Ede Care Ltd

Harlow Enterprise Hub

Inspection report

Kao Hockham Building
Edinburgh Way
Harlow
CM20 2NQ

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30 June 2021

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03 September 2021

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service caring?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Harlow Enterprise Hub is a domiciliary care service providing personal care to people in their own homes. The registered manager told us before and during the site visit they were providing a service for two people. However, in our follow up calls to relatives and professionals, we learnt that people had not been in receipt of a service from the provider for a number of weeks. The evidence in this report is focused on those who had been in recent receipt of the regulated activity of personal care.

People's experience of using this service and what we found
People who had used the service were not happy with the care and support provided.

The provider did not have processes in place for the safe management and oversight of the service. Risks to people's health and wellbeing had not been assessed and actions put in place to mitigate them. Staff were not recruited safely in line with current requirements. People's medicines were not recorded or managed safely. Infection control including COVID-19 policy and procedures were not in place to keep people safe from the risk of infection during the pandemic. Lessons had not been learnt when things had gone wrong.

People's needs had not been assessed and care not carried out in line with legislation and guidance. Staff did not have the skills or training to meet people's needs. There was insufficient support, supervision and training to care for people. People did not get the care and support around their meals.

Arrangements were not in place for services to work together. People were not supported to live independent lives and have access to healthcare support. 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 management and staff were not always caring and kind. Care provided was not consistent, reliable or person centred. People's dignity and respect was not considered.

Staff did not have access to clear information about people needs and wishes. The care plans provided minimal information about how care was to be delivered. Concerns and complaints were not always listened to. There was no evidence of people being cared for at the end of their lives.

The provider did not have robust processes in place for the effective and safe management and oversight of the service. A quality assurance process was not in place to monitor, review and audit the care provided.

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

Rating at last inspection
This service was registered with us on 7 January 2020 and this is the first inspection.

Why we inspected
This was a planned comprehensive inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to Regulation 9, 12, 17, 18, 19 at this inspection.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inspected but not rated

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inspected but not rated

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inspected but not rated

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inspected but not rated

The service was not well led.

Details are in our well led findings below.

Harlow Enterprise Hub

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 one inspector.

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

Inspection activity started on 29 June 2021 and ended on 5 July 2021 We visited the office location on 30 June 2021.

What we did before the inspection
We reviewed information we had received about the service. 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 spoke with two relatives about their experience of the care provided. We spoke with two staff on the phone and the registered manager when we visited the office. Two professionals provided their views of the contact they had had with the service.

We reviewed a range of records. This included two people's care records. We looked at two staff files in relation to recruitment and staff training and supervision. 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. Not all information requested was provided.

Inspected but not rated

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risks to people's health and well being had not been completed sufficiently to understand their needs. Information was inadequate and confusing. In one person's care plan, it was recorded, "If left alone will fall," and, "Should only do step transfers, not mobilise or walk." For another person, it was recorded they used walking and bathing equipment, but no risk assessments had been completed in order to keep them safe from harm.

● Environmental risk assessments had been completed. However, we were unclear how correct these were as the registered manager had not been to the person's property.

Using medicines safely

● The provider did not have a system in place for the safe administration of medicines. People's care plan identified they needed support with their medicines but did not adequately describe the support needed and any risks to them not having their medicines as prescribed.

● No information was available on the care plans as to what medicines people were taking, the dose, the times or any specific instructions in how to take them.

● The registered manager told us staff signed the medicine administration record (MAR) when they had given or prompted the person with their medicines. One staff member told us, "There was nothing at the person's house for me to write down that I had given [person] their tablets. Another told us, "There is a MAR at the house, but I only prompt the person with their medicines, so don't always fill in the form."

● The registered manager told us they audited the MAR to check it had been completed correctly when they visited people. However, relatives and staff told us the registered manager had not been to the person's home and therefore no checks had been completed.

● Staff had not undertaken up to date training in medicines administration. Checks on their competency to administer people medicines had not been completed

Preventing and controlling infection

● The provider did not have an infection control policy and procedure in place. They had not followed government guidance in relation to COVID-19 and the pandemic. We could not be assured people and staff were safe from the risk of infection.

● We were not assured that the provider was accessing appropriate testing and vaccinations for staff. The registered manager told us staff were tested monthly with a Polymerase chain reaction (PCR) test. They did not use Lateral flow tests (LFT) and were unclear as to how and when they should be used. Staff informed the registered manager these had been completed by sending the result via email.

● One out of four staff had received their vaccination, with three refusing to have it. The registered manager had received their vaccinations. No company or individual risk assessments had been completed for those

staff members who refused the vaccination. The registered manager told us a person refused their service because they only wanted staff who were vaccinated.

● The registered manager told us all staff, including themselves, had other jobs as they were unable to provide enough hours to work full time for the service. The registered manager was not aware of the government guidance about restricting workforce movement between care services and the risks this may pose to staff and people they supported.

● We saw evidence that staff had undertaken some training in infection control. One staff member had completed a COVID-19 for nursing professionals course and another staff member PPE for healthcare workers. New staff, yet to be interviewed for the role, had completed on-line infection control training.

● A generic risk assessment for staff from a black and ethnic minority background had been produced. However, no individual risk assessment relating to the protected characteristics of staff had been undertaken to ensure risks to their health were minimised.

● Staff told us they used personal protective equipment such as masks and gloves when going to see people. However, we were not assured that the provider could effectively prevent or manage any COVID-19 outbreaks as systems were not in place and staff were not trained enough or aware of the providers policy and procedures in relation to outbreaks.

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

● The registered manager was not able to identify areas where improvements were needed as they were still putting systems in place to manage the service. There was no record of any incidents, accidents, near misses or lessons learnt.

● We were made aware of a safeguarding concern regarding a person who fell whilst trying to open the door to a staff member from the service. The local authority raised a safeguarding about the incident but CQC did not receive a relevant statutory notification from the provider.

● There was a detailed safeguarding policy and procedure. However, it did not refer to the local authority safeguarding adults' guidelines where the service was being provided but instead to a London Borough safeguarding team. Incorrect reporting procedures would place people at risk of harm.

Staffing and recruitment

● There was not enough staff deployed appropriately to meet people's needs. People had not received the care they needed as appropriate staff were not available. One family member told us, "[Registered manager rang and said [relative] would have to have a man visit. I told them, that was not right as [relative] needed a shower. They just said, we would have to put up with it till they found someone. In the end they didn't turn up the next day and we never heard from them again." Another family member said, "We got on well with the staff member till we were told they had left after a week. We found out they were just wandering around the village in between the calls as they didn't drive, and it was too far for them to go home."

● We asked the registered manager about the rota arrangements they had in place to meet people's needs. They told us, "[Staff member] does all of the hours, four times a day x seven days a week for [person]. If sick, will have to ask other staff to do it."

● The provider did not have systems in place for the safe recruitment of staff. The application forms for two staff members employed and two new applicants had not been completed correctly and did not provide the required information. The registered manager was unable to provide any references for staff as to their suitability and good character or notes of the interviews. Risk assessments had not been carried out in relation to the employment of relatives and any potential conflict of interest. Disclosure and Barring Service (DBS) checks had been done.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. 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.

Inspected but not rated

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.

There were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- There was no induction, support, training or supervision process in place for staff. Staff did not receive an induction to the service or shadow other staff to get to know the role and responsibilities before they went out alone. One staff member said, "I was told about the person and I was given the address and just went. [Relative] helped me with what was needed so thankfully I wasn't alone."
- The registered manager could not confirm that all staff had received up to date training in topics relating to their role. They showed us certificates for one staff member dated 2017 with only PPE 2020, first aid and equality 2021 up to date. Another staff member had a certificate 2021 showing they had completed 12 subjects in one day online. The registered manager told us practical moving and handling people training has been hard to do due to COVID-19 and "Staff just do online training and put it into practice by applying it."
- Staff told us they felt they could go to the registered manager should they need to, but no formal meetings had taken place. No records were available as to any discussions with staff members in relation to their support, training, supervision and checks on their competency to provide high quality care.

There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff available to care for people. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider had not accessed established resources in order to properly understand and implement current good practice guidance and procedures. This included a range of policy and procedures and current government guidance in relation to the pandemic.

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

- People were assessed as needing support with their meals. The information about their needs was very poor. For example, "Full support with meal preparation" and, "Give hot drink independently" would not support staff in knowing the person's likes, dislikes, wishes or preferences. A family member told us, "First staff member sent, was a young person, they went in making hot drinks that is all they were doing. One hour we had, and they never stayed the whole time."

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

- We have no evidence to support that staff worked with other agencies to support people to access healthcare services.

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.
- Information about people's capacity to make their own decisions had been provided by the local authority and was recorded. An assessment by the service had not been completed.
- Staff told us they had not been trained in the MCA but would listen to the wishes of the person they were caring for and ask for their consent before helping them.

Inspected but not rated

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.

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

- People told us they did not feel well treated or supported by the provider. One family member said, "We were not introduced to the staff member, they just turned up. They didn't know what they were doing. [Relative's] care was to make sure they took their tablets. They did this but nothing recorded, no notes of anything."
- A family member was pleased with the staff member they had been provided with. They told us, "We got on very well with the staff member who came. They were lovely and [relative] really liked them too."

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

- People's views were not contained in their care plans. People told us the registered manager had not visited them to do the assessment, it was completed over the phone. The registered manager told us that they transferred the information from the local authority into the care plans and read it to people and then made any changes. They then recorded the person had agreed to the care plan. We did not see any agreements recorded.

Respecting and promoting people's privacy, dignity and independence

- There was a mixed response about the way individual staff provided care. One family member said, "They [staff member] asked me things and I would show them, and we worked together very well." Another said, "Staff were turning up 8am in the morning for a 10am call and [relative] was still in bed. Then they did not come at all, will not use them again."

Inspected but not rated

Is the service responsive?

Our findings

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

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

- Care was not personalised, and people had little choice and control over how it was delivered, for example, being offered a male staff member for personal care and staff turning up at the wrong times.
- People's care plans did not contain enough information about their physical, mental and health needs for staff to respond appropriately. For example, it was recorded a person had, "Body pains at times." No information was available to say when, how and what this meant for them and what to do about it.
- People's preferences about their meals, food and drinks was not detailed so as to give them choice and promote their independence.
- Information about whether people had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) was confusing and inaccurate on the care plan. This could have serious consequences in terms of the action to take in the event of a cardiac arrest.
- The care plans were written in a task orientated way, with little information about the person. We did not see any evidence that staff recorded daily notes of what they had done for the person on each visit. Therefore, there would not be a story of how the care had been provided previously and any changes to the care required.

People were not receiving care which met their needs and preferences. This is a breach of regulation 9 (Person-centred care) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- Care plans identified if anyone had any sensory needs. For example, eyesight and hearing and any communication needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's next of kin and family were recorded in their care plan. No details were contained of any social care needs.

Improving care quality in response to complaints or concerns

- The registered manager told us they had a complaints process in place and had not received any written complaints.

● Relatives told us they were unhappy with the standard of care provided and had withdrawn from using the service. They had expressed their concerns to the registered manager and the response from the registered manager had been unsatisfactory. We saw no recording of the conversations, comments or concerns. There was no mechanism for capturing complaints, concerns and people's views of the care provided.

End of life care and support

● The registered manager told us the service had previously provided end of life care to two people. However, they said they would not be able to provide end of life care to people now as staff were not trained so would have to refuse to take the care package.

Inspected but not rated

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.

Leaders and the culture they created did not assure the delivery of high-quality care.

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 had not been open and transparent about the service provided to people. They had told us of two people they were providing a service for when we visited the office and saw their records. Staff we spoke with told us they were not currently providing care for them and were unsure who was. The registered manager confirmed one staff member was providing care for both people. However, we found out that people had not been in receipt of care for some weeks when making telephone calls to them. This was distressing for one of those people who had recently been bereaved.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Family members told us their relatives had not received good outcomes and the service had been detrimental to their health by turning up late, not turning up at all, only being offered a staff member of one gender which was inappropriate and lack of communication and respect.
- People did not have an appropriate and person-centred plan for their care. Their needs and risks to their health and wellbeing had not been assessed as no visit had taken place to assess their needs.
- Staff did not have the necessary information and records to complete care for people safely.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager was also the provider of the service. They were unclear about their role and responsibility to assess, review and monitor the service provided. Statutory notifications to CQC were not always provided.
- There were no quality assurance processes in place.
- Safe procedures for the recruitment, training and supervision of staff, administration of medicines, records relating to the management of the service were not in place.
- Records of activities relating to the management of the service were in disarray and difficult to find, both in a filing cabinet and records on the computer.
- The office was shared with two other companies not related to the provider and therefore information and communication was not kept confidential.

Continuous learning and improving care; Working in partnership with others

- There was no evidence that the registered manager was continuously learning and improving care.
- The registered manager was not working openly or sharing information appropriately with other agencies to support people's quality care.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. 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.

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

- Involvement of people in their care was minimal and feedback from relatives said it consisted of a phone call.