Atlas Care Services Ltd

Atlas Care Services Ltd Wisbech

Inspection report

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Date of inspection visit:
30 December 2019
08 January 2020
15 January 2020
30 January 2020

Date of publication:
18 March 2020

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Atlas Care Services Ltd Wisbech is a domiciliary care agency providing personal care to people in their own homes. At the time of the inspection 113 people were receiving a service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
There was a continued lack of provider oversight of the service, in spite of the enforcement action we took following our last inspection. People's health, safety and welfare continued to be at risk because the provider did not have effective systems in place to assess, monitor and improve the quality of the service. Ten of the 11 people/relatives we contacted told us they were not satisfied with the service they received. Staff continued to not be deployed effectively, which meant that care calls were frequently late, did not always last the correct amount of time and some people received care from a high number of different staff.

The provider had failed to manage safety effectively, which placed people at risk of harm. Risk management was not robust enough to ensure staff knew how to minimise risks to people. Safeguarding policies and procedures were not always followed, putting people at risk of abuse. Staff did not always have the training or support to carry out their role in line with current good practice.

People's care plans had not all been reviewed or kept up to date so there was a risk that people did not get the care they needed in the way they preferred. Complaints were not always responded to and not addressed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We have made a recommendation about involving people in decisions about their care.

Some improvement had been made since our last inspection in that there had been far fewer missed calls. People spoke highly of the staff who provided their care and were satisfied with the way staff gave them food and drink.

During our first site visit there was a registered manager in post. They resigned from their post before the inspection was concluded.

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 (report published 10 September 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

This service has been in Special Measures since our last inspection. During this inspection the provider demonstrated that not enough improvements had been made and they remained in breach of regulations. The service is rated as inadequate overall and in three of the key questions. Therefore, this service remains in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

The provider had appointed senior staff to oversee and improve the service. However, they had been in post for three months but had not addressed and rectified the shortfalls we found at the last inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Atlas Care Service Ltd Wisbech on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to complying with regulations; governance; staffing; safe care and treatment; person-centred care; complaints; and safeguarding people from abuse and avoidable harm at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains 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.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, 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 the 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.

Further update
Following the inspection we met with the provider to discuss the actions we would be taking. The provider told us they had decided to apply to CQC to remove the location from their registration. The regulated activity previously carried out from that location would be carried out from another of their locations. After the meeting the provider submitted their application to remove the location Atlas Care Services Ltd Wisbech from their registration from 01 march 2020.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

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. 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 Care Act 2014.

Inspection team
The inspection team consisted of three inspectors and an inspection manager. On 30 December 2019 two inspectors began to make telephone calls to people who used the service, their relatives and staff. On 8 January 2020 two inspectors carried out a visit to the agency's office. On 15 January 2020 an inspection manager accompanied an inspector to the office to meet representatives of the provider. The inspection was completed on 30 January 2020.

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

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.

Notice of inspection
We gave the service 24 hours' notice of the inspection visit to the site office on 8 January 2020. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. This included the provider's action plan and the weekly reports the provider had sent us. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke over the telephone with seven people who received a service and another four people's relatives. We spoke over the telephone with six staff and spoke with another six staff during our visits to the office. These staff included care workers, field-care supervisors, care coordinators, the registered manager, the Head of Business Development and Operations (referred to in the report as the provider's representative) and the Operations Manager.

We looked at a range of records. These included five people's care records, including medication records and daily care notes. We looked at two electronic staff files in relation to recruitment and folders relating to complaints and accident and incidents.

In between the two days we visited the office, the provider's representative updated us on actions they had taken to address some of the issues we had found. Following our discussion with them during our second site visit, the provider's representative updated us on further action they had taken.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; using medicines safely

At our last inspection the provider had failed to have robust risk assessments in place and had failed to operate an effective system to review medication records. This had placed people's health and safety at risk. 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.

- Risks to people were not effectively managed. Risk assessments were in place, but these had not all been updated. One person's care records had not been updated since April 2019. These records included risk assessments and guidance for staff relating to the person being able to stand and walk around with staff assistance. This person was now being cared for in bed but there were no risk assessments or guidance relating to their changed care needs. This put the person at serious risk of harm.
- Another person's risk assessment included risks that had been identified. However, there was no reference to these in the person's care plan, nor any guidance to staff on how to manage and reduce these risks. This put the person at serious risk of harm.
- There was a risk that people were not always given their medicines safely because the provider did not have a sufficiently robust system in place to monitor medicine management. Senior staff carried out audits of medicines but issues found were not always dealt with.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our site visits the provider's representative told us they had made improvements. They said they had done a review of all care plans to make sure they were detailed, included the correct information and in a clear format for staff to read. They had revised their auditing of medicine management.

Staffing and recruitment

At our last inspection the provider had failed to provide staff at the agreed times, which placed people's health and safety at risk. 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.

● Although there had been some improvement since our last inspection, the provider had still failed to deploy staff effectively to fully meet people's needs and keep people safe. The number of 'missed calls' had decreased considerably. However, 10 of the 11 people/relatives we spoke with told us that staff often arrived late for their care visit. One person told us their care visit had been an hour and 20 minutes late. They told us about the impact of receiving late calls: they didn't know whether to get their own breakfast/dinner or get dressed/undressed. They told us how bad they felt when they had to sit around all morning in their nightclothes.
● People and staff also said that the time of some of people's care calls had been changed from the original agreement. Staff were now rostered to visit them earlier or later than previously agreed. One person said their last care visit of the day was sometimes at 6:15pm instead of 8 - 9pm: they did not like having to go to bed so early. These changes had resolved some of the issues for the provider. However, this meant that people were not getting the care package they had requested and which had been in place when they first received a service. A member of staff told us, "Sometimes we don't get to [people] at the times they need their care." A relative said, "Sometimes staff turn up early, or too late – my family have to check every day."
● Following our last inspection the provider told us they had arranged for staff to have sufficient travel time in between care visits. At this inspection management confirmed that staff had five minutes to travel between care calls. However, some staff said that there were times they travelled for 20 minutes between two people's care visits.
● Staff were not always staying with each person for the time agreed with the person and the funding authority. One person's care visits were meant to be for 45 minutes once a day: records for the month of December showed that every visit was shorter, most being around 20 minutes and sometimes as short as 15 minutes. Records for this person also showed that care visit times were consistently late, up to one hour and 51 minutes late and that they had 10 different care workers over the 31 days.
● Some people had regular care workers, but nine people/relatives us they saw different staff and frequently did not know who would be turning up at their home. One person said, "I don't like it when complete strangers come through the door." Records for one person (who had two staff, four times a day) showed that for seven days from 30 October 2019 to 5 November 2019, they had 18 different staff to provide their care. Over the seven days from 28 November 2019 to 4 December 2019 they had 19 different staff, six of whom had not provided their care in the earlier period. A member of staff said that some people "are very displeased because they've had umpteen different [care staff]." This created a risk of care being unsafe as not all staff were familiar with the person's needs. This led to an incomplete picture of how the person was and whether their needs were being met in the way they preferred.

Failure to provide staff at the right times and failure to provide some people with a consistent staff team put people at risk of not having their needs met safely or in the way they preferred. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person who used the service said they were really pleased. They told us, "I'm very lucky – most of the time I get the same four staff." They also said staff were "almost always on time – if running late they let me know." Some of the staff also said that things had improved over recent weeks. They were not aware of any missed calls, they found the five-minute travel time sufficient and had a "regular round" where they always provided care to the same people.
● The provider had an effective recruitment procedure in place, which ensured as far as possible that only staff who were suitable to work at the service were employed. Staff told us about the pre-employment checks the recruiter carried out, such as references, proof of identity and criminal records checks through

the Disclosure and Barring Service.

Systems and processes to safeguard people from the risk of abuse
● People were placed at risk of harm and abuse because the provider did not have a robust enough system in place to ensure that people were protected. The management team had failed to respond appropriately when a person receiving a service alleged physical abuse by a member of staff. The incident had not been reported to the safeguarding authority and had not been investigated. The management team had allowed the member of staff to continue working with people, thus possibly putting other people and the member of staff at risk.

People were at risk of abuse as staff were not following the local authority's safeguarding protocol: they were not always reporting incidents of alleged abuse. 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.

Following our site visits the provider's representative wrote and told us they had spoken with the person concerned who did not want to pursue this. The provider's representative also contacted the safeguarding team to check they had taken the correct course of action.

Learning lessons when things go wrong
● The provider had failed to learn from our concerns and from the enforcement action we took following the last inspection.
● The provider had an online system for reporting issues so that all staff across the provider's services could learn lessons when things had gone wrong. However, the registered manager at this location had not used the system effectively. The issues we found showed that the team at Atlas Care Services Ltd Wisbech had not used errors or concerns to improve the service.

Preventing and controlling infection
● The provider had systems in place to prevent and control the spread of infection. Staff wore personal protective equipment such as aprons and gloves when they delivered 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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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 previous inspection we found that staff did not always receive adequate training or support to enable them to carry out their duties effectively and safely. At this inspection we found little improvement had been made.
- Not all staff had received adequate training to make sure they knew how to do their job effectively and safely. The provider had a training matrix, which showed the training topics they offered the staff and whether staff had received the training. For some topics, only 48 of 78 staff had been trained. This clearly demonstrated that the provider was not keeping up to date with training. This meant there was a risk that staff were not fully aware of current best practice guidelines when caring for people in their own homes.
- Staff had not received training in topics relevant to people's conditions (such as dementia, diabetes, multiple sclerosis and Parkinson's disease) other than what one member of staff described as a "bog standard, basic course [about dementia]". They told us, "We've asked for in-depth dementia training."
- People and their relatives had mixed views about whether the staff knew what they were doing. This tended to be based on the care a person needed and whether they received that care from a consistent team of staff. A relative said, "Staff understand [my family member's] needs and have the skills to care for [name]." However, one person told us, "Some staff need more training – I have a [condition] and I have to tell some staff what to do." Another person said, "I have to tell new staff what my routine is."
- The provider's representatives told us the provider had appointed a trainer for the company. The trainer was arranging for all staff to receive the training they needed, including in topics not previously offered, such as people's medical conditions.
- Some staff made positive comments about the support they had had received from the registered manager. Staff told us they had supervision twice a year and senior staff carried out spot checks to make sure their practice was satisfactory. Other staff made less positive comments and felt they were not supported in the way they needed.

Failure to ensure that staff had received appropriate support and training to enable them to carry out their duties meant that people were at risk of not receiving appropriate care. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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 we found that, although staff had undertaken training, not all staff had a good understanding of the MCA or how it should be applied. The provider's service improvement plan (updated on 6 January 2020) showed that progress to improve this had been marked as 'poor'.
● During the first site visit day of this inspection we noted that people's legal rights were not fully protected. This was because the registered manager had not ensured that each person's capacity to make particular decisions had been assessed. Assessments of mental capacity that had been done were not in sufficient detail.
● Staff told us they offered people choices relating to their care and support. One member of staff said that it was documented in people's care plans about the support the person needed and how to give this.
● Following our site visits, the provider's representative told us they had reviewed the capacity assessment and the training given to senior staff so they could carry out the assessments. They had devised a much more detailed assessment form and bespoke training to upskill the senior staff.

We recommend the provider seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their care, treatment and support.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed by the local authority so staff at the service had the information they needed before they delivered care to the person.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff supported people with their food and drink if that was part of the support the person needed. This usually involved heating up microwave meals or making sandwiches. People or their families supplied all the food.
● If people were at risk of not eating enough, staff ensured the person's family were aware or there was the involvement of healthcare professionals such as the person's GP.
● Training records showed that 65 out of 78 staff had undertaken nutrition and food hygiene training.

Staff working with other agencies to provide consistent, effective, timely care
● The provider's representative told us they had a 'no refusal' contract with Lincolnshire County Council (LCC), which sometimes meant they had to start providing care at very short notice. They met regularly with LCC to discuss any issues and how they would make improvements.

Supporting people to live healthier lives, access healthcare services and support
● People made their own healthcare appointments, which their families supported them with if needed.
● Staff monitored people's health and well-being as far as they were able to. If they had any concerns, and if the person wanted them to, they spoke to people's families or the person's GP.
● One person told us, "Once I had to go to hospital and one of the staff gave up her day off to come with me – this was really nice and made a big difference."

Requires Improvement

Is the service caring?

Our findings

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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

● The provider had not demonstrated a caring attitude. They had not ensured that everyone who used the service received the care they needed, at the times they had requested, from a consistent team of staff. One person told us, "I never know what time they're coming or who's coming." Another person explained that sometimes staff turned up so early to assist them to bed that they were still eating their dinner. A third person said, "Staff are kind and caring but I feel uncomfortable when staff turn up and I don't know who they are."

● People and relatives made very positive comments about most of the staff. People's comments included, "Most treat me kindly and are caring"; "The staff are like friends to me. Staff have always been marvellous – they're always kind and respectful"; and "Staff are very professional and very helpful." A relative told us, "Staff do what they're supposed to. They're kind and caring. I think he's safe. I have no issues – he's always treated nicely."

● One member of staff had given up their time to take one person to hospital as they had no family to help. Other staff had attended a person's funeral recently in their own time.

● The provider's representative told us that staff "were brilliant" over the Christmas and New Year period. They said, "The staff have truly pitched in. They truly care about the [people using the service] and have a commitment to them. They recognise there's a job to be done and they want to improve."

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

● People told us that their regular care staff knew them well. One person said, "Staff do know me – we have a good laugh." Another person told us, "Some staff are better than others and take time to chat." Staff explained that when they had "a regular round" they were able to get to know people well.

● One person said they had been fully involved in decisions about their care. However, other people and a relative told us they were never asked about the care that was needed. One person had made a request about a particular member of staff but their request was ignored. Other people also said their concerns were not always listened to.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

At our last inspection the provider had failed to ensure care plans were up to date, which meant that people's needs may not have been met in a safe way or in the way they preferred. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person-centred care).

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

● At our last inspection we found that care plans provided by the local authority were in place but the service had not always completed their own care plans. We also found that most care plans had not been reviewed, which meant staff did not always have the information they needed to support people in the way they preferred.
● At this inspection there had been some improvement in that each person had a care plan in place. However, these had not all been reviewed and were not all up to date. The registered manager told us that, in the six months since our last inspection, only 61 out of 115 care plans had been reviewed. This meant that staff could not be confident they had up to date information to support the remaining 54 people.
● One person's care plan had been reviewed in April 2019. It included guidance for staff that was no longer relevant as the person's needs had changed considerably. For example, staff were guided to support the person when they moved around using their frame. The person was no longer able to do this and was being looked after in bed. There was no indication throughout the whole care plan that the person's needs had changed. This meant there was a serious risk, especially as this person had received care from numerous different staff, that the person's needs were not being met safely or in the way they preferred.
● People and their relatives were not always involved in reviewing the person's care plan. One person told us, "I've read my care plan quite a few times and I'm happy with what's in there." However, another person said, "No-one talks to me about my care plan." A relative told us they were "not aware of care plan reviews."
● Care plans did not include a plan for end-of-life and staff had not received training in how to support someone at the end of life. This meant that in the event of sudden illness or death, people might not get the care they would have wanted.

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The registered manager told us that care plans could be printed in normal, large or extra-large print. We saw no evidence of this, or that any other documents such as the complaints procedure were available in large print or any other format. This meant that the provider was not always identifying or meeting people's needs.

The provider had failed to ensure that all care plans were up to date. This meant that people's needs may not always have been identified, met safely or met in the way they preferred. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person-centred care).

Following our site visits and feedback the provider's representative told us, "This has prompted our need to review the systems and processes on how care plans are put together and presented to the staff."

Improving care quality in response to complaints or concerns

At our last inspection the provider had failed to operate an effective complaints procedure. This meant that complaints may not have been investigated thoroughly or the necessary action taken to make improvements to ensure the issue did not happen again. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Complaints).

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 16.

● The provider had failed to operate an effective complaints procedure. They had a complaints procedure in place. However, people and their relatives were not aware of it nor who they should speak to if they wanted to complain. They told us they had raised concerns with staff or the registered manager, but nothing had been done to address the problems. One person told us, "Problems never seem to get resolved." Another person said, "I've made a complaint, but nothing seems to happen." A relative said, "I don't know how to complain – I ring up if I have a problem but nothing seems to change much."
● One person had asked the management team to ensure that a particular care worker did not visit them again. Following this they were upset and frightened when this care worker arrived at their home, twice, over the Christmas period to provide their personal care.

Failure to operate an effective complaints procedure meant complaints had not always been investigated and action taken to ensure the concern did not recur. This was a continued breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Complaints).

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 the last inspection this key question was rated as inadequate. Following our last inspection we imposed conditions on the provider's registration. They appealed this to the tribunal and agreed to make improvements within six months. However, at this inspection this key question has remained rated as inadequate. This meant there continued to be widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

The evidence we found at this inspection shows that the provider had failed to comply with regulations, in spite of the assurances they gave us. This was a breach of regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (General).

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

At our last inspection the provider had failed to follow effective governance procedures to identify areas for improvement and ensure the action taken to make improvements had been taken in a timely manner. This was a breach of regulation 17 (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.

● The service was not well-led and the provider continued to lack oversight of the quality of the service being delivered to people. Our findings at this inspection demonstrated that the provider had failed to learn or to sufficiently improve the care they delivered to people in spite of the enforcement action we took following our last inspection. Although some improvements had been made regarding missed calls, they remained in breach of all five of the regulations they were in breach of at our last inspection. At this inspection we found a further breach.
● The failures we found included: the failure to recognise and respond to concerns appropriately and in line with safeguarding policies and procedures; the failure to assess, monitor and review people's safety and well-being; the failure to ensure there were sufficient staff deployed with appropriate skills and competence to provide care that was safe and met people's needs; the failure to ensure and monitor that people received personalised care; the failure to respond to complaints or have a system in place to learn from incidents; and the failure to have effective oversight of the service. This meant that people were at significant risk to their health and safety and to not receiving good quality care that met their needs.
● The provider had a service improvement plan in place based on the findings from our last inspection. Although they had marked progress in some areas as 'good', there remained several areas where they had

marked progress as 'poor'.
● The provider did not have a sufficiently robust system in place to audit and monitor the quality of the service. Some audits had been completed but these had not always identified shortfalls or, where they been identified, no action had been taken. For example, in one person's care records a staff member had completed an audit and stated 'call times within reasonable times'. However, we noted that throughout the period of the audit, staff had consistently arrived late. In one instance this was one hour and 51 minutes late.

● The provider did not have a sufficiently robust system in place to seek the views of people using the service, their relatives or staff and to use those views to improve and develop the service. The registered manager told us that a member of staff from the provider's head office was making quality assurance telephone calls to people to gather their views. However, one person told us, "No-one asks if I'm happy with the care." Another person said, "No-one's asked if I'm happy. No-one has told me how to complain but I do ring if there are issues – but nothing gets resolved."
● People and relatives could not recall completing any surveys to enable them to give their views about the care being delivered by the staff. A relative said, "Never had a survey – no-one contacts me, no-one ever speaks to me about [family member's] needs." The registered manager told us they had given staff dates for meetings but no staff had turned up.

The provider had failed to establish and operate an effective system to monitor and improve the quality and safety of the services provided. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Governance).

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The culture of the service was not person-centred or open. Ten of the 11 people and relatives we spoke with raised several issues with us, such as late calls, the number of different staff and lack of response or action if they raised any concerns. They said that communication from the office was poor. They were not told which staff would be providing their care nor if the staff would be late. Only one of the 11 people and relatives we spoke with told us they were happy with the service they received. This person told us, "Quite honestly, I have nothing to complain about and I'm very happy with the service."
● Staff felt some improvements had been made in that there were not so many missed calls. Staff rotas had been sorted out so that staff were no longer rostered to be in more than one place at a time. However, they also felt they were not always listened to and improvements they suggested were not considered.

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
● People and relatives were not confident that the provider was open and honest with them. They told us they rarely or never had had any contact from the registered manager or from "head office".

Working in partnership with others
● The provider's representative told us they were meeting monthly with commissioners from the local authority to ensure they were satisfied with the care being provided.