Jigsaw Homecare Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Jigsaw Homecare is a domiciliary care agency providing personal care to older people, some of which live with dementia. The service currently supports 213 people. 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 90 people receiving regulated activity at the time of the inspection.

People's experience of using this service and what we found
The provider's systems for assessing and monitoring the safety and quality of the services provided were not always effective in identifying shortfalls and improving the service. Quality control audits were not carried out effectively to improve the service in some areas.

Risks to people's health, safety and welfare had not been adequately assessed and mitigated. People's medicines were not managed safely.

We were not assured that the provider was following guidance for good infection control practices.

The service was not consistently well-led. People were put at risk because the provider and registered manager failed to ensure suitable quality assurance checks were in place. The provider did not ensure staff always followed policies and procedures for the delivery of safe care.

The provider had not consistently notified CQC of significant events as they are legally required to do.

Staff worked in partnership with other health and social care professionals.

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

Rating at last inspection
The last rating for this service was good (published 30 January 2018)

Why we inspected
We undertook this inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received related to staffing levels, training, missed calls, missing care plans in people's homes and medicine administration records. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. 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 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 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 safe care and treatment, management of medicines, staffing and governance 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 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not always 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 Care Act 2014.

Inspection team
The inspection was conducted by one inspector and one 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, flats and specialist housing.

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
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 10 March 2021 with a visit to the office and ended on 29 March 2021.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We reviewed information received from other agencies and statutory notifications. A notification is information about important events which the provider is required to send us by law. 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. We used all this information to plan our inspection.

We spoke with four people and seven relatives about their experience of the care provided. We spoke with seven care staff, which included the registered manager, a planning coordinator, office assistant and four care staff. We looked at the relevant parts of the care records of seven people who used the service. We also looked at six staff recruitment files and other records relating to the management of the service. This included complaints, safeguarding and incident records.

After the inspection.
We asked the provider to give us additional evidence about how the service was managed. They sent some of the information we requested but did not send all the evidence to us. We continued to seek clarification from the provider to validate evidence found after the inspection. We looked at care plans, electronic medicine administration records (MAR) charts, training data and requested further quality assurance records, which they did not supply.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- People's safety needs associated with their health conditions were not always effectively assessed or detailed in their care plan. We found not all risks were recorded. For example, people who lived with conditions such as anxiety, diabetes and epilepsy did not have risk assessments in place to detail how staff could care for them safely. We also found that people who were at risk of falls and displayed behaviours that may challenge did not have risk assessment in place. This meant there was an increased risk to people of receiving unsafe care.
- One person's care plan had embedded in the critical information the person had good mobility, however it also stated they used a falls watch (a device alarm that is activated when a fall is detected) that they needed to wear all the time. There was no information to identify the risk or impact if the person did not wear the device or had a fall.
- Risk assessments that were in place were not fit for purpose. For example, one person's risk assessment stated [name] mobility is in decline and memory is in decline. Control measures were identified such as make sure [name] had their frame close by and remind them of this. However, there was no impact or instruction identified if control measures were not followed.
- Risks for hazards within the home environment had been completed, although, there were no personal evacuation plan (PEEP) in place to identify how people would be supported fully and kept safe in case of a fire. We discussed this with the registered manager, who agreed to address this for people's safety. They implemented a new process and form after our inspection.
- Staff were mindful and generally understood their responsibility for people's care but felt the care information was limited.
- Relatives told us of two incidents where they felt their family member had been put at risk.

Using medicines safely

- Arrangements for people's medicine support was in place, however these were not fully effective to ensure people received their medicine safely.
- The provider had provided an electronic record keeping system (EMAR) for people's medicines, which staff accessed via their phones.
- People and other healthcare professionals involved in people's care did not have direct access to the individual records unless they purchased the app. This meant there was a risk to people's safety from medicine errors including overdoses due to the lack of accessible information. After the inspection the provider told us, "The App can be shared with other healthcare professionals upon request."
- We found discrepancies with some people's EMAR charts which were contradictory to people's care plan

information. We discussed this with the registered manager who agreed the information was unclear.
● The provider did not complete any medication audits for the electronic records. This meant they were not aware or managing discrepancies with medicines. One person's medicine record stated staff should make sure they observe the person take their medication. The person received four calls per day. We found between the 28 February and 6 March 2021 that one tablet was left out at most of the calls with no reason why. On two occasions during that period the person was observed to take this medicine. On the 2 March 2021 at the lunch time and afternoon call five of the persons medicines were left out with no reason why or observation. This meant staff were not following the instructions given or the providers medication policy for administering medicines safely.

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

● Staff had received training to administer medicines.
● Most people who had medication given to them by staff were happy with how and when they received it, however one family told us their relatives medicines were time specific and felt this was not being addressed. We asked the registered manager to complete a review of the persons care needs. Which they did on the 29 March 2021.

Staffing and recruiting
● There was sufficient staff however staff had not always been effectively deployed.
● Before the inspection the local authority raised concerns surrounding the service not being able to cover care calls on the weekend of 17 February 2021. We spoke with the registered manager who told us after a discussion with the local authority the service had covered the calls as part of their contingency plan.
● People and relatives told us at times they had been asked to step into care because of staff shortages. Some people felt the availability of staff was poor. One person said. "COVID-19 is not to blame for everything but it's a factor. It would be nice to know who's coming and if it's cover staff a phone call would be nice, but nothing is usual at the moment." They told us the care staff had at one time arrived one hour late for their care call. One relative said, "The times are not as consistent as I'd like but I understand because of the current situation, my. [Relative] has no regular time; mornings seem to be the same time, times have slipped because of COVID-19, which I agree with."
● Rotas we looked at supported what people told us and we found that care was delivered at times in line with staff availability rather than people's choice.
● One relative described a time due to the lack of staff their family member had been left without a lunch time call for a whole week. Staff also told us that staffing at weekends was an issue.

The provider failed to ensure people's call time preferences were adhered to and to ensure staff were deployed appropriately. These failures are a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Measures in place to recruit staff safely including relevant safety checks to ensure suitable staff were employed. However, staff interview notes were not fully completed. We assessed this as a recording issue.

Systems and processes to safeguard people from risk of harm.
● Systems were in place to investigate and monitor safeguarding concerns. We saw staff had raised safeguarding concerns with the local authority themselves when they had concerns for people's safety.
● The registered manager demonstrated related records and actions taken for known safeguarding

referrals. We reviewed outcomes of safeguarding concerns that had been reported and found lessons learnt and where needed practice had been changed. However, we were not assured all incidents were safeguarded in a timely manner. For example, we found a number of incidents which were only discussed with an individual's social worker and not the safeguarding team. We were not assured the provider was following their own safeguarding policy effectively.

Preventing and controlling infection

● We were not fully assured that government guidance relating to COVID-19 was consistently being followed.

● People and staff in high risk groups and who may be disproportionately at risk of COVID-19, were not thoroughly assessed and supported. We signposted the provider to resources to develop their approach.

● The providers infection control policy dated April 2020 had not been updated to include COVID-19. We assessed this as a recording issue.

● Management records showed staff had received training in infection control. The registered manager said they had not completed any face to face training since the pandemic, but this was now being reviewed.

● Staff we spoke with were aware of the procedures and importance of wearing personal protective equipment [PPE] and said they all wore masks and relevant equipment. However, when issues and concerns were reported to the management these were addressed with individual members of staff.

● All people and relatives told us staff wear full PPE and had been since the start of the pandemic. One relative told us about a time when one staff member was not wearing a mask, but they spoke to the manager and now they wear it all the time.

Lessons learned when things go wrong

● Changes to care practice were put in place when things went wrong. The registered manager demonstrated this by a change to the providers policy for hospital discharges.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The provider had changed their address on companies house and failed to notify us on two occasions. We wrote to the provider on 11 March 2021 with no response to date.
- We were not assured all notifications for incidents, such as, falls with hospital admissions had been submitted to CQC. We had not received any notifications for the service for 12 months.
- We found one person had been admitted to hospital with a fall and suspected head injury and no notification had been submitted. Another incident where a person had a flood at their property when staff arrived at the call and no incident form was submitted.

This meant the registered persons for 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 is a breach of regulations 18 of the Care Quality Commission (Registration) regulations 2009.

- The providers governance was not always in place to effectively ensure the quality and safety of people's care.
- We requested information and supporting evidence from the registered manager after our inspection and they failed to fully respond or engage with us.
- No medication audits were in place to monitor people's were always receiving their medicine in a safe and timely manner. Risks were not identified or recorded to support people care. The providers infection control policy date April 2020 had not been updated to include COVID-19. This meant the providers audits and governance systems were not effective.
- Care plan information was limited. There was no monitoring to ensure information was accurate and up to date. Care plans shared with us had historic information in that was not relevant to the persons care needs at the time of the inspection. One relative told us their [relatives] care was based on a previous care plan after a previous hospital admission . There had been no assessment from the service, and the family had to provide a care plan for the carers. This meant the provider had no system or process in place to identify these shortfalls and therefore unable to take relevant action to improve the service provided.
- One person's care had not been fully assessed by the service and we were not assured all people had care plans in their homes or access to information. The registered manager told us people and families could purchase the app used by the service, however there was no alternative if people could not use/access technology.

● There was no consistent monitoring of call times to ensure they were within the relevant time frame preferred by the person. People had no access to rotas other than if they purchased the app.
● The registered manager had no oversight of governance for the service. During our inspection we found information had been updated on a care system and a new process put in place to identify and manage a person's medicines. The registered manager said they did not know this had been implemented. This meant the registered manager lacked oversight of the service.

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

● The registered manager told us after the inspection they reviewed the service management structure and were implementing new management arrangements and roles for the office.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were encouraged to share their views. The registered manager told us they had previously sent out surveys, but this had not happened in the last 12 months. People confirmed they had not completed any recent feedback. The registered manager also told us they used to provide a newsletter, but this had stopped through the pandemic.
● People and families gave positive feedback about the care they received and felt comfortable speaking with management. They knew who the manager was and how to contact the office. One person said, "Excellent service from them [the service], girls are very kind and friendly. It's sometimes difficult at the moment with everything going on but they're always respectful."
● Staff told us they were able to make suggestions and where possible changes were made to people's care. Staff felt feedback from people was shared with them and we saw this was added to people's notes on the system.
● Staff confirmed they mostly received updates on the electronic app and emails from the office to ensure they were aware of any changes to people's care needs. One staff member told us "sometimes we have to contact the office to make sure we have the most up to date information".

Planning and promoting person-centred, high-quality care and support; and 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
● Care was not always planned efficiently and, in a person-centred way. Critical information was task orientated. The terminology on some care plans were written in a derogatory way. For example, "30 min teatime call to prep hot meal and watch over eating it" and 'do not ask person what they want to eat just go in the kitchen and make it'. There was no best interest decision visible on documents we reviewed. We requested copies of best interest decisions from the registered manager with no response. This meant care documents lacked information to assess a full picture of the person, their needs or conditions they were living with and any consent or choices they may make.
● The registered manager told us they were aware of what to report to the Care Quality Commission (CQC) and notify us if issues did occur, but we were not assured they reported all incidents, as no notifications had been reported in the last 12 months. Where minor concerns had occurred, the provider had contacted relatives and next of kin to keep them informed of the persons condition.

Working in partnership with others
● Staff worked with other health and social care professionals to ensure people received the care and

support they needed. When a person was receiving end of life care staff followed recommendations given by the district nurse.

● The registered manager told us they had a good working relationship with other healthcare professionals. They shared relevant information by completing information tracker forms when needed for the local authority.

Continuous learning and improving care

● The registered manager shared some of the service achievements where they had supported a person with their diet, so they were no longer medicine dependent and reversed their health condition.

● The registered manager was passionate about providing a high standard of care for people and acknowledged there were improvements to be made. The number of staff allocated to the office was under review. The registered manager wanted to review their position to ensure the service was run well. They had implemented a restructure of office roles. However, this had not been sustained to show how improvements would be efficient and effective.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents 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.

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 risks and medicines for people. This placed people at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure their systems and processes to monitor people's care was effective and could not assure the Commission they had good governance systems in place.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure people's call time preferences were adhered to and to ensure staff were deployed appropriately.