

Justintime Healthcare Services Limited

Justintime Healthcare

Inspection report

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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?

Requires Improvement 

Is the service responsive?

Inadequate 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Justintime Healthcare is a domiciliary care agency. It provides personal care and support to people living in their own home. On the first day of our inspection, 21 people were receiving this service. On the second day of inspection this number was 17 people and on day three this had reduced to 11 people.

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 and their relatives did not always feel safe and had raised concerns about care workers arriving late or missing care visits.

People were not protected from abuse and improper treatment. The registered provider was not always identifying safeguarding concerns, investigating them in a timely way and reporting them to the appropriate local authorities. These incidents were also not being reported to the Care Quality Commission (CQC).

Risk assessments were missing, lacked detail or contained general statements. Insufficient action had been taken by the registered provider to reduce the risk of harm to people.

The management of medication was not safe. We found gaps in the recording of medicines administration, lack of consistency in the instructions for one person who required crushed medication and protocols for the use of 'as required' medicines were missing. People who required support with their medication did not always have a medication care plan or risk assessment. We could not be sure all staff administering medication had an up-to-date medication competency assessment and the registered provider was not completing medication audits.

The recruitment of staff was not robust as up-to-date backgrounds checks had not been completed. Staffing levels were not sufficient to meet people's needs as people, relatives and records we saw showed missed and delayed calls on a regular basis.

Staff were routinely asked to give care and support for people with specific health needs which they were not trained to provide. The registered manager said they provided staff with supervision, although staff told us this did not happen.

The registered provider was not completing mental capacity assessments for people who lacked capacity to make certain decisions. 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 did not receive care and support that was person-centred. Care plans were not sufficiently detailed. There was an over-reliance on the assessments carried out by commissioners such as local authorities. End of life care needs were not assessed even though the registered manager told us most people required this support.

Management oversight was not evident over key aspects of the service. This demonstrated that systems to assess, monitor and improve the service were not sufficiently robust. We saw evidence of some complaints being responded to appropriately.

The registered provider was unable to demonstrate how people's communication needs were met.

People told us their healthcare needs were met by staff who provided their care. We saw people's care records did not always include contact details for healthcare professionals. People told us their dietary needs were met, although one person's care records needed further detail around their diabetes.

People and relatives were mostly positively about the staff who provided their care. We were also told that care staff protected people's privacy and dignity.

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 13/09/2018 and this is the first inspection.

Why we inspected

This was a planned inspection based on the date this service was registered with the Care Quality Commission.

Enforcement

We have identified a total of eight breaches of regulation in relation to the recording of people's mental capacity, a lack of person-centred care, the management of medicines, management of risks to people, protecting people from harm, oversight of the service, recruitment of staffing. We have also identified a breach of our registration regulations.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate ●

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-Led findings below

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

This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

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

What we did before the inspection

Before the inspection we reviewed the information we had received from the service. This included statutory notifications about incidents in the service which the registered manager is required to make. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make; this is called a Provider Information Return (PIR). We also asked the local authority, safeguarding teams and other professionals, including Healthwatch who have contact with the service for any information they could share. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We did not receive any information of concern.

During the inspection we spoke with the registered manager, the nominated individual, the care manager, the business development consultant, the field care supervisor and three members of staff, four people who received this service and six relatives. The nominated individual is responsible for supervising the management of the service on behalf of the provider. Throughout the report we refer to them as 'the registered provider'. We looked at six people's care plans as well as other records including those connected with recruitment and training, medicines administration and quality monitoring.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and other records. We shared information of concern with the relevant safeguarding teams and commissioners.

Is the service safe?

Our findings

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

We have rated this key question as Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from abuse and improper treatment. Inadequate systems were in place to ensure people were safeguarded from abuse. Allegations of abuse had not been recognised as reportable and were not investigated. These included allegations of abuse related to missed care visits, allegations against staff and the registered manager and poor management of both known risks and medication. As part of this inspection we raised eleven safeguarding concerns with the relevant local authorities.
- The training matrix showed staff had received safeguarding awareness training and staff we spoke with were able to recognise signs of abuse. However, during this inspection, we found this had not always happened and the provider was not following their own safeguarding policy.
- People and relatives we spoke with shared mixed views about how safe they felt with the care provided. One person told us, "My care workers do make me feel safe and comfortable when they are here." One relative said, "With the majority of the care workers yes, my relative does feel safe, however once one of the care workers turned up near midnight, [relative] now puts the key in the lock when [relative] goes to bed."

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment as the registered provider was not effective in promptly responding to allegations of abuse.

Assessing risk, safety monitoring and management

- Risk assessments were either missing, or where available, lacked detail or contained general statements.
- One person who needed a soft diet did not have a choking risk assessment. Another person who needed staff to use a hoist to assist them did not have a moving and handling risk assessment.
- In one person's care plan, there was no guidance for staff on moving and handling, equipment needed and pressure care management. The local authority assessment of needs stated this person needed two hourly repositioning. There was no evidence to show how this need was met.
- Care plans did not always have completed environmental risk assessments to ensure staff worked in a safe space and that people were also kept safe.
- During the inspection, we discussed with the registered manager our concerns about how risks to people's care were being managed and we asked them to review these immediately. In our ongoing contacts with the registered provider, we were not reassured all the necessary actions were being taken to address the issues identified. We issued a letter of intent informing the provider that CQC was considering whether to use its powers pursuant to the urgent procedure (for suspension, or imposition or variation or removal of conditions of registration) under Section 31 of the Health and Social Act 2008 and asking the registered provider for assurances of how the risks were being mitigated. We also shared our concerns with the relevant safeguarding teams and commissioners of care.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment as the registered provider did not assess or mitigate the risks to the health and safety of people when receiving personal care.

Using medicines safely

- People who required support with prescribed or over the counter medication did not have a medication care plan and risk assessment as indicated in the provider's own medication policy. We looked at medication administration records (MARs) and saw unclear instructions for staff on how to administer medication. Gaps were seen in the recording on MARs making it difficult to establish whether people had received their medicines.
- We looked for evidence of 'as required' (PRN) protocols and found these were not in place.
- The staff training matrix showed that only three out of 17 staff had their competency to administer medication checked.
- One person received their medication in crushed form. The instructions for staff were not clear and the registered provider's medication policy did not cover the use of crushed or covertly (without knowledge) given medicines.
- There were no medication audits in use at the time of our inspection. This meant there was no oversight to ensure people received their medication safely. For example, one person's MAR showed staff ticked to indicate they had administered medicines, when they should have recorded their initials to show who administered.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment as the registered provider was unable to demonstrate the proper and safe management of medicines.

Staffing and recruitment

- Recruitment procedures did not protect people from the risk of unsuitable staff being employed. One staff member's file showed they did not have a new DBS check when they joined the service. The same staff member only had one reference and it wasn't clear this was from an individual qualified to provide this. We saw the reference did not come from the staff member's last employer.
- Other staff files we checked also contained gaps in recording of recruitment of staff such as in their employment history. We discussed these concerns with the registered manager and asked them to take immediate action to make sure safe recruitment procedures were reviewed and implemented.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed as relevant background checks to ensure only suitable staff were employed could not be demonstrated.

- People and relatives told us they experienced late and missed calls. One person said, "Yes, many times they have not turned up and many times they have been late." One relative said, "This is one of our main issues. They do not turn up sometimes, they turn up late and they never call us to let us know they are not turning up or are late."
- Rota management was not effective in making sure care visits were always completed and provided on time.
- One relative told us a staff member had carried out a visit which we saw was due at 7:00pm at midnight in July 2019. The relative told us this was upsetting for their family member as they had noticed this when they checked the signing-in book to find a staff member had been in their house when they were asleep. They described this as unacceptable.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing as rota management was not robust, leading to late and missed calls.

Learning lessons when things go wrong

- When we reviewed accidents and incidents forms, we saw several instances of missed or late visits had been recorded in the months prior to this inspection however this information was not used by the registered manager to make necessary changes in a timely way.
- Between days of our inspection, people continued to experience late or missed calls. The registered provider was in the process of introducing an electronic rota management system which they told us would make this process easier to manage.

Preventing and controlling infection

- People and relatives told us staff took steps to ensure infection control was suitably managed. They said most of the care staff wore appropriate gloves and aprons when they visited people's homes to provide personal care.

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.

We have rated this key question as 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

- People and relatives told us they felt staff were capable of carrying out their duties effectively. One person said, "The care workers are very skilled and know what they are doing, they are trained."
- We looked at one staff member's training as they had been asked to provide cover in an emergency. The registered provider assured us this staff member had received training, although there were no records to support this.
- Training records we looked at showed staff were not always adequately trained in specialist areas, for example, caring for people with a learning disability, epilepsy awareness and challenging behaviour. Mandatory training was found to be up-to-date.
- The provider could not demonstrate that effective support was in place for staff. We saw some evidence of staff supervision, although staff told us they had not received this support. The registered manager told us they provided these sessions, but said staff likely didn't recognise this as 'supervision'. We saw three probation reviews, although these were not dated or signed and showed limited recording.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing as formal staff support was not consistently provided to enable staff to provide effective care.

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.

- Staff told us some people they cared for did not have capacity and said relatives made decisions on their

behalf. There was no assessment of capacity and record of best interest's decisions in these cases.

- The care plan of a person who lacked capacity to make decisions about their care stated they had specific dietary needs, although daily records showed staff were not following this. The registered manager said the person's food was prepared by a relative and the choices were made in their best interests, although there were no records to support this.
- The registered manager did not demonstrate the required understanding of the MCA (2005) in line with her accountabilities and was therefore unable to offer assurance of her competence in this important area of work.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Consent to care and treatment as mental capacity was not assessed.

- People told us they were supported by staff who asked for permission before providing care. One person said, "They always ask me for my consent. They tell me what they are doing and they talk to me as a person."

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

- Care plans did not routinely list the health professionals who were involved in the person's care. The registered manager told us they received this information from the local authority or Clinical Commissioning Group.
- We asked people if staff met their healthcare needs. One person said, "The regular care workers are excellent. They know what to do when I feel ill. They are good." A relative told us, "We work together to ensure all my relatives general health is looked after."
- We saw one person had been referred to a moving and handling service as they needed more assistance with walking and staff felt it was safer to provide an extra staff member for this person.

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

- People and relatives told us staff provided choice around what they wanted to eat and drink.
- One person told us, "They prepare food for me. Sometimes, if they are not going to turn up they will prepare a sandwich for me." One relative said, "They do support giving my relative food. They are very caring when they do this."
- We saw one person's care plan noted they had diabetes, although there was no further information regarding how staff should meet this dietary need. The registered manager told us they would rectify this information and make sure staff were aware of it.

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

- We found the registered provider was aware of recognised national guidance, such as the National Institute for Healthcare and Excellence (NICE) and legislation such as the Mental Capacity Act (2005), although we found these were not being followed.
- The registered provider received assessments of people's needs from neighbouring local authorities. They subsequently carried out their assessment of the person's needs and produced a care plan. However, we found this lacked sufficient detail to guide staff.

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.

We have rated this key question as 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

- Some people and relatives told us and records reviewed showed that care was not always good. People were not always well supported as there were missed or late calls and some people reported that they were not always treated with kindness.
- However, we also received positive feedback about the relationships some people and relatives had established with some staff members and the positive impact this had on them. One person told us, "Care workers are fantastic. They are caring, always giving me dignity and respect." Another person said, "I have a good relationship with the care workers. They are fine with me."
- Relatives commented, "I have watched them [staff] and they always speak to my relative. They have such a good relationship and [name of person] looks forward to seeing them", "Indeed they are [caring] at all times. Even if my relative is grumpy and moody, they know how to support [name of person]" and "Staff are wonderful. [Name of staff] is excellent, gentle, kind and punctual. I could not ask for anyone better. [Name of other staff member] is also excellent."

Respecting and promoting people's privacy, dignity and independence

- People and relatives confirmed the majority of staff were respectful working in their own homes and they supported them to maintain privacy and dignity.
- People told us, "Absolutely without any doubt staff are kind and caring" and "They are very kind and always respectful to me."
- One person told us, "I am very independent. They do listen to me."
- One staff member described how they maintained people's privacy and dignity. They told us, "I make sure everything is covered. We always ensure curtains are closed."

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

- There was some evidence in care plans we looked at which showed people's preferences had been listened to and recorded.
- We asked the registered manager how they involved people in their care. The registered manager told us this happened when a new service started. They also said the care manager was scheduled to go out and meet all the people and relatives receiving this service to review their needs.
- Care plans we looked at did not show how people's equality, diversity and human rights were respected in accordance with the Equality Act (2010). For example, where people had specific requirements relating to their religious or cultural needs, this was not recorded in their care plan.

Is the service responsive?

Our findings

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

We have rated this key question as Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- There was an over-reliance on the assessment of needs which the Local Authority or Clinical Commissioning Group completed before the registered provider commenced their service. This information was not always transferred into the registered provider's own documentation meaning there was no evidence to show the assessment of needs received was still valid.
- Individual care plans we looked at were task focused and there was little information about individual risks, goals, skills and abilities. For example, there were no life histories in the registered provider's care records we looked at.
- One person was recorded as needing a soft diet, although two staff we spoke with were unaware of this and the person's needs.
- The registered manager told us reviews of care plans took place every six weeks and increased to every two weeks where people were in receipt of end of life care. However, the sample of care plans that we looked at did not evidence this and we saw one person whose service commenced in April 2019 had not received a review of their care needs at the time of this inspection.
- The registered provider confirmed that most people who received this service were on an end of life care pathway. Despite records showing they had received this training, staff we spoke with about end of life care were unable to demonstrate they had the required knowledge in this area. Care plans we looked at did not contain an assessment of people's end of life wishes to ensure their preferences were met during this important stage of their life.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care as people's care records and staff knowledge of their care needs was not sufficient to meet people's needs and reflect their preferences.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The 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 insufficient evidence to demonstrate that the service had identified people's communication needs. Where people had a disability or a sensory loss, there was no evidence their communication needs had been explored or any effort to communicate with them in ways they could understand. For example, one person was recorded as having a learning disability, but there was little information about what support was needed to enable effective communication.

- Another person was recorded as having sensory needs with hearing and their sight. There was no communication plan in place for this person to meet the Accessible Information Standard.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person centred care as the provider did not evidence how they were able to meet people's specific communication needs and preferences.

Improving care quality in response to complaints or concerns

- We looked at how the service managed and responded to complaints. One person told us, "It does take time for them to do something. I told them that I do not need a Saturday call, but they send someone when I am not here. I have complained about the lateness and times. This is slowly changing now." One relative said, "I have spoken to the management. They say they will come back to me, but they do not come back and I do not chase it either."
- There was some evidence to show complaints were being responded to, although we saw a 'staff meetings log' dated 8 August 2019. It was recorded 'a complaint was raised by a [person] regarding language'. On the third day of our inspection, we saw this was not recorded in the complaints log.

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.

We have rated this key question as Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Management oversight over key aspects of the service was not evident. Recruitment, rota management, person-centred care and management of risk were poorly managed.
- There were no systems in place to assess, monitor and improve the quality and safety of the service provided. The registered manager was unable to provide any evidence of audits and said they were in the process of doing these. For example, there were no checks taking place to ensure care plans contained sufficient and accurate information.
- There was no effective system to assess, monitor and reduce the risks to people's health and wellbeing. Records of accidents and incidents were maintained, but these were not used to inform and update people's risk assessments.
- The registered provider had failed to recognise their systems for recruitment of new staff were not robust.
- Rota management was not effective as people and relatives told us they had experienced late and missed calls.
- We looked at daily notes for one person and found a week of recording was missing from June 2019. The registered manager was unaware of this and there was no evidence to show this had already been identified or addressed.
- The registered manager told us they carried out spot checks on staff every six weeks. There was insufficient evidence to demonstrate this. The registered manager commented there was a backlog and some of these checks had not been carried out.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance as management oversight was not evident over key aspects of the service. This demonstrated that systems to assess, monitor and improve the service were not sufficiently robust.

- Prior to our inspection, we had not received any notifications for reportable events within the service. The registered manager did not have a sufficient knowledge of their reporting duties. We found incidents concerning neglect and other forms of abuse had not been reported which is a legal requirement. We asked the provider to submit the required statutory notifications for the safeguarding concerns identified during the inspection but this was not done.

This was a breach of (registration) regulation 2009: Regulation 18 as the registered provider had not

submitted statutory notifications concerning reportable events which is a legal requirement.

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

- We asked people and relatives whether they thought the service was well-managed. One person said, "The management have to go back to school. They need to deal with co-ordination. They need to sort out turning up as well [for contracted visits]." One relative said, "They are not organised. They send different care workers without letting us know." However, other people and relatives expressed they were satisfied with the support.
- One staff member told us the registered provider had taken on further packages of care without having sufficient staffing levels to meet the needs of these people.
- Another staff member said, "[Registered manager] misses calls and tries to blame this on carers. [Registered manager] sends out rotas and [they] will miss clients and then afterwards says it is our fault."

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

- The registered manager said they held staff meetings from time-to-time, but there were no records of this.
- The registered manager told us they carried out satisfaction surveys when people were supported by staff new to them. We saw four responses to the survey which showed mostly positive feedback.

Working in partnership with others

- The registered provider was working with several local authorities and Clinical Commissioning Groups.
- There was some evidence to show the registered provider worked with other partners to meet people's care needs. The registered provider's PIR submitted before our inspection stated they waited for contacts to be given to them when new packages of care started.