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 were living with dementia. The service supported 99 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 44 people receiving a regulated activity at the time of the inspection.

People's experience of using this service and what we found
People's lived experience of receiving support from Jigsaw Healthcare had improved since our last inspection. People's individual risks had been assessed; however, staff were still not provided with guidance to support and manage them.

People's records did not consistently contain all the information required to be able to support them in a personalised way, there was also a lack of recorded information around people's capacity.
The registered manager had made improvements with the governance of the service by implementing audits and carrying out quality monitoring. Despite improvements made this continued to be an area of improvement and audits implemented needed to be embedded and sustained. People and staff felt more involved in the service and supported.
Medicines management had improved; however, we made a recommendation around guidance for staff on medicines administered when required. People were receiving their calls more consistently, both in terms of timings and lengths. People received care from staff who were trained to undertake their role, who felt supported and had been recruited safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

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 (4 April 2022). 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 improvements had been made. However, the provider remained in breach of some regulations.

This service has been in Special Measures since 4 April 2022. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We undertook this focussed inspection to check whether the Warning Notices we previously served in relation to Regulation 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

This report only covers our findings in relation to the Key Questions Safe and Well-led. 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 inadequate to requires improvement. This is based on the findings at this inspection.

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 and Recommendations
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 risk management and record keeping at this inspection.

We have made a recommendation in relation to medicine management.

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

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 Health and Social Care Act 2008.

Inspection team
This inspection was carried out by an inspector 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

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

Inspection activity started on 13 July 2022 and ended on 22 July 2022. We visited the location's office on 13 July 2022.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is

information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from the local authority. We reviewed information we had received about the service since the last inspection. We contacted Healthwatch for feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We visited the office on 13 July 2022 and spoke with the registered manager, deputy manager and care coordinator. We reviewed audits and recruitment files. On 15 July 2022 we spoke with six people who used the service and 15 family members of people who use the service. We sought feedback from 10 care staff. We reviewed the care and associated medicine records of eight people.

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed 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; 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.

● There had been some improvement around the management of risks associated with people's health conditions and mobility, however we found there was still a lack of documented guidance for staff.
● At the last inspection, we found a lack of guidance for staff to enable them to safely support people who had a catheter. At this inspection, we found a continued lack of information to guide staff on how to identify and manage associated risks, such as signs of infection, and there continued to be a lack of guidance for staff on catheter care.
● Some people had moving and handling risk assessments in place, which we found were now more consistent with care plans, however they did not identify or guide staff on how to manage associated risks. For example, some people were noted to be "prone to falls", yet there were no identified associated risks.

There was a lack of detail to guide and support staff to monitor and mitigate risks to the health and wellbeing of people using the service. This placed people at increased 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.

● Since the last inspection staff had been trained in Infection Control. People told us staff wore the appropriate personal protective equipment whilst on calls.

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 MCA 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's records did not contain clear information about their capacity, where it was identified someone lacked capacity there were no records of mental capacity assessments or best interest decisions. However, we did not find this had impacted the care people received and feedback from people and their relatives was positive regarding the support they received. You can read further about shortfalls in record keeping in the well led section of this report.
● Staff had not been trained specifically in the MCA, although this was covered in other modules of training they undertook. When we brought this to the attention of the registered manager, they immediately arranged specific MCA training for all staff. Staff we spoke with had an understanding of the MCA.

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 (7) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvement had been made at this inspection. However, as stated above the provider is still in breach of regulation 12.

● People were supported to receive their medicines in a safe and timely manner.
● Staff who supported people with medicines had completed medicines training and had their competency regularly checked.
● People who were required to receive their medicines at specific timed intervals had their calls arranged to meet this need.
● At the last inspection we found very little guidance for staff around medicines that were 'when required', for example pain relief or inhalers for people with asthma. At this inspection there remained very little information for staff, such as detailed protocols.

We recommend the provider consider current best practice guidance on how to manage and support people with 'when required' medicines and how this should be documented.

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.

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

● People told us calls had improved, although they found the calls times remained inconsistent.
● People said, "Things have improved but they still come at different times," and "Calls are different every single day."
● People told us most calls were on time and if staff were running late, they received a phone call. People said, "They are a little bit late sometimes, but they do stop the full time and have never completely missed and they do ring me if being a bit late," "The carer's that come in are wonderful, punctual, never short change us on time," and "They didn't use to ring if running late, but now they do."
● Safe recruitment practices had been implemented and checks had been carried out on all staff since the last inspection. For example, all staff had a Disclosure and Barring Service (DBS) check. Disclosure and

Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions
● Staff now felt supported by management and had all received supervisions or appraisals. Staff said, "We have supervisions every 6 months where a planned visit is made out in the community. I find these helpful to discuss any issues/how to further develop ourselves."

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

At our last inspection the provider had failed to ensure systems and processes were in place to safeguard service users and failed to put the needs of the service user first. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People were protected from the risk of abuse by the systems and processes in place.
● People and their relatives spoke positively about staff, "I do feel that [name] is safe and [name] is lucky with these carer's" and "They[staff] are very nice and I feel very safe."
● Since the last inspection, staff had been trained in safeguarding and understood their responsibilities to protect people, as well as how to report and escalate any concerns.
● The registered manager explained to us how they had focussed on putting people first and ensuring they had a clear process in place to look into concerns and learn from them.

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

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.

● The management and governance of the service had significantly improved, although there were still areas to work on.
● There were still some concerns around risk management, particularly on the lack of detail in risk assessments. We also found there to be a lack of documented information regarding people's capacity and any MCA assessments that had been carried out were not being recorded in people's care records.
● Following reviews, care plans and risk assessments had not consistently been updated to ensure personalised care was being delivered, which would contribute to better outcomes for people.

The provider failed to ensure they kept accurate, complete and contemporaneous records in respect of each person, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had taken action to downsize the service in order to be able to focus on making necessary improvements to care delivery, to regain oversight and to implement quality monitoring.
● Audits were now in place including a medicines audit to pick up on any errors, a concerns audit and a process was in place to check recruitment files. We identified that whilst they monitored call times on the live system there was no audit in place. We raised this on the day of inspection and action was taken to implement a new audit focussing on call times.
● People told us they had noticed improvements and they were happy with the service provided, they felt they received personalised care.
● People said, "I think they are all brilliant. Can't fault any of them, they do a difficult brilliant job… They all

know our needs now," "The administration is so much better now, my folder is now up to date and they have done a new assessment," and "Drastic improvements, no one had come out to review but now they have come out twice."

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

● People, staff and relatives now felt more involved and engaged in the service.

● The registered manager had actively sought out feedback from people and staff through the use of questionnaires. We saw how the results from these had been analysed and actions taken where necessary.

● Staff, whilst staff meetings were still yet to be restarted, felt they were more included in the service and received regular communication. Staff told us, "We don't have staff meetings, we have daily and weekly emails that are set out to all staff with any updates or information we need or if anything has changes, I can say I'm very well informed," and "There is an open door policy and can pop into the office anytime."

● The provider had made changes to the office layout to make it more inclusive and created a separate meeting area which could be used for private conversations or training.

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

● Following the last inspection, the registered manager had developed an action plan which they were working though to improve care and had a clearer understanding of their responsibilities.

● At the last inspection, we found there were no processes in place to investigate incidents. Now when any concerns were raised from people, staff or external agencies, they were reviewed by the registered manager and actions were identified where improvements could be made.

● Where required the service worked in partnership with external agencies, for example making appropriate referrals to healthcare teams or contacting social workers.

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 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of detail to guide and support staff to monitor and mitigate risks to the health and wellbeing of people using the service. This placed people at increased risk of harm.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they kept accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.