J.C.Michael Groups Ltd

J.C.Michael Groups Ltd Docklands

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
J.C.Michael Groups Ltd Docklands is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to younger disabled adults and older people, some living with dementia. It also supports people with more complex care needs who require regular monitoring and overnight support. 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.

At the time of the inspection the provider was supporting 48 people in the London Boroughs of Hackney, Haringey, Islington, Tower Hamlets and Wandsworth with personal care.

People's experience of using this service and what we found

People and their relatives were positive about the caring attitude of their care workers and how they supported them to keep them safe. One person said, "The carer is very good, helped me out a lot and has looked after me. It's good care, he is my guardian angel."

People and their relatives told us how well they had been supported during COVID-19 and how the provider had taken infection control procedures very seriously. One relative said, "They washed their hands, always had a face covering and followed the guidelines. They also helped to have PPE delivered straight to our home."

Feedback from people and their relatives about the management of the service had improved since the last inspection and we could see the work that was being done by the registered manager to improve the service people received.

People were supported by a dedicated staff team that were grateful for the advice and reassurance they received, especially at challenging times during the peak of the pandemic. People and staff told us the registered manager was available and responded to any concerns.

Although we saw improvements had been made since the previous inspection, there were still some minor inconsistencies in the accuracy of people's records. The provider had also failed to notify us about all the incidents that had occurred across the service.

The registered manager was aware of this and acknowledged where improvements needed to be made.

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 19 March 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

Although we found improvements at this inspection it had not been sustained and the provider was still in breach of regulations. The service remains rated Requires Improvement. This service has been rated Requires Improvement for the last seven consecutive inspections.

Why we inspected
We carried out an announced comprehensive inspection of this service on 24 January 2019. A breach of legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same. 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 J.C.Michael Groups Ltd Docklands on our website at www.cqc.org.uk.

Enforcement
We have identified one breach in relation to notifiable incidents. Please see the action we have told the provider to take at the end of this report.

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 commissioning authorities to monitor progress. 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.

J.C.Michael Groups Ltd Docklands

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 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 service.

Service and service type
J.C.Michael Groups Ltd Docklands is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. A registered manager is a person who is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the provider four days' notice because we needed to ensure somebody would be available to assist us with the inspection and to review records before the site visit.

Inspection activity started on 11 September and ended on 30 September 2020. We requested a range of documents related to people's care that were sent to us by the registered manager between 11 and 15 September. We visited the office location on 15 September to see the management team and to review care records and policies and procedures. We made calls to people and their relatives between 14 and 16 September and calls to care staff between 11 and 16 September 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included any significant incidents that occurred at the service. 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 contacted three local authority commissioning and safeguarding teams and reviewed the previous inspection report. We used all of this information to plan our inspection.

During the inspection
We reviewed a range of records related to 13 people's care and support. This included people's care plans, risk assessments, medicines records and six staff files in relation to recruitment and training. We also reviewed records related to the management of the service, which included safeguarding investigations, incidents and accidents, quality assurance checks, electronic call monitoring (ECM) records and minutes of team meetings.

We spoke with eight staff members. This included the registered manager and seven care workers.

We made calls to 23 people and spoke with 10 people and four relatives.

After the inspection
We continued to seek clarification from the provider to validate evidence found related to training records, staff rotas, ECM data, incident records and feedback we received from people and their relatives. We had a teleconference call with the registered manager on 21 and 30 September 2020 to discuss information about notifiable incidents and provide formal feedback. We spoke with four health and social care professionals who had experience of working with the service.

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 requires improvement. At this inspection this key question has stayed the same. This meant some aspects of the service were not always safe and there was limited assurance about safety.

Using medicines safely

● The service had made significant improvements in how people's medicines were managed and we received positive feedback about the support people received with this. Comments included, "I am very happy with this. I need my medicine and it is managed really well" and "This support has gone really well and they make sure they are trained."

● However, we found this was not always consistent. People had medicines plans in place but were not always updated. Two people's records did not highlight the current level of support being provided. The registered manager acknowledged this and confirmed this had been done shortly after the inspection.

● Medicine administration records (MARs) had started to be returned consistently on a monthly basis and had picked up minor recording issues which was shared with staff. Where one person's MAR chart had not been completed accurately for August 2020, the registered manager showed us regular difficulties the care worker had engaging with the person but acknowledged better recording was needed. The registered manager sent us records after the inspection that confirmed the care worker had been invited into the office for supervision and memos were sent out to staff reminding them of their responsibilities.

● Staff completed medicines training and had their competencies assessed by an suitably qualified member of staff. Staff were positive about the content of this training that supported them in their role.

Staffing and recruitment

● Timekeeping and punctuality had improved since the last inspection in January 2019. People and their relatives were positive about this. One person praised the provider's ability to supply emergency cover care at the last minute. Another person said, "She is extremely responsible and calls if she is running late, even if only five minutes." Only one person told us they were not always informed if their care workers were running late.

● Rotas were scheduled to ensure people received their calls on time. Staff we spoke with told us their rotas were manageable and were given time to get to their calls. One care worker told us during the peak of the COVID-19 pandemic they worked in their local area so it was easier and safer to get to people's homes.

● Although improvements were seen in the accuracy of electronic call monitoring (ECM) data since the last inspection, there were still some minor inconsistencies. Samples of ECM data showed care workers were not always logging in and out of their calls, resulting in office staff having to manually log calls. The registered manager told us care workers reported technical issues with the system and we saw regular reminders were sent out to care workers about the importance of logging in and out of their visits.

● The provider continued to follow safer recruitment procedures to ensure staff were suitable to work with people who used the service. All appropriate checks for staff had been completed and there was evidence of photographic proof of identity and two references, with further character references requested if applicants

had no previous experience in health and social care.

Assessing risk, safety monitoring and management

● Risks to people's health continued to be assessed before the service started and if there were any changes in their support needs. Risk assessments had been completed with detailed guidance in place for care workers to follow, with supporting information from a range of health and social care professionals who were closely involved in people's care.

● Areas of risk included people's mobility, skin integrity and more complex health conditions, such as support with tracheostomy care and percutaneous endoscopic gastrostomy (PEG) feeds. This is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

● Staff we spoke with had a good understanding of the support people needed and were positive about the level of training they received, especially with more complex care. Care workers confirmed they had been assessed as competent by a registered nurse. One care worker added, "This helps us to understand what we need to do so we keep people safe and look after them."

● We saw samples of correspondence with a range of health and social care professionals where specific training with complex care conditions was also provided to care workers in people's homes. One person said, "The specialist nurse showed them how to get me out of my chair. New carers come with an experienced carer and I feel safe in the hoist as they know what they are doing."

● We did receive feedback from one relative about the competency of cover care workers who did not know how to use specific healthcare equipment. We followed this up with the registered manager who assured us all staff had completed training and arranged to meet with the family to get further information.

Preventing and controlling infection

● The provider had an updated infection and prevention control policy and this had been regularly reviewed and discussed during the COVID-19 pandemic.

● Government guidance, including the correct use of personal protective equipment (PPE) was regularly shared with care workers with reminders about what was needed and best practice. Staff were reminded about wearing a face covering if they used public transport to get to people's homes.

● Managers and staff both felt supported during the pandemic. The registered manager had regular teleconference meetings with other managers across the organisation which discussed key issues and contingency plans. Staff were extremely positive about the support they received during this period and told us they were never short of PPE.

● Staff had access to the necessary information to help keep people safe and reduce the risk of infection. Staff completed infection control training and accessed further learning via webinars from the local commissioning authorities and advice from community health teams. One care worker added, "We have had the links to the donning and doffing video and they have made us very aware of infection control. I'm confident I'm keeping people safe with my understanding."

● People and their relatives were also positive about the infection control protocols carried out in their homes. Comments included, "They are always washing their hands" and "The manager made sure weekly PPE supplies were sent to us and staff are aware of what to do. This was taken very seriously."

Systems and processes to safeguard people from the risk of abuse

● There were safeguarding procedures in place and the registered manager had completed investigations and shared them with the relevant authorities when any allegations had been raised. There was only one incident which had not been reported to the local authority however the registered manager did this on the day of the inspection. He added they were still liaising with the person to get further information.

● Staff understood their safeguarding responsibilities. They had completed safeguarding training and this

item was also discussed in team meetings. They were confident any concerns they reported would be dealt with appropriately by the registered manager. One care worker said, "He is a good man and will follow up any issues. If we do the wrong thing, it will be followed up and he will ensure we improve as necessary."

● People and their relatives told us they felt safe with their regular care workers and the service worked hard to resolve any initial teething issues. Only one person told us they felt unsafe, which we saw was related to their care arrangements commissioned by the local authority. The registered manager was aware of this and confirmed they had requested a review with the relevant health care professional.

Learning lessons when things go wrong

● There were procedures in place for reporting incidents and accidents, with regular reminders to staff about their responsibilities. We saw examples of safeguarding incidents shared across the staff team as a learning experience.

● The registered manager responded proactively where we highlighted areas of improvement and shared this across the staff team.

● Health and social care professionals confirmed the registered manager kept them updated and reported any incidents or concerns related to people using the service. One health and social care professional added they felt the service had responded well to a concern that had been raised and had learnt from the incident, with improvements being made.

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 requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. However, positive feedback was received about the management team and improvement in the service.

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

- The registered manager failed to notify CQC of all safeguarding incidents since the last inspection, of which they were required by law to inform CQC. We also found there had been a delay in notifying us for one safeguarding incident in September 2019.
- The registered manager acknowledged the oversight and assured us it would not happen again. We saw correspondence that confirmed these incidents had been followed up and shared with the relevant health and social care professionals. We also reminded the registered manager that notifications were to be submitted without delay.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- Regular memos and updates were sent to staff about their responsibilities and to ensure they completed all their necessary tasks and records. It was also discussed during team meetings and supervision sessions.

Continuous learning and improving care

At our last inspection the provider continued to have ineffective systems for collecting and auditing people's care documents, which was something we had been told would be addressed at the previous four inspections. Their monitoring processes had not identified consistent issues we highlighted at the inspection. This was a breach of regulation 17 (Good governance) of the Care Quality Commission (Registration) Regulations 2009.

Although we found some minor inconsistencies, enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- Improvements were seen with the monitoring of the service. An audit process for daily logs and MARs had been implemented by the registered manager who was appointed in March 2020. Audit records showed examples of issues being picked up and addressed by the registered manager.
- Where there were minor inconsistencies related to one person's care records, we saw the registered manager followed this up with the care worker involved during the inspection and shared further reminders to all care workers to remind them of their responsibilities.

● The registered manager was proactive in responding to our findings during the inspection and acknowledged their improvements needed to be more consistent. He added that it had been a challenging time dealing with the pressures of the COVID-19 pandemic and the provider was looking to recruit further office staff to help continue making improvements to the service.
● Staff confirmed they could see the improvements that had been made and told us despite the pandemic, they were still monitored. One care worker said, "It is good they are checking on us as they can give us advice and let us know we are doing everything correctly and that we are providing a good service. We never know when they are coming and it has been helpful with making sure we are wearing PPE correctly."
● A relative told us the registered manager would regularly phone to check if visits had taken place and if they were happy with the service, with follow up calls if any issues were raised.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The registered manager was committed to being open and honest and trying to improve the level of care people received. Feedback had dramatically improved since the last inspection with the majority of feedback being positive and issues raised were being addressed.
● People and their relatives told us there had been improved communication and were positive about the registered manager. Comments included, "I have had a lot of agencies and this is the only one which is interested in what I have to say and follows through on it", "They are very accommodating, supportive and friendly which is important. I have not had one instance of bad care" and "[Family member] is treated as a person and is at the centre of everything, they are empathetic to her condition."
● Only one person felt communication was inconsistent and the relationship with the service had broken down. We discussed this with the registered manager and saw they were working with the person and the relevant healthcare professionals to address their concerns.
● Staff were positive about the support they received and the working environment that was being created by the registered manager. Comments included, "They have been very flexible, understanding and accommodating. I'm very proud to work for them" and "It has been a challenging and difficult time but the manager and other carers have been lovely and very supportive."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were opportunities for people and their relatives to give feedback about their care and be involved in the service they received. This was through reviews, spot checks, telephone monitoring calls and evaluation surveys. The majority of responses were positive and people and their relatives told us issues raised were promptly dealt with.
● One relative was reassured as they had been provided with a care worker who spoke their family member's first language and understood their cultural needs, which helped them to be fully involved in their care.
● Staff were incredibly positive about how they were treated within the organisation, especially during the peak of the COVID-19 pandemic. Staff felt reassured the registered manager and monitoring staff came out for support and to know what was going on in the community.
● Comments from staff included, "They appreciate the work we have done and have an understanding of us and the effect on our wellbeing" and "The best thing is there is no racism and they treat us all equal. We have all worked very closely and we are treated well which makes a caring attitude across the whole team."
● Care workers also spoke positively about the improvement in communication and how they were all in a digital messaging chat group where they were regularly kept updated and involved about the service. One care worker said, "We all get to see it and what we need to be aware of, getting advice and guidance. This really helps us out."

Working in partnership with others

● The provider worked closely with a range of health and social care professionals to ensure and changes in health were reported and people's needs were met. We saw many examples where the registered manager had regular correspondence with social workers, clinical leads and occupational therapists, including arranging further training and guidance for people with complex care needs.

● Health and social care professionals did not raise any issues or concerns and were positive about the relationship they had with the registered manager and were generally updated if there were any changes in the service.

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 registered provider had not notified the Commission without delay about serious incidents in relation to service users. Regulation 18 (1), (2) (a) (ii) (iii) (b) (e)