Errand Plus and Personal Services Ltd

Errand Plus and Personal Services

Inspection report

Suite 22, Henderson Business Centre
51 Ivy Road
Norwich
NR5 8BF

Tel: 01603319998
Website: www.errandpluspsltd.co.uk

Date of inspection visit:
11 September 2019
26 September 2019

Date of publication:
05 November 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Errand Plus and Personal Services is a domiciliary care agency providing personal care to people living in their own homes. It also provides a 'live in carer' service. At the time of the inspection there were 13 people who used the 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
People did not always receive a service that provided them with safe, effective, compassionate and high-quality care.
Systems for checking the quality and safety of the service were not in place. Audits and checks had not been carried out to identify where improvements were needed. This put people at risk of potential harm.

Individual risks to people were not effectively managed and mitigated against. People's care records were not person-centred and did not always contain accurate information. This meant care and support could not be delivered effectively.

There were shortfalls in the systems to support staff to provide effective care and to carry out their duties. Medicines were not managed safely and in line with best practice.

Recruitment processes were not robust, and staff had been knowingly sent to work in people's homes before checks of their suitability had been completed.

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 support this practice.

Rating at last inspection:
This service was registered with us at their current location on 28 August 2019 and this is the provider's first inspection.

The provider previously operated a service at a different location that was registered 22 October 2018 but was not inspected. Since their first registration the provider has changed their legal entity.

Why we inspected
This was a planned inspection based on their registration.

Enforcement

We have identified breaches in relation to the safe care and treatment of people, recruitment processes, staffing and governance systems.

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.

Please see the action we have told the provider to take at the end of this 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 of the care provided. 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.

The overall rating for this service is 'Inadequate' and the service is therefore 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 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Errand Plus and Personal Services

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 was carried out by an inspector and a assistant inspector.

Service and service type
Errand Plus and Personal Services is a domiciliary care agency providing personal care to people living in their own homes. It also provides a 'live in carer' 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.

The service did not have a manager registered with the Care Quality Commission. A manager had recently been appointed and at the time of the inspection had been in post three weeks. They were in the process of registering with CQC. In the absence of a registered manager, the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced.

We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection site visit activity started on 9 September 2019 and ended on 25 September 2019 when we gave feedback. We visited the office location on 11 September 2019 and met with the provider's nominated individual and manager and reviewed care plans and other records.

What we did before the inspection
We sought feedback from partner agencies and professionals, ongoing monitoring such as information received, was used to plan our inspection We received information of concern about the service which we shared with the local authority safeguarding team and asked the provider to investigate.

Before and during the inspection we received information from whistle blowers. Whistle blowing is a recognised way in which staff can raise concerns to bodies including the Care Quality Commission (CQC) regarding people's safety and the quality of care.

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.

During the inspection
We carried out telephone interviews on 10, 17 and 18 September 2019 and spoke with two people who used the service, six relatives and four members of staff. We received electronic feedback from one member of staff and a relative about their experience of Errand Plus and Personal Services.

We reviewed a range of records. This included five people's care and medicine records. We looked at seven staff files in relation to recruitment and training. We also looked at a variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found including recruitment and training data. We received electronic feedback from two professionals involved with the service.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- People told us they felt their care was rushed, with staff either arriving late, leaving early and not staying for the allotted time, because of the pressure they were under to complete all the calls allocated to them. One person told us, "The company seem to be short staffed, disorganised, been a lot of different carers, different faces coming. The carers are okay but sometimes are in a hurry to get to the next person and it feels impersonal."
- Staff told us they were often late arriving for people's calls. They said this was because rotas did not include adequate time for the distances they had to travel between visits.
- We received information that calls had been missed or carers were late and people who required two staff to assist them, would only have one staff member arrive or the other carer was late. These concerns could not be disputed due to a lack of audits and checks in place. This meant people were at risk of receiving unsafe moving and handling and receiving care that was not in line with their assessed needs.
- The provider did not have a system in place to monitor people's call times to ensure they were not put at risk by variance in punctuality or call duration. This placed people who were unable to use or access a telephone at increased risk. The provider relied on people being able to contact them or the manager to alert them if a carer had not arrived.
- An effective rota system was not in place. People were not assured of continuity of care as visits often changed and this was not always communicated to them. One relative said, "There is no rota it could be anyone of a number of people that might come. It would be nice to know who is coming and when as the times seem to have changed.".
- Staff told us the visits often changed and communication from the office was inconsistent.

The provider did not have an effective system to monitor and identify that people received their care on time and for the planned duration This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had failed to ensure staff were recruited safely. An effective system to ensure staff had completed all necessary checks before being employed was not in place. The provider did not have oversight of recruitment processes to ensure that fit and proper persons were employed. This failure placed vulnerable people at risk of receiving care from staff who were not of good character.
- We reviewed records where we identified legal requirements had not been met. This included ensuring staff had provided a full employment history, records of an interview and satisfactory references.
- All staff that are employed to provide care to people must undertake a check with the Disclosure and Barring Service (DBS) to ensure they are suitable and safe to work with vulnerable people. We found discrepancies for four members of staff deployed to work with people before these checks had been

completed and where disclosures had been identified no evidence of how risk was being mitigated. We brought this to the attention of the manager who acted to address this. These risks and concerns had not been identified or addressed by the provider, or the risk management procedures in place by the service and were only identified as a result of our visit.

Due to unsafe recruitment practices which put people at risk of harm, this was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong, Using medicines safely

- Although people and relatives told us they felt safe with the care provided, we identified people were not always protected from potential harm. Risks to people's health and wellbeing were not always effectively identified, assessed or mitigated.
- People relied on the staff to maintain their safety. Risk assessments had been completed for people, however these were generic and not specfic to individual needs. They were not person-centred to give staff the direction they needed to provide safe care. For example, moving and handling risk assessments did not provide detailed information on the equipment needed and how to safely transfer people. For another person at risk of pressure areas there was limited information on how to provide personal care and to monitor and assess skin integrity.
- Further guidance for staff to follow in respect of people's specfic needs for example falls, pressure areas, diabetes, behaviours that may challenge was required.
- The provider was not able to demonstrate how they monitored or managed missed and late calls. There was no system in place to enable this, or for any analysis to be undertaken to make improvements. The provider was also not monitoring individual staff performance and addressing any shortfalls.
- There was no formal system for recording and managing accidents, incidents, and near misses. The management team had not reviewed or undertaken detailed investigations to mitigate risk and reduce re-occurrence when instances had occurred. We could not be assured that the provider understood their regulatory responsibilities.
- We were not assured that staff and the management team understood how to report and record effectively so that lessons were learnt, and improvements made when things went wrong.
- Medicines were not managed safely and in line with best practice. Analysis of incidents, such as medicines errors, had not been undertaken to enable the provider to learn lessons and resolve medicine issues. There had been no audit of medicine records since the service was first registered on 22 October 2018.
- We brought to the attention of the manager gaps in the medicine records for one person's morning visit where medicines should have been administered. It was unclear if the person had received their medicines as prescribed and this had not been picked up by staff and reported to the manager.
- Information in people's care records about medicines was limited and did not reflect their preferences, for example how they took their medicine. There were no 'PRN' as required medicine protocols in place. PRN protocols guide staff in safely administering medicines that are only needed for a specfic situation for example pain, allergies or constipation in line with their prescribed medicines to reduce the risk of ill effects or harm.

The provider did not have an effective system to monitor and identify that people received their care on time and for the planned duration This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- Staff had received training in safeguarding and concerns had been reported to the relevant authorities.

● People and relatives told us they felt safe with the staff when they were in their homes.

Preventing and controlling infection

● Staff had received training in infection control and told us they wore appropriate personal protective equipment PPE) such as gloves and aprons when necessary.

● The majority of people and relatives confirmed this, although two relatives told us staff at the beginning of their care package had arrived without the relevant PPE.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- We were not assured that systems were in place to ensure staff were supported in their roles. There were gaps in the training matrix, no formal induction and shadowing processes and no supervision or appraisal plan in place for staff. Feedback on staff performance was informal and not well organised or recorded.
- Training was mainly completed online with no competency assessments or processes to check staff understanding. Records showed that one person had completed 21 modules of online training in one day and we queried with the management team the effectiveness of this and the quality of training to be done in such a short space of time.
- There were no records to show that staff completed a detailed induction when they first were employed. Staff records did not evidence that staff worked under supervision until they were confident and competent that they could work independently or had been signed off by management as there were no systems for recording this.
- For example, for one staff member new to care there were no records of them shadowing experienced colleagues or being signed off by management they were competent to work alone. Records showed within a period of three months from them completing online moving and handling training it was a further three months before they completed the practical version of this training. The provider's nominated individual advised us that the staff member had not been involved in moving and handling transfers and had undertaken shadow shifts but acknowledged there were no records to confirm this.

Ineffective systems and processes to support staff meant the provider was in further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was mixed feedback from staff on being supported in their role by the management team. The changes in management had affected the running of the service and morale. Although staff feedback about the current manager was positive.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before being supported by the service. However, improvements were needed to ensure people, their family members and significant others were consistently involved in the process.
- Assessments had not been completed in line with current legislation and best practice guidance. This information would help to create a tailored person-centred care and support plan for people.
- People's care records were not consistently updated as staff got to know people or when there were

changes in risk presentation.

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

- Improvements were needed to people's care records to show that they had consented to their care and support when they began to receive the service and were involved as much as possible in their ongoing developments.
- The new manager had identified that capacity assessments for people and best interest meetings had not always been carried out and had taken steps to address this. Our discussions with the manager showed they understood the requirements of the MCA and they were arranging further training for staff on the MCA to support understanding in this area.
- People told us the staff consistently sought their consent before providing any care or support. One person said, "The carers ask me if am ready before they do anything."

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

- No one we spoke with during this inspection was receiving assistance with eating and drinking but shared examples of staff leaving them with a drink and snack at the end of their visits.
- Staff demonstrated they understood the importance of ensuring people ate and drank enough to maintain their health. The manager told us they were currently monitoring someone's food intake where they were at risk of losing weight and had set up a multi-agency meeting to discuss next steps.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff supported people to access healthcare services when they needed them and made appropriate referrals or sought advice from a range of health and social care professionals where required.

Requires Improvement

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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; Supporting people to express their views and be involved in making decisions about their care

- The provider had not ensured that people always received a caring service. For example, appropriate recruitment checks and processes had not been completed on staff to ensure they were safe to work with vulnerable people.
- There was mixed feedback about the approach of the staff from people and relatives. In the main people said staff were kind and caring and treated people with respect. One person said, "The carers are always friendly and nice to me."
- However, we were told of instances where staff had not always been compassionate or had been disrespectful. One relative told us, "There was one carer who was rude. I told [provider's nominated individual] and they said they would sort it and they did, that carer has never been back." The provider's nominated individual confirmed this member of staff no longer worked at the service.
- There was mixed feedback from people and relatives about continuity of care enabling them to build caring and trusting relationships with staff. One person commented, "I have the same carers come several times a day. They know the routine and it works well enough." Whilst other comments included, "lots of different faces, changes all the time, don't have a regular carer have to explain everything several times as they don't know me." The provider's nominated individual acknowledged there had been some personnel issues which they had dealt with and this had affected continuity of care but advised that new staff had been appointed and things were settling down.
- Staff were aware of people's diverse individual needs and how to meet them. However, these were not reflected fully in people's care records.
- People and relatives where appropriate told us they were supported to express their views and make decisions about their care. One person told us, "I am listened to, been involved from the start; I know what my care consists of." However, people's care records were not always person- centred and did not depict how they were involved in making decisions about their care.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was respected, and their independence encouraged. One person told us, "The carers are discreet, professional and kind. They treat me with respect and dignity."
- Staff demonstrated they understood how to protect people's privacy and dignity, for example when providing them with personal care using towels to protect their modesty.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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

● In the main people and relatives told us the care they received met their individual needs and preferences. However, some feedback cited instances where their preference for the gender of carer who would be visiting them or agreed time was not always adhered to and they had to mention this to management for this to be resolved. The lack of an effective system for planning and coordinating people's visits including the use of rotas so people would know who to expect and when further compounded this issue.

● Improvements were needed to ensure people's care records were person-centred and used language that valued people. Records seen were task led and did not always reflect individual preferences and wishes.

● Documentation did not show how people and their representatives, where appropriate were involved in the planning and delivery of their care arrangements.

● The new manager had identified that the care plans needed improving and were taking steps to address this through a review of all care plans and training for staff in record keeping. They showed us one care plan they were working on and we saw that information was detailed, clearly involved the person in decisions about their care and guided staff on how to meet their specfic needs.

● The new manager needs to be supported by the provider to ensure the planned improvements to care plans are fully implemented in the service. It will take time to make the changes and ensure these are embedded and to alter associated staff culture.

Improving care quality in response to complaints or concerns

● The provider's complaint process was not robust. There were no formal systems to show how complaints and concerns were investigated, responded to and used to improve the quality of the service.

● The provider's nominated individual told us that they dealt with any issues when they arose but acknowledged there were no records to reflect this.

● People and relatives told us that they knew how to make a complaint and said they would contact the office. However, some feedback cited issues had not always been addressed due to the changes in management but where people had escalated their concerns to the provider's nominated individual these had been resolved.

Meeting people's communication needs

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 service was complying with AIS and where required information was provided to people in alternative

formats such as pictorial format, large print, easy read to enable them to access the information in a way they could understand.

End of life care and support

● No-one at the time of our inspection was receiving end of life care and support.

● People's care records showed us that the service had sought the wishes and preferences of people including if they wanted to be resuscitated and these were kept under review.

● The manager told us that the service would work with the relevant professionals to ensure people had a comfortable and pain free death. They advised us they were planning further training and support for staff on end of life and advance care planning (ACP). ACP is used to describe the decisions between people, their families and those looking after them about their future wishes and priorities for care.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There was a lack of effective leadership in the service. We found a chaotic and disorganised service with no formal systems and processes. Since the service was first registered there had been one registered manager who no longer worked at the service. The current manager had been in post three weeks at the time of our inspection.
- There were no quality monitoring systems to ensure people received safe care.
- The provider had failed to establish effective quality assurance and governance systems that identified areas of risk and improvement needed within the service.
- We found the provider was failing to ensure that records in the service were comprehensive and accurate. For example, records relating to the recruitment of staff and the management of complaints and medicines.
- There was no system to identify missed or late calls in a timely way to reduce the risk of people using the service experiencing harm.
- The provider did not have effective oversight to ensure staff sent to provide support to people in their own homes had completed their suitability, training and competency checks.

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

- Before and during our inspection we received information of concern from whistle blowers. Whistle blowing is a recognised way in which staff can raise concerns to bodies including the Care Quality Commission (CQC) regarding people's safety and the quality of care. Providers should make arrangements for their staff to raise concerns under their duty of candour arrangements. The provider's system regarding this was ineffective.

Due to poor governance and oversight of the service people were placed at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were encouraged by the approach of the new manager. Despite being in post a short time they had identified shortfalls in the service and had developed an action plan to address this. These improvements need to be fully embedded and supported and recognised by the provider.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics; Working in partnership with others

● Most people told us they felt that staff providing support to them listened to their views and opinions. However, this was not reflected in their care records or used by the provider to shape and improve the culture of the service. For example, people's feedback about requests for rota's, preference of gender of staff and timings of care calls were not always met or prioritised.

● Staff told us they felt supported by the provider and had meetings and supervision. However, we were unable to view the staff meeting minutes and supervision records as there were no records of this taking place. Given the shortfalls found at this inspection we were not assured by the effectiveness of the supervision and meetings.

● The provider did not recognise their own regulatory accountability to ensure accurate records were kept and could not evidence management of staff performance and support.

● The service worked with other services such as the social care and community district health teams for the benefit of people using the service. However, despite feedback from one professional citing a positive working relationship our findings showed the service had not acted regarding shortfalls in records which had been previously brought to their attention by the local authority.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always managed safely. The provider did not ensure the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems or processes were not in place to ensure compliance with the requirements in this regulation. The provider did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that staff employed were suitable to work in social care and had undertaken the required checks. Staff had been knowingly deployed to support people without these checks in place.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not operate an effective system to monitor and identify that people

received their care on time and for the planned duration.
The provider did not have effective systems in place to fully support staff in their roles.