dissatisfied with the standard of service."

However, despite this clear commitment to responsive customer service, the people we spoke with were very unhappy with the response they actually received whenever they raised concerns. For example, one person told us, "Every time I manage to have a conversation with a manager, I will try to tell them about how poor their service is. The manager will invariably nod and say she will look into it urgently and address the issues. But then time will pass and it will just return to their old ways again." Another person said, "I've never been able to get anything useful out of anybody who works at the office. Even just trying to find out where my carer is proves difficult. I fail to see why they can't keep account of where their carers are."

People also expressed their dissatisfaction with the provider's response to telephone calls they had made to try to discuss issues or concerns. One person said, "When I have tried to phone the office, the phone will usually ring for a long while before someone picks it up. When they do, they don't know anything. They promise to ring back and never do." Another person told us, "I've lost count of how many times I have phoned the office over the last few months to find who is coming to look after me or what time they are going to arrive. If you get through they never know the answer and will usually just say they are on their way." Discussing their experience of using the provider's out of office hours telephone number, one person said, "I tried to phone [it] the other evening. The number just rang and rang. It then went dead so I couldn't even leave a message to get somebody to ring me back." Similar frustrations were shared by staff. For example, one staff member told us, "I ring the coordinators [in the office]. I always get someone different. [Last week] I spoke to three different people and had to explain [my issue] three times."

Although we saw that there were systems in place to ensure any formal complaints were managed in accordance with the provider's complaints procedure, people told us that the provider's repeated failure to respond effectively to their concerns made them reluctant to invest time and energy in taking matters further. For example, one person said, "I am fed up with complaining and nothing ever being done about it, so what is the point?" Another person said, "I know far too well how to make complaints but I've become so cheesed off with the whole service that there isn't really any point any more. It would be a waste of my time." Another person told us, "I certainly know how to complain but when I just keep getting ignored there is very little else I can do. I am so pleased you called today because I can tell you what I think and hopefully you will do something about it."

We talked to the managing director and assistant manager about the failure to respond effectively to people's concerns and complaints. The assistant manager acknowledged the shortfalls in the service provided by the office and said that she was taking action to ensure a better service in the future. However,

further significant improvement was required 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.

If someone had decided to use Atlas Care Services Ltd Lincolnshire for the first time, a senior member of staff normally met with them and their family to agree a care plan to address their personal needs and wishes. One person told us, "My care plan is in my folder. I remember having a discussion with the manager about what help I needed." Another person said, "I was asked about my [preferences] when I started with the agency and they have listened to me and respected my wishes."

We reviewed people's care plans and saw that they written in a very detailed way, enabling staff to respond effectively to each person's individual needs and preferences. For example, one person wanted their hall light left on all night and another person liked one sugar in their coffee. Care plans were understood and followed by staff when they provided people with care and support. For example, one person had asked that staff help them with their open fire and, reflecting this request, we saw that staff recorded whenever they had put fresh coal on the fire. One staff member told us, "The care plans have useful information and can help with communication. If someone has a particular interest, it can start a conversation."

Senior staff conducted regular checks to ensure that care plans were up to date and that the support provided by staff was line with people's agreed needs and wishes. The assistant manager told us that she was about to schedule a first round of annual care plan review meetings with people and their relatives.

Staff were aware of people's individual needs and wishes which enabled them to provide support in a responsive way. One person told us, "The carers are good and will chat to me while we are doing all the jobs that need to be done." Describing their approach, one member of staff told us, "I like looking after people and doing the best I can [for them]. I get to know their routines and little ways." Reflecting on their interaction with one person who was living with dementia, another staff member said, "[She] loves her teddy. I kiss and cuddle the teddy and sit it down to watch telly. [She] gives it a tissue and we sing together."

Requires Improvement

Is the service well-led?

Our findings

Everyone we spoke with told us they were extremely dissatisfied with the way in which the service was managed and the negative impact they felt this had on the quality of the care and support they received. For example, one person said, "There is no way I would recommend this agency to my worst enemy! The regular carers are lovely but they are badly let down by the management side." Another person told us, "I used to run a business and if I'd been as bad at it as these people, I'd have been bankrupt a long time ago." Another person said, "If there were another agency that covered the area where I live, I would have moved my care a long time ago."

Both the assistant manager and managing director were quick to acknowledge and accept people's feedback and told us that they were committed to addressing the concerns that had been raised with us. The managing director said, "We need to focus on the clients. They need to be at the centre of what we do. It's really unfortunate that we haven't got that balance [at the moment]."

The provider had a number of systems in place to monitor the quality of service delivery but we found only limited evidence that action had been taken in response to any issues identified. For example, 'service quality spot checks' and 'customer quality audits' were used to gain people's feedback on the service they received. We reviewed some of the comments people had made and saw that when concerns had been raised about very specific issues, such as requests to replace worn out equipment, these had been addressed by senior staff. However, when people raised their continuing concerns about call scheduling and the significant impact this was having on their lives, there was no evidence that the provider had analysed this feedback systematically to identify opportunities to improve the quality of people's experience of using the service for the future. Acknowledging these shortfalls, the assistant manager said, "We need to tighten up our data gathering and follow up action."

The provider maintained records of accidents and incidents that had occurred in the service. However, again, there was no evidence that senior staff had analysed these events to identify any trends or actions that might reduce the chance of something similar happening again. Most significantly, in response to a serious incident involving someone who used the service, the provider had failed to properly identify and implement the measures necessary to reduce the chance of a repeat occurrence and minimise the risk of harm to people using the service. For example, staff had not been briefed specifically on the issues involved in the incident to ensure they were alert to the possibility of something similar happening again. Additionally, the provider had not completed one of the follow up actions we had been assured would be taken in response to the incident. Acknowledging these further shortfalls, the assistant manager told us, "This is where we need to tighten up in future. Lessons learned need to be reflected in our practice."

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

The provider maintained records of untoward incidents or events which had been notified to CQC or other

agencies. However, in preparing for our inspection visit, we noted that in the previous 12 months there had been several cases involving people using the service that had been considered by the local authority under its adult safeguarding procedures but which the provider had not notified to CQC. The manager director apologised for the failure to submit the necessary notifications and told us he would ensure that these were submitted as required in future.

The provider's failure to notify CQC of these significant issues was a breach of Regulation 18(e) of the Care Quality Commission (Registration) Regulations 2009.

The service did not have a registered manager. The provider had appointed a manager but they had taken a period of extended leave before their application to become registered could be considered by CQC. Pending this person's return, the manager director had stepped in to provide direct management support to the service, and shortly before our inspection visit, had applied to become the registered manager himself. The managing director was based in the service office and had also recently recruited a full-time assistant manager to support him in the running of the service.

Throughout our inspection visit both the assistant manager and managing director demonstrated an open, non-hierarchical leadership style. Talking of the staff team, the assistant manager said, "We are all as important as each other." The manager director told us, "I am pretty hands-on. At the moment I am here every day." Their approach was clearly appreciated by staff. Describing her relationship with the managing director, one member of staff told us, "[He] is lovely, very nice. You feel you can talk to him without sitting on the edge of your chair." Speaking of the (recently recruited) assistant manager, another staff member said, "[She] is doing well."

Staff also told us that they felt supported by the other senior staff in the service. One member of staff told us, "[My supervisor] is helpful and supportive. They know their stuff [and] if I have any problems I go and talk to her." Another staff member said, "If I have any worries, I speak to [my supervisor] and she will listen."

Staff told us they worked together in a friendly and supportive way. One member of staff said, "I think we are a good team. I get on with everyone." Agreeing with this view, another staff member told us, "There are problems with the rota [which] needs to get better. But I think everyone is really happy. It's a good company to work for. If you've got a problem they will sort it out." Staff meetings were organised for each of the local teams and staff were encouraged to attend whenever possible. We reviewed the notes of recent meetings and saw that there had been an open discussion about a wide range of issues. Staff knew about the provider's whistle blowing procedure and said they would not hesitate to use it if necessary.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of several allegations of abuse relating to people who used the service which had been considered by the local authority under its adult safeguarding procedures.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure people's concerns and complaints were handled in a responsive and effective way.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to monitor effectively the quality of service delivery and to fully assess and mitigate risks to people's safety.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure the safe and effective deployment of staffing resources and scheduling of care calls.