Justintime Healthcare Services Limited

Justintime Healthcare

Inspection report

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16 July 2020
17 July 2020

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Justintime Healthcare is a domiciliary care agency. It provides personal care and support to people living in their own homes. At the time of our inspection two people were using the service.

People's experience of using this service and what we found
Recruitment practices remained unsafe, and we found the provider was still not following a robust process to ensure people were safeguarded from abuse. The safety of care and the management of medicines remained areas of the service we were concerned about. We saw improvement in the management of calls since the service began supporting fewer people, and we did not have concerns about the use of PPE during the Covid-19 pandemic.

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.

People's consent to their care was still not well recorded. Staff induction and training remained areas of concern, however people told us they felt the care provided was beneficial to their overall health. We received good feedback about how people felt involved in their care and about positive relationships with staff members.

The care planning continued to lack a person-centred approach, however, people told us they discussed how they liked their support to be delivered. The provider had not acted to ensure people's end of life wishes were understood and planned for, which was also highlighted in our last report. People knew how to raise concerns, and we found most complaints were dealt with appropriately.

There was a lack of evidence to show how improvement had been planned and monitored, and the provider remained in breach of regulations. People told us their experience of the service had improved, however systems and processes to measure and improve quality in the service still lacked rigour.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate, (published 25 October 2019) and there were multiple breaches of regulation. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains rated Inadequate.

The service has been in special measures since 24 October 2019.

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

We carried out an announced, comprehensive inspection of this service on 14 August 2019 and 2 September 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safeguarding service users from abuse and improper treatment, safe care and treatment, fit and proper persons employed, staffing, consent to care and treatment, person centred care, good governance, and registration regulation relating to submitting statutory notifications.

We undertook this inspection to check they had followed their action plan and to confirm they now met legal requirements.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Justintime Healthcare on our website at www.cqc.org.uk . .

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 continued breaches in relation to safety of recruitment, safeguarding of people from abuse, safety of care provided, induction and training of staff, supporting people to give consent to their care and treatment, making care person-centred, submitting notifications and the overall governance of the service.

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 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 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.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Justintime Healthcare

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 three inspectors. Two inspectors visited the service and reviewed documents sent to us electronically. A third inspector made phone calls to people who used the service, their relatives and staff.

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

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 registered manager would be in the office to support the inspection.

Inspection activity started on 13 July 2020 and ended on 17 July 2020. We visited the office location on 15 July 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. When we told the provider we would be inspecting we asked them to send us information about care and the running of the service which we reviewed before our visit. We sought feedback from the local authority and local authority safeguarding adults team.

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 reviewed care records for both people who used the service. We looked at a range of other information including audits, complaints records, recruitment files for five staff and records relating to accidents, incidents and safeguarding. We spoke with the registered manager, three members of staff, one person who used the service and two relatives.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 the provider had failed to demonstrate robust improvement and the rating remains the same. This meant people were not safe and were at risk of avoidable harm

Staffing and recruitment; Learning lessons when things go wrong

At our last inspection the provider had not always carried out robust checks on potential new staff's background when they were recruited. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of Regulation 19.

● When we reviewed recruitment records we found background checks were still not robust. The approach to obtaining references was inconsistent, and the origin of some references could not be verified. One staff file showed references had been received after they had started work for the provider, another showed the provider had not received a Disclosure and Barring Service (DBS) check until after the staff member had commenced work.
● The provider was still failing to explore and document the reasons for gaps in potential new staff member's employment. We had asked the provider to take immediate action to ensure safe recruitment practices were in place during our last inspection.

Recruitment processes remained unsafe. This was a continued breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection people were experiencing missed calls as rota management was not robust. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection people told us there had been improvement in this area, and the provider was no longer in breach of this regulation.

● People and their relatives told us there was an improvement in the staffing arrangements, and said regular staff provided care. One person confirmed they were told in advance which staff to expect.
● The provider had introduced an electronic call management system since our last inspection. They told us they had concerns about its effectiveness in one area due to a poor phone signal. The registered manager said because of the nature of the calls they were providing they were able to monitor call performance easily.

Systems and processes to safeguard people from the risk of abuse.

At our last inspection the provider had failed to ensure they promptly responded to allegations of 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.

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

● As at our last inspection, we identified incidents which the provider had failed to consider or respond to as potential safeguarding matters. Reports to the local authority safeguarding adults team and CQC had not been made to enable an independent assessment of the incidents in line with legal requirements and the provider's own policy.
● Incidents included an allegation staff had shouted at someone who used the service, medicines had been given late and a failure by staff to call an ambulance when someone became ill whilst out in the community.

● The registered manager was able to show us what they had done in response to these incidents, however, we found their approach was not always thorough.

Although we did not identify evidence people had been harmed as a result, the provider was still failing to respond appropriately to potential instances of abuse. This was a continued breach of Regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely

At our last inspection the provider had failed to assess or manage risks associated with people's care and could not demonstrate the safe and proper management of medicines. 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 remained in breach of Regulation 12.

● Care plans did not always include information about risks people faced, which were in the documentation provided by commissioners of that care. For example, information about a skin condition, a degenerative health condition and a nutritional risk was not included in the information available to staff. We received documentation after the inspection.
● One person's medicines risk assessment stated staff did not administer medicines, however records showed this was not the case. There were gaps in the recording of medicines when these were given by family rather than staff.
● Care plans lacked information about medicines which people took on an 'as required' basis. When we asked the registered manager about this, they told us the documentation was in people's homes and no copies were held in the office. The information we received from the provider after the inspection often lacked detail other than the name of the medicine.
● Some medicines given on an 'as and when required basis' were not listed in the person's care plan. We received documentation after the inspection.

There were still issues with the quality of care information and the safe management of medicines. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People told us staff used appropriate PPE such as gloves and aprons and used hand sanitiser to help prevent the spread of infection. Staff we spoke with said they had access to good supplies of these items.

● The provider had carried out a risk assessment for Covid-19 in March 2020. There was a lack of evidence to show how the provider had acted in accordance with this assessment.

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.

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.

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty. This did not apply to anyone receiving this service at the time of our inspection.

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

At our last inspection the provider had not assessed people's capacity to consent to care and treatment. This was a breach of Regulation 11 (Consent to care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider remained in breach of this regulation.

- One person's care plan had been completed to show they lacked capacity, however the guidance for staff stated they should assume the person had capacity and also involve family members in making decisions.
- Another person's consent form had been signed by their relative, although the person had capacity to do so for themselves. A learning disability had been listed as the reason they could not sign.
- Some information about people's capacity to make decisions was poorly written, for example indicating unspecified best interests decisions needed to be made for one person who had capacity to make their own decisions. We raised this with the registered manager during the inspection as we were concerned about instructions for staff to monitor and report on the person's expenditure.
- When we spoke with the person they told us they felt able to make decisions for themselves which staff

respected. They did not have any concerns about management of their finances.

The approach to recording information about people's capacity did not demonstrate a thorough understanding and application of the Mental Capacity Act 2005. This was a continued breach of Regulation 11 (Consent to care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection the provider was not providing staff with formal support to enable them to provide effective care. 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 remained in breach of Regulation 18.

● Staff we spoke with told us they had a mixture of in person and online training. Some staff told us they shadowed more experienced staff before providing care to people. People and their relatives did not express any concerns about staff's ability to provide care.
● Records showed newly recruited staff completed the majority of their induction training in one day, and evidence to show when any shadowing or assessments of their competence were carried out did not demonstrate a controlled process was in place. One member of staff completed induction and shadowing in one day, although their application form showed they had not worked in care before. Another member of staff had not had their competence assessed, however had been 'spot checked' on their first day of working for the provider.
● Ongoing checks on staff competency were also sporadic. For example, one member of staff had their competency to administer medicines checked four months after they completed their induction, another staff member's medicines competency check was dated four days before they started working for the provider and completed their induction training.
● Staff we spoke with did not have any concerns about the support they received from the provider, however records of formal supervision of staff were sporadic or non existent.

The approach to training and performance management of staff lacked robust structure. This was a continued 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 registered manager told us they completed assessments of people's needs before they began to use the service, however was only able to show us completed care plans. Care plans contained the assessment carried out by the local authorities who commissioned the care, however the provider was not always thorough in ensuring people's needs were accurately transferred into care plans.

Supporting people to eat and drink enough to maintain a balanced diet
● People and their relatives told us staff made food which they liked. Staff we spoke with could tell us about people's preferences for eating and drinking.
● One person's care plan referred to staff monitoring the person's intake and ensuring they had a balanced diet, however there was no information to show why the person's intake was being monitored or why they

may be unable to make independent choices about what they ate and drank. There was a lack of guidance to show what a balanced diet may look like.

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

- Care plans included some information from health professionals about specific conditions people had.
- People and their relatives told us they experienced fewer complications with their overall health and said this was a result of the care they received.
- One person's care plan lacked information about their oral care needs.

Good

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People and their relatives were complimentary about the care they received. Comments included, "All the carers are super", "We have peace of mind," and "I can tell them [staff] how I want things."
- People who preferred to speak a language other than English had staff who could also speak this language.
- Staff we spoke with were aware of people's preferences and how to meet them. This included making sure food was appropriate for people's faith.
- Staff's caring and committed approach was a key strength of the service, in spite of the shortfalls in all of the other domains and the weaknesses in the leadership and management of the service.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- Feedback from people about their experience of involvement in their care was positive. One person told us they had time to get to know staff before they started to provide overnight care. A relative told us the provider wanted to listen to their views.
- Staff we spoke with knew people and their needs well. One member of staff we spoke with told us they had time to read care plans before they provided care to the person.

Requires Improvement

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 inadequate. At this inspection this key question has improved to requires improvement. This meant people's needs were not always met.

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

At our last inspection the provider had failed to ensure people's care plans reflected their preferences and were sufficiently detailed to support staff to meet their needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● At our last inspection there was no information in care plans about people's wishes for end of life care. Although the provider's Covid-19 risk assessment referred to the importance of ensuring end of life planning was put in place, this had still not been done.
● Some information from the local authority assessments was missing from people's care plans. This meant staff may have been unaware of these needs and how to meet them. This included information about health conditions, pain and adaptations needed to support one person to eat safely.
● One person's care plan contained a challenging behaviour risk assessment. The guidance for staff, however, stated this could be as a result of staff failing to provide enough to eat or drink, and that staff should 'walk away' if these challenges occurred.
● Care plans lacked evidence of robust review to ensure they were complete and up to date.

People's needs and preferences were not fully documented in their care plans. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives told us they were happy with their care plans and the support they received. One person told us, "At the beginning I said to them [the provider] what I like and dislike. They said they wanted to find out about me, they asked how I wanted things."
● People and relatives told us their overall health and wellbeing had improved and told us this was as a result of the care they received. Examples shared with us included having fewer seizures and a lack of hospital admissions.

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.

● There was some improvement in the provider's approach to ensuring people were supported to receive information in ways they could understand. For example, one person received care from staff who were able to speak the same language. However, the person had signed an English language version of their care plan despite this stating they struggled to understand English.

We recommended the provider ensures people's communication preferences are met.

Improving care quality in response to complaints or concerns

● People and relatives we spoke with were able to tell us how they would raise any concerns about care. One person told us, "If anything was untoward, I would tell them [staff and the provider]. If things were difficult, we would compromise. I would speak out."

● There was evidence most complaints were recorded and responded to, however we found some inconsistencies as one issue had not been recorded and another lacked evidence of a full response from the provider.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; 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

At our last inspection the provider did not have robust systems to assess, monitor and improve the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection not enough overall improvement had been made and the provider remained in breach of Regulation 17.

- People and their relatives told us they had seen a considerable improvement in their experience of care. They told us they were now happy with the quality and consistency of the service. However, our findings were that some aspects of the organisation of care still needed further improvement to enable the provider to demonstrate they were fully meeting their responsibilities under the Health and Social Care Act 2008.
- Systems in place to monitor quality in the service lacked rigour and had not been effective in addressing areas of concern raised in our last report, although there had been a considerable reduction in the number of people using the service. The provider remains in breach of eight regulations.
- Some audits lacked detail to show the process followed or the documents reviewed. For example, medicines audits provided to us lacked information as to what had been checked and confirmation actions had been taken when needed. The audits dated from January to April 2020 were completed on a form which was dated May 2020. This meant they had not been completed on the dates stated.
- Some confidential personal information had been moved to a member of staff's domestic address, and could not be retrieved. The member of staff no longer worked for the provider. There had been a lack of robust response to this. The Information Commissioner's Office (ICO) had not been informed in line with best practice, and there was no documentation available to show why this decision had been made. No other bodies had been informed of this event, and the decision to remove confidential information to a member of staff's domestic address had not been risk assessed.
- The provider's policies and procedures were not always being followed.

The provider still lacked robust systems to monitor and improve quality in the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the provider had not submitted notifications which they were required to do by law. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● At this inspection we identified one allegation of abuse incident which should have been notified to us at the time it was made. This was because the nature of the allegation indicated potential abuse towards a person using the service.
The provider did not always recognise when notifications should be submitted. This was a continued breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Working in partnership with others
● Care plans contained evidence of the provider working with local authorities and health professionals to support people with their care and support needs.