Jigsaw Homecare Ltd

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Inspection report

Suite 19 Block B
Brunts Business Park, Samuel Brunts Way
Mansfield
NG18 2AH

Tel: 01623662200
Website: www.jigsawmansfield.org.uk

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09 February 2022
23 February 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Jigsaw Homecare is a domiciliary care agency providing personal care to older people, some of which were living with dementia. The service supported 124 people at the time of the inspection. Not everyone who used the service received personal care. The Care Quality Commission (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. There were 80 people receiving regulated activity at the time of the inspection.

People's experience of using this service and what we found
People's care was not planned in a way to ensure their needs and preferences were being met. People told us call times and lengths were inconsistent and they didn't know which carer was coming or when. Risk management was poor and placed people at increased risk of harm or injury. People were supported with their medicines but management of this placed people at increased risk of not receiving their medicines as prescribed.

People were placed at increased risk because the provider and registered manager failed to implement effective quality monitoring systems and auditing processes. The registered manager did not effectively carry out their duties and responsibilities and had a lack of understanding of their statutory obligations.

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 requires improvement (published 4 May 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to staffing, safeguarding, call times and management. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection

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

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Jigsaw Homecare Limited on our website at www.cqc.org.uk.

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 monitor the service and will take further action if needed.

We have identified breaches in relation to staffing, safeguarding, risk management, medicines and how the service is managed 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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Jigsaw Homecare Ltd

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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by two inspectors.

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

Inspection activity started on 9 February 2022 and ended on 24 February 2022. We visited the location's office on 9 February 2022.

What we did before the inspection
The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used all this information to plan our inspection.

During the inspection
On the 9 February 2022 we visited the location's office and spoke with office staff and the registered manager. We reviewed four staff files in relation to recruitment. We reviewed electronic files in relation to people's visits. On 22 and 23 February we spoke with eight care staff about their experience of working at

Jigsaw Homecare Limited. We also spoke with 13 people and their relatives about the experience of the care they received from Jigsaw Homecare Limited. We reviewed documentation in relation to eight people's care and the visits they received. We reviewed a range of information requested from the provider, including policies and training data.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection the provider had failed to ensure proper and safe management of risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People's safety needs associated with their health conditions and mobility were not always effectively assessed or detailed in their care plans. We found not all risks were identified and there was a lack of guidance for staff.
- One person's care plan contained brief information which indicated they had a catheter. However, there was no information to identify the associated risks, particularly the signs of infection, or any guidance for staff on catheter care.
- Some people had moving and handling risk assessments in place, however we found information in these conflicted with information in people's associated care plans. For example, one risk assessment indicated the person was "unable to walk" whereas the care plan stated the person "walks short distances". Information on which equipment to use to safely transfer people was also inconsistent across documentation.
- Over half of the staff had not received infection control training at all, or not in the past five years. Although people and their relatives told us staff do wear personal protective equipment (PPE), they said they do sometimes have to remind them to put it on, or to change it when required. A relative said, "During summer staff never wore PPE, they still never wear aprons, they only wear masks at my insistence. Staff don't change their gloves, they come and leave with same pair on."

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure proper and safe management of medicines for people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Systems and processes in place were not effective to ensure people received their medicines safely.
● Staff electronically recorded when they had supported people with their medicines. However, these were not always being filled in correctly. A relative told us, "We did have a problem with MAR (medicine administration record) sheets, we do get problems as they [staff] are not used to using them."
● There was no documented system to monitor whether medicine administration was accurate or timely. We found incidences of poor pain management which had gone unnoticed.
● Staff had very little guidance on how to support people with their medicines safely, for example there were no protocols in place for people who received medicines as and when required.
● People were being supported by staff who had no recorded medicines training.

The provider failed to ensure proper and safe management of medicines for people. This placed people at risk of harm. These failures are a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure people's call time preferences were adhered to and to ensure staff were deployed appropriately. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● People and their relatives told us there was no consistency to call arrival times or lengths.
● A person told us, "They are not coming at the correct times, I am left in bed for an average of 15 hours, I have left them know, they say they haven't got the staff. They put me in bed at 6.30pm when I'd prefer to go to bed at 8pm." A relative said, "Sometimes the bedtime call is really early, mum likes the bedtime call at 7pm, but it is often early, they have done the bedtime call at 4pm."
● People said that calls were being cut short. A relative said, "How long they are there is a big issue at the moment. Carers only getting 30mins, instead of an hour."
● Whilst most people felt staff knew them well, others felt staff had not had appropriate training. A person told us, "The staff are not trained in what they are doing, not to come into people's homes, they never know what they are doing." We reviewed training records and found significant gaps in staff training.
● We reviewed recruitment records and found a lack of evidence that pre-employment checks were being carried out. For example, Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staff told us there was no structured support from the provider, although most felt they could ring the office when needed. Staff said, "I haven't had a supervision for 3 years." Another said, "There is not enough support for staff from management."

The provider failed to ensure appropriate staffing was in place to meet people's preferred needs and to ensure people's safety. The provider failed to appropriately train and support staff. These failures are a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not kept safe from the risk of abuse or neglect due to the lack of systems, processes and training in place.

● The provider had a safeguarding policy in place; however, this was not being followed. The registered manager told us they did not write anything down in relation to safeguarding investigations, which went against the policy which stated, "A written record must be kept."

● Not all staff had received safeguarding training and safe recruitment practices were not in place, for example pre-employment checks were not being carried out consistently.

● Some staff we spoke with lacked a fundamental understanding of their safeguarding responsibilities.

● Care was not planned or delivered in a way that enabled all people's needs to be met, leaving them at risk of neglect.

The provider failed to ensure systems and processes were in place to safeguard service users and failed to put the needs of the service user first. These failures are 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.

Learning lessons when things go wrong

● The registered manager was unable to sufficiently demonstrate they had kept any records or taken any actions following incidents.

● Staff we spoke with said they did not feel feedback was taken on board when things were not going right and had not seen any improvements.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to 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.

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

At our last inspection the provider had failed to ensure their systems and processes to monitor people's care were effective and could not assure the Commission they had good governance systems in place. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● At management level we found evidence of a culture that significantly disregarded the needs of people. Care was not planned to meet people's specific needs. People and their relatives had very little input.
● A relative told us, "I have never been involved in any care planning, I have never seen any care plans, I didn't get a reply to my emails with information [about my relative]." Another said, "I have never been involved in [relative's] care plan… I have mentioned on the phone to the office about a review but was surprised to hear they had one only the week before…I was annoyed that I had not been asked to add my views."
● The registered manager did not understand their duties and had not implemented a clear system for quality monitoring or auditing of any kind. They were unable to produce any documentation in relation to incidents or concerns. They were unaware of the business continuity plan. Not only were they not meeting statutory requirements, they were not following the provider's own policies on such matters.
The provider failed to ensure effective oversight and robust governance which placed people placed at increased risk of harm. This was a continued 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
● People told us they still struggled to access an 'app' used by the provider and some believed they had to pay for it. It was therefore not accessible to all and people were unable to find out basic information such as the time of their calls.
● People and their relatives did not feel engaged by the service. A relative told us, "We have never received a questionnaire, or been asked by [registered manager] …asking if [named person] needs are being met."

● Staff did not always feel listened to or communicated with and no staff meetings, in any format, had been arranged in the past two years.

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; Working in partnership with others

At the last inspection the provider had not always notified us of important events when they happened, to help us monitor the quality and safety of people's care. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● The registered manager did not understand their responsibility to investigate incidents and accidents in a structured way and consequently share the information with the relevant parties.
● The local authority stated they had very little engagement from the registered manager.
● There was no system in place to learn from errors, as these were often not even identified, and there was no evidence of any improvements.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure proper and safe management of medicines for people. Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.

The enforcement action we took:

We issued a warning notice and placed the service in Special Measures.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems and processes were in place to safeguard service users and failed to put the needs of the service user first.

The enforcement action we took:

We issued a warning notice and placed the service in Special Measures.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective oversight and robust governance which placed people placed at increased risk of harm.

The enforcement action we took:

We issued a warning notice and placed the service in special measures.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure appropriate staffing was in place to meet people's preferred needs and to ensure people's safety. The provider failed to

appropriately train and support staff.

The enforcement action we took:

We issued a warning notice and placed the service into special measures.