St Gregory's Homecare Limited

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

Summary of findings

Overall summary

About the service
St Gregory's Homecare Ltd is a domiciliary care service providing personal care. 138 people were receiving care from the service at the time of the inspection. The service provides support to people living with dementia, learning disabilities and/ or autism, mental health needs, sensory impairments and physical disability and older people and younger adults across the Lancashire and South Cumbria areas.

Not everyone who used the service received personal care. The Care Quality Commission (CQC) only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where services provide this care, we also consider any wider social care provided.

People's experience of using this service and what we found
Although the provider had made improvements following the last inspection, people remained at risk of not receiving high-quality and person-centred care. The provider's systems and processes meant there continued to be shortfalls in the governance of the service and this placed people at risk of harm. The provider was not effective in monitoring all aspects of the service and driving improvement; their quality assurance system had not identified issues we found on inspection.

People were at risk of harm as they were not always protected against the risk of abuse. Actions by the provider and staff had led to safeguarding concerns being raised about the service. Risks to people were not always identified or managed effectively to keep people safe. The provider did not always have systems in place to ensure people received their medicines properly and safely.

People did not always receive effective support to meet their care and support needs. Care staff had not always had their competence assessed to enable them to provide aspects of people's care needs, including specialist tasks. The timings and lengths of people's care visits did not always ensure their needs were fully met. People and their relatives told us there were variations in the quality of care they received.

People were not always supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support people's choice and control across all aspects of their care.

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

People and their relatives gave mixed feedback about their experiences of care. Although there were positive examples of individual care staff being caring, respectful and supporting people's independence, the provider's approach did not always promote this.

People did not always receive person-centred care that reflected their preferences. For example, where people had preferences for female care staff, this was not always accommodated and impacted on people's support. When people's care needs changed following them receiving end of life care, this was not always recorded fully in their care records to guide staff in their support needs at that time.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 04 April 2022) and there were breaches of regulation.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider had addressed some breaches in regulations but remained in breach of other regulations which had not been met.

At our last inspection we recommended that the provider reviewed and implement the Accessible Information Standard (AIS) guidance to identify how to support people to access information. At this inspection we found the provider had acted on this recommendation and made improvements.

The service is now rated requires improvement. This service has been rated requires improvement or inadequate for the last two consecutive inspections.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

Enforcement and Recommendations
We have identified breaches in relation to person-centred care, safe care and treatment, safeguarding people, staffing and good governance. We issued a warning notice for the breach of good governance. You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Requires improvement'. The service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. For this service, the 'Well-led' key question has been rated 'Inadequate' for the past two inspections.

If the provider has not made enough improvement within the 6 month's 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. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of registration.

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

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 always safe. Details are in our safe findings below.	**Requires Improvement**
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**

St Gregory's Homecare Ltd

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 3 inspectors. 2 inspectors attended the location's office and 1 inspector made telephone calls to staff off-site. 3 Experts by Experience made telephone calls to people who use the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with CQC to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced on the first day. The second day of the inspection was announced.

Inspection activity started on 23 November and ended on 15 December 2022. We visited the location's office on 23 and 25 November 2022.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authorities who work with the provider. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 20 people who use the service and 17 relatives about their experiences of the care provided. We spoke with 23 staff including the nominated individual, registered manager, deputy manager, office staff and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 14 people's care records and multiple medicines records. We looked at 5 staff recruitment files and 8 supervision records. A variety of records relating to the management of the service, including policies and procedures, training information, audits, complaints, meeting minutes and questionnaire results were reviewed. We spoke with 2 professionals who regularly work alongside the service.

Requires Improvement

Is the service safe?

Our findings

Our findings - Is the service safe? = Requires Improvement

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure people were protected from abuse and improper treatment and effective systems were not in place to prevent this. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 13.

● People were not always protected against the risk of abuse. On occasions, people were subjected to neglect by care staff, causing people distress and discomfort. This led to safeguarding concerns being raised by their relatives.
● Safeguarding was not always given sufficient priority and people were not always safe from avoidable harm, abuse, neglect or discrimination.
● Lessons were not always being learnt to prevent further safeguarding allegations being raised about people. This had been an issue identified at the last inspection. For example, the provider sent a care worker to a person following previous allegations being raised about the same care worker.

We found some evidence that people had been harmed. The provider failed to ensure people were protected from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse or improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider raised safeguarding concerns with the relevant local authority in an open and transparent way when people had experienced actual or potential harm.
● Feedback from people and their relatives showed most felt safe with the staff supporting them. One person said, "I do feel safe with the care staff who come to see me."

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to provide care and support in a safe way to people, assessing risks to their health and safety and reducing these. This was a breach of Regulation 12 (Safe care and

treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● People were not always effectively protected against the risk of harm. For example, care plans and risk assessments did not always contain information on risks linked to people's health needs, such as catheter care.
● Full information about risks to people's safety was not always identified in people's care records to alert staff and guide them in how to reduce the risk. This included risks linked to people's emotional or behavioural needs. For example, one person was known to express a strong emotional reaction at times. Their care records did not detail the level of risk to the person and staff or how staff could support the person to de-escalate the situation.
● Relatives told us they were not always confident care staff managed risks to their family members effectively.

We found no evidence that people had been harmed. Systems were not robust enough to demonstrate that people's safety was managed effectively. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the provider was awaiting further information and advice from a specialist to inform how they supported the person that could present with emotional reactions. However, this should have been obtained prior to the inspection when the issue was first realised.
● Improvements from issues at the previous inspection had been made to ensure risks linked to people's safety and security in their homes were managed.
● Information was available in people's care records to guide staff on any moving and handling techniques and equipment people may need to support them to walk or transfer safely.

Using medicines safely
At our last inspection the provider had failed to ensure medicines were managed properly and safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● Systems were not always in place to ensure medicines were used properly and safely.
● Best practice guidance was not always followed. This included guidance to support the safe use of topical medicines, such as creams, gels and patches.
● 'As and when required' protocols were not always in place to identify when people may need these medicines and to ensure their appropriate use.
● A small number of relatives raised concerns about how care staff supported their family members with their medicines. One relative said, "We think [person] is reasonably safe, although we aren't sure about medication."

We found no evidence that people had been harmed. Systems were not robust enough to support the proper and safe use of medicines. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider told us 'as and when required' protocols were in development and had yet to be implemented across the service.
● People were supported to manage and administer their own medicines where possible. Information about people's medicine management arrangements was clearly recorded to ensure responsibilities for providing this were understood.

Staffing and recruitment
● People were supported by care staff who had been safely recruited to help ensure their suitability for their roles.
● The provider had made improvements to the coordination of care visits requiring more than one care worker. This helped support people's safety.
● At the last inspection, people and their relatives gave mixed feedback about the timing of their care visits. Their feedback remained mixed at this inspection. Comments included, "[Care staff] arrival times can be a bit variable. They don't let me know when they are going to be late. Sometimes they can be late for the lunchtime visit and early for the teatime visit."

Preventing and controlling infection
● The provider had made improvements to protect people against the risk of infection.
● People and their relatives told us there had been some instances where staff had not worn face masks in-line with best practice guidance. The registered manager advised spot checks were used to monitor care staff practice in this area and this would be looked into.
● The provider had an infection prevention and control policy in place. However, this had not been updated to reflect changes to guidance.

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.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection, the provider had failed to ensure care staff were suitably qualified, competent, skilled and supported to carry out their roles. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● People did not always receive support from care staff who had the necessary training, competence, skills and experience to provide their support.
● Care workers carried out specialist care tasks for which they had not always had their competence assessed to ensure they were safe.
● Competency assessments did not cover the range of medicines support care staff may be expected to support people with. For example, administering creams, eye drops and compression hosiery. One member of staff described supporting a person with compression hosiery and causing them discomfort as they had not done this before, they then received further training in this area.
● Care staff had not always received practical basic life support training in-line with guidance.

We found no evidence people had been harmed. However, the provider had failed to ensure staff providing care to people had the competence, skills and experience to do so safely. This placed people at risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the registered manager took action to review people's care arrangements where staff were providing specialist care tasks to keep people safe. Further changes were planned by the registered manager to improve staff training, competence assessments and relevant recording.
● The provider had introduced a full staff training programme to support staff knowledge and skills. Care staff spoke positively about training. One care worker said, "Being online we can look at the training at anytime, I like being able to go back to things."
●The provider took appropriate action where gaps in staff training were found. However, they had not identified the gap in staff receiving practical basic life support training.
● People and relatives' feedback on staff training and skills was mostly positive. One person told us, "They

[care staff] are reasonably trained, once they have been a few times, they know what to do."
● Care staff received supervisions by managers to monitor their practice and ensure they understood the provider's expectations.
● Care staff had noticed improvements in the support they received to carry out their roles and felt well supported by the registered manager. One care worker said, "I feel supported 100%, if I had a problem there would be someone there to help out."

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection the provider had failed to ensure people's nutritional and hydration needs were met. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 14.

● People received support from care staff with eating and drinking.
● Comments from people and their relatives showed the provider had made improvements in this area. One person said, "My meals are all organised, I have plenty of food for snacks and treats and they reheat my ready meals."
● Further work was needed to ensure people's nutritional needs were consistently met. Information and risks linked to people's dietary needs were identified to enable care staff to identify and manage any risks . However, we found some people who were identified as at risk of losing weight, did not always receive effective support to prevent this.
● The timings of people's care visits remained an issue from the last inspection. The organisation of care visits meant people's mealtimes could be close together on occasions. One relative said, "Sometimes there may only be 1 hour 30 minutes between [persons'] breakfast and lunch."

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 MCA 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

At our last inspection the provider had failed to follow the MCA. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 11.

● People were able to make decisions about aspects of their care, these were respected, including where people chose to make unwise choices.
● The provider acted in-line with the MCA where it was unclear if people had mental capacity to make decisions about their care.
● The provider obtained the relevant documents where people had relatives or representatives legally authorised to make decisions on their behalf.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider assessed and considered a range of factors including the complexity of people's care needs prior to agreeing to providing a service to people. This helped ensure the provider was able to meet people's needs and that the service operated within its capacity.
● People's care records had been reviewed and developed to include detailed information about their care needs and preferences to support staff in meeting these. However, people did not always have access to be able to see this information once their care plan had been recorded electronically. The registered manager advised this information could be provided to people in other formats if required.
● People and their relatives felt there were variations in the quality of the care. One person said, "I have a regular care worker who is very good and very reliable but the rest of the time it's not at all reliable."
● People did not always receive care visits that lasted their full length to ensure their needs were fully met. One person said, "We're paying for a full hour but they rarely stay for more than half an hour."
● At the time of our inspection, no-one with a learning disability and/or autism was receiving the regulated activity of personal care. The provider had ensured staff had received training in this area and policies were up to date to support them to deliver this care if required.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The provider understood the roles of relevant health and social care organisations.
● Further work was needed to ensure the provider obtained up to date information on people's medicines from health professionals and followed any specific directions for administering these.
● Information provided by social care professionals was used to inform people's care and support. For example, information from occupational therapists was used by the provider to develop their moving and handling care plans and risk assessments.
● People told us their GPs were contacted when there were concerns about their health. One person said, "If they [care workers] think I'm not well, then they will call a doctor for me."
● Care staff, office staff and management worked together to provide people's care. Although the coordination of this had improved, further work was needed to ensure people received effective care and support.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. 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

At our last inspection the provider had failed to ensure people received appropriate care to meet their needs at preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9.

● The provider's approach and systems did not always support the delivery of high-quality person-centred care.
● Safeguarding concerns raised by relatives showed care staff did not always treat people with dignity, kindness or respect.
● The provider did not always understand the importance of person-centred care, including care visit times and lengths in meeting people's needs. One person said, "The care I get is pretty good, it's only spoilt by the poor timings of care visits which are not suited to my needs."
● There had been some instances where care staff had been rushed, abrupt and judgemental, which impacted on people's wellbeing. One person said, "[Care worker] just stood there and watched me really struggle with nightclothes [care worker] was really not kind. The next day [care worker] came and didn't lock the door, I felt so awful."

We found some evidence that people had been harmed. However, the provider had failed to ensure people received appropriate care that met their needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People, relatives and a professional gave mixed feedback on the approach by some care staff. People and their relatives spoke positively about regular care staff and felt treated with kindness. Comments included, "I have one regular care worker who is very good and I trust" and "Most of the care staff have been really good, friendly and chatty and they will do anything they can to help."

Respecting and promoting people's privacy, dignity and independence
● The provider did not always prioritise people's dignity. This included people's preferences for female care staff. One relative said, "We made it very clear no males for personal care. They [the provider] will still send a

man, we've asked many times."

● The provider did not always make sure people's care visits were organised to ensure people received care and support from familiar staff. One person said, "The care staff are all different, it's very random and there are no regular patterns, which is very difficult for someone with dementia."

● Care staff promoted people's independence, encouraging them to meet their own care and support needs where possible. This had led to positive outcomes for some people, including a reduction in their care. One person said, "I am frightened of falling and unsteady on my legs but they help me and encourage me to do things."

Supporting people to express their views and be involved in making decisions about their care

● People were encouraged by care staff to give their views how they were providing their care. One person said, "They do ask if I am happy with what they are doing for me, particularly when I get personal care."

● A member of office staff had a role as a 'service user champion' and spent time visiting people in person to gather their feedback and use this to make changes to their care.

● Information on advocacy support was available to people should they require support with making their views about their care known.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

At our last inspection the provider had failed to ensure people received appropriate care to meet their needs at preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9.

- The provider did not always organise care in person-centred ways to reflect people's individual needs and preferences.
- People's preferences for female care workers were not always considered or recorded in their care records. This included for one person who chose to live in an all-female setting. One person said, "I will only have a female care worker to help me with anything personal. They occasionally have sent males; I just don't have my shower."
- People's care visits did not always accommodate their routines or preferences. This caused some people discomfort and distress. One person told us there were times when their evening care visits could be 3 hours earlier that they would like, they said, "It's too early, it makes it difficult for me to have friends round in the evening if I want to. It really restricts me."
- End of life care plans were not always in place for people receiving end of life support. We were not assured staff would have sufficient information to guide them in how to support people at this sensitive stage of their life.

We found no evidence that people had been harmed. However, the provider had failed to ensure people received care appropriate to their needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection, the registered manager advised us people were made aware the service could not provide female care staff for all care visits prior to receiving support.
- The registered manager told us they made efforts to accommodate people's preferred care visit times where possible and that care visit times were set by commissioners. We saw examples of where care visit times had been changed based on people's wishes.
- The registered manager told us people's relatives and representatives were given the opportunity to discuss and record people's end of life needs and preferences and often declined this.

● People felt able to speak to care staff about how they wanted their support to be, to personalise it for them. One relative told us, "They do listen to how we like things done."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The AIS tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● At our last inspection we recommended the provider reviewed and followed AIS. The provider had made improvements.
● Information on people's communication needs and styles was recorded in people's care records with details of how care staff could support this. For example, one person communicated through writing on a screen, they needed care staff to hold this to enable them to use the device.

Improving care quality in response to complaints or concerns

At our last inspection the provider had failed to ensure all complaints were investigated and action was taken in response to any issues identified. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 16.

● The provider had made significant changes to their complaints process since the last inspection. A clear process with set timescales had been introduced to show how any concerns or complaints had been received, acted on and any learning needed.
● People and their relatives received a response and a summary of work carried out to make improvements following their complaints.
● People and their relatives gave mixed feedback on the effectiveness of the provider's complaints process and whether changes had been sustained. One relative told us they had complained about care visit times, they said, "They [the provider] investigated my complaint but sometimes the same problems occur."

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.

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to have effective systems in place to monitor and improve the quality and safety of the service and seek feedback to improve the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● People remained at risk of harm as effective systems were not always in place to monitor quality and safety across the service and drive improvement.
● The provider's quality assurance system had not identified issues we found on inspection, including with safeguarding, risks to people, medicines, staff competencies, care records and care visit lengths and times.
● We were not assured the provider's quality assurance checks were effective in making improvements. A system of audits had been introduced by the provider since the last inspection. However, these were limited in their scope. For example, medicines audits sampled less than 1% of records for people using the service.
● The provider did not always have effective systems in place to monitor the experience of people that used the service and their relatives and use this feedback to drive improvement. Feedback that the provider had gathered from people did not match the views shared by people and their relatives on inspection.
● 33% of people and relatives we spoke with gave negative feedback about the provider, 50% gave mixed feedback and 17% gave positive feedback. Key issues raised by people and relatives were care visit times, care staff not staying for the duration of the care visit, irregular care staff and people's preferences for female care staff.
● We were not assured robust systems were in place to monitor care visit times and lengths across the service. For example, for one person we identified for only 2 out of 28 visits care staff stayed for the full length of the care visit that the person was commissioned to receive. Whilst the registered manager advised they had taken action to address this, we were not assured this was happening consistently.
● The service had been rated requires improvement or inadequate for the last two consecutive inspections and had failed to improve to provide a good level of care.

We found no evidence that people had been harmed. However, the provider had failed to assess, monitor

and improve the quality and safety of the service. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection the provider had made significant changes and was working to make improvements. Further work was needed to ensure people received consistently high-quality and person-centred care.
● The registered manager was committed to driving improvement at the service. One member of staff said, "Since the new registered manager things have improved massively."
● The provider had introduced a separate out of hours service to enable office staff to carry out their roles. This had a positive impact on the service; people, relatives and staff gave consistently good feedback on how this had improved the responsiveness of the service.
● Feedback from people and their relatives on the management of the service was mixed. One relative said, "It is a well-managed service and they respond well to problems." In contrast, another relative told us, "The office is not that helpful, I think the service could be managed better."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager and provider understood their responsibility to apologise when issues occurred with people's care.
● Appropriate records were in place to demonstrate where the provider had acted on their duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had made changes to gather feedback from people and staff about the service through various routes, including via surveys and a new 'service user champion'.
● Staff expressed higher levels of satisfaction around their employment since the last inspection and felt involved in the work the provider was doing to improve the service. One care worker told us, "St Gregory's is turning around, we all do care and I feel quite at home here."
● Regular newsletters were introduced by the provider to inform people, relatives and staff of work and changes being made at the service. These were available in alternative formats to support people's communication needs.

Working in partnership with others
● The provider worked in collaboration with other organisations to provide people's care and support.
● The provider had started holding charity and fundraising events to support their local community and voluntary organisations.

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 The provider failed to ensure service users received appropriate care to meet their needs and preferences. (1)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure service users were provided with care in a safe way, assessing risks to their health and safety, doing all that was practicable to mitigate these risks. The provided failed to ensure the proper and safe management of medicines. (1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure service users were protected from abuse and improper treatment and have effective systems and processes to prevent abuse. (1)(2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to ensure staff were suitably qualified and competent to carry out their duties.
(1)(2)(a)

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 The provider failed to ensure systems and processes were established and operated to assess, monitor and improve the quality and safety of the service. (1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:

Warning notice issued against the provider.