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

We undertook an announced focused inspection of JC Michael Groups Ltd Docklands on 10 April 2018. This inspection was carried out to check that improvements to meet legal requirements after our last comprehensive inspection on 14, 16 and 20 November 2017 had been made. At the time of the last inspection the provider was registered under the name of AQUAFLO CARE LIMITED and changed their registration in January 2018. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'AQUAFLO CARE LIMITED' on our website at www.cqc.org.uk'.

We inspected the service against two of the five questions we ask about services: is the service safe and is the service well led? This is because at our previous comprehensive inspection a continued breach of legal requirements was found. The provider was issued with a warning notice in relation to safe care and treatment. The warning notice asked the provider to make improvements within a limited period of time.

No risks or concerns were identified in the remaining key questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection.

At this inspection, we found that the provider had made improvements in how people's medicines were managed and further improvements with the monitoring of the service were still in progress.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. At the time of the inspection they were supporting 18 people in the London Boroughs of Islington and Tower Hamlets. Not everyone using JC Michael Groups Ltd Docklands receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements had been made to how people's medicines were managed. Care records had been updated since the last inspection and checks had started to be completed to ensure people received their medicines safely.

We received mixed feedback from people and their relatives about timekeeping and missed visits. Although some comments were positive and highlighted improvements had been made since the last inspection, negative comments said these issues had impacted upon the service people received.

Risks to people continued to be assessed with detailed information and guidance in place for care workers to reduce the likelihood of people coming to harm.

Robust staff recruitment procedures were still in place which minimised the risk of unsuitable staff being employed.

There was evidence of positive action being taken after the last inspection and staff spoke highly of the support they received to make the necessary improvements. Systems to monitor the quality of the service were in place however were still in the process of being fully implemented.

We continued to receive mixed comments from people who used the service and their relatives about how well the service was managed. Negative comments highlighted the impact that poor communication had on the support that people received. Missed visits had not always been documented or followed up appropriately. The provider contacted us after the inspection to update us on their investigations and what action had been taken.

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.

People and their relatives told us that issues with timekeeping and missed visits had impacted upon the service they received.

Improvements had been made to ensure people received their medicines safely and effectively.

People's risks were assessed and detailed information and guidance was in place to reduce the likelihood of people coming to harm.

Robust staff recruitment procedures were still in place which minimised the risk of unsuitable staff being employed.

We were unable to change the rating for this key question as although some improvements had been made, we need to see evidence of sustained improvement over time. We will check this again during our next comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Improvements had been made and there was evidence of action being taken after the last inspection. Systems to effectively monitor the quality of the service were still in the process of being fully implemented.

We continued to receive mixed comments from people who used the service and their relatives about how well the service was managed. Inconsistencies with communication and timekeeping had impacted on the support that people received.

Information we received about missed visits had not always been documented or followed up appropriately.

Staff felt that improvements had been made since the last inspection and spoke positively about the support they received from management.

We were unable to change the rating for this key question as although some improvements had been made, the provider was still in the process of implementing the necessary improvements and we need to see evidence of sustained improvement over time. We will check this again during our next comprehensive inspection.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We were aware of a past serious safeguarding incident in November 2016 which related to the use of a percutaneous endoscopic gastrostomy (PEG) feed. 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. Although we had checked this at a previous inspection we reviewed the care and treatment of people who were supported with this to check the provider had mitigated the risks appropriately. We were also aware of an alleged missed visit that had occurred after the last comprehensive inspection in November 2017 and reviewed the investigation records.

The inspection took place on 10 April 2018 and was announced. The provider was given 24 hours' notice because we needed to ensure somebody would be available to assist us with the inspection.

The inspection was carried out by one inspector. Inspection activity started on 10 April and ended on 16 April 2018. We visited the office location on 10 April 2018 to see the registered manager, office staff and to review care records and policies and procedures. Following the site visit we made calls to people who used the service, their relatives, care workers and health and social care professionals.

Before the inspection we reviewed the information the CQC held about the service. This included notifications of significant incidents reported to the CQC and the previous inspection report. We also spoke with local authority commissioning teams and used their feedback to inform our planning.

We called 15 people using the service and managed to speak with four of them and four relatives. We also

spoke with six staff members. This included the registered manager, a care coordinator and four care workers. We looked at four people's care plans, three staff recruitment files and audits and records related to the management of the service.

Following the inspection we spoke with two health and social care professionals who worked with people using the service for their views and feedback.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection on 14, 16 and 20 November 2017 we found that people's safety was at risk. Appropriate policies and procedures were still not in place to ensure that people received their medicines safely and effectively. People's care plans were not always clear as to what support they received and their records were not always being completed or being checked to ensure they received their medicines safely. We issued a warning notice to the provider asking them to make improvements by 15 February 2018.

During this inspection we found that improvements had been made.

Where people were supported with their medicines, we saw that improvements had been made in how they had been recorded in people's files. For two people where we highlighted issues at the last inspection, we saw that their records had been updated. It was made clear the level of support they needed, including whether relatives or other health and social care professionals were involved. We spoke with relatives for both people who told us they were happy with how this part of the care and support was being managed. One relative added, "The responsibilities have been highlighted and they follow all of the procedures. It has taken a huge amount of stress away from us."

We reviewed a sample of medicine administration records (MARs) for three people. The provider had updated their standard MAR sheet to include a code that could be used when it was confirmed that relatives had administered their family member's medicines on a specific day. Where people were prompted with their medicines, we saw it had also been recorded in people's daily logs. People's MARs had also started to be returned to the office and we saw action had been taken with any issues that had been identified. We saw that two people were being supported with a pain relieving patch however it had only been recorded in the care plan and MAR sheet for one person. We spoke to the registered manager about this who told us that the record would be updated right away.

The registered manager told us that 14 of the 26 active care workers had completed medicines refresher training and the remaining 12 members of staff were scheduled to complete it by the end of April 2018. Staff we spoke with had a good understanding of their responsibilities and told us it had been regularly discussed since the last inspection. One care worker said, "They stressed the importance of completing the records properly and we had group training to make sure we knew how to fill them in. We had to do a test as well. They made it much clearer and always remind us which makes me feel more confident." The registered manager said, "We have spent a lot of time highlighting this area to the care workers and we feel they've taken a lot in and have started to see improvements."

Electronic call monitoring (ECM) was in place and we looked at ECM data for four people for the period of a week prior to the inspection. Where we found differences between scheduled and actual visit times for two people, the care coordinator explained that flexible arrangements were in place that had been agreed with people and their relatives. We spoke with both relatives who confirmed this and said they were happy with how the scheduling was managed. One relative said, "This has definitely improved and they are always on

time, never later than five minutes and they do let us know if they are running late." We did receive information from one person and two relatives about timekeeping issues and some late and missed calls since the last inspection. We shared this information with the registered manager, who was already aware of the issues raised by one relative, who said they would look into it and get further information. One relative said, "There has been a slight improvement but there are still issues with timekeeping. I expect them to be on time as it is an issue with a double up visit because one [care worker] is late and it has be reorganised, which is an issue and not convenient."

Risks to people continued to be identified with management plans in place and guidance for staff to minimise the risk of people coming to harm. We reviewed the records for two people who were supported with a percutaneous endoscopic gastrostomy (PEG) feed. The provider continued to work closely with the health and social professionals who were responsible for the funding of this care and we saw PEG regimes were in line with recommended guidance. We spoke with relatives for both people who were happy with how it was being managed. One relative said, "I was present when they did the training with the district nurses and they know what they are doing. I'm happy with how they support me with this."

There was detailed information and guidance when people were at risk of pressure sores. For one person who was unable to reposition themselves, there was information for the care workers about how the task was to be carried out safely, including monitoring their skin and looking for any signs of deterioration. Where one person had displayed behaviour that challenged the service, information about the behaviour and associated risks had been highlighted and guidance had been sought from a health and social care professional. We saw any concerns had been raised and control measures put in place. Nutritional risks were highlighted and guidance was in place for safe positioning during mealtimes. One person who was living with diabetes had information about the support the district nurses provided but there was no further information about the signs and symptoms that care workers should look out for if they became unwell. The registered manager said they would update the records for people with diabetes right away.

Staff we spoke with had a good understanding of safeguarding and what their responsibilities were when supporting people in the community. They were able to explain the types of abuse people could be at risk of and felt confident that any concerns raised would be followed up appropriately. One care worker said, "We must protect our clients from any kind of abuse and inform the manager. They have been very helpful with this since I started and take action as soon as possible." We saw investigations had been carried out when concerns had been raised, with the appropriate disciplinary processes being followed and action taken. Safeguarding issues had been discussed at the most recent care worker meeting with a refresher about the types of abuse and the importance of reporting concerns to the office. The meeting also highlighted that there would be no victimisation to any member of staff if they raised concerns about people using the service or other colleagues.

The provider continued to have safe recruitment procedures in place. The files we looked through showed Disclosure and Barring Service (DBS) checks for staff had been completed in the last three years. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working in care services. Appropriate references were in place and photographic proof of identity had been checked and signed that the original document had been seen. For one member of staff, we saw that a third reference had been followed up and verified before they started their employment. Interview assessment forms were in place which showed that the provider had assessed the suitability of staff they employed.

There were procedures in place for the reporting of any accidents and incidents. We saw health and social care professionals involved in people's care had also been notified, with correspondence to show when incidents had been reported they were followed up by the provider. We saw an incident related to late calls

had been discussed with the staff emphasising their responsibilities to notify the office if they were running late or unable to make a call. One care worker said, "They do follow up on issues and discuss them with us."

Staff were reminded of their responsibilities to ensure infection control procedures were followed. We saw that the use of personal protective equipment (PPE), such as gloves and aprons was followed up at spot checks to ensure that care workers adhered to infection control guidelines. Care worker meetings also discussed the importance of washing hands before starting any task and making sure gloves were changed when moving onto the next task.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. Our records showed she had been formally registered with the Care Quality Commission (CQC) in April 2014 and became the registered manager for this service in April 2017. She was present on the day and assisted with the inspection, along with the office team.

At the last comprehensive inspection there was correspondence relating to three missed visits for two people and there was no further information about what action had been taken. We spoke to the registered manager about this and asked to see what action had been taken but we did not receive any further information by the time the draft report was sent to the provider. We were aware of an alleged missed visit that had occurred after the last comprehensive inspection in November 2017 as the registered manager had submitted the relevant statutory notification to us. The investigation was still underway and we saw the provider had taken the necessary disciplinary action. We were told that there had been no further missed visits since the last inspection however we received information about three incidents of missed visits that had not been recorded. One person told us about an incident where a care worker did not turn up for an evening visit over the Easter weekend. They added, "I absolutely rely on somebody being there twice a day and their failures in guaranteeing this and their excuses are unacceptable." The care coordinator followed this up after the inspection and informed us of their investigation findings. They acknowledged that the calls had been missed and said they had updated the missed visits log record.

We received a mixture of positive and negative comments from people who used the service and their relatives about how well managed they thought the service was and if they had noticed any improvements since the last inspection. One person said, "I have no issues or concerns at present and am happy with the care I'm getting." Another person said, "I am happy at the moment and they do look after me when I'm not well." Comments from relatives included, "Since the last inspection they have improved 100%. They are very supportive and try their best to support us. Communication has improved and I have nothing to complain about" and "They are always at the end of the phone and have been with me through thick and thin, they are like extended family to us." Negative comments we received related mainly to timekeeping and communication issues. One person said, "I wasn't informed about a change and there are certain people I don't like coming in." Another person said, "In spite of several reminders, they failed to arrange a replacement and nobody showed up. I also reminded them twice, this happens regularly." Comments from relatives included, "Although it has got better, it isn't always good enough and I shouldn't have to be following up everything all the time" and "Where things haven't gone right on a couple of occasions, they've told me they've spoken to staff but I do not get an outcome. However, I'm confident enough in them at the moment."

We saw correspondence that showed the provider worked in partnership with other agencies and shared information with other health and social care professionals who were involved in people's care. A health and social care professional told us that they were happy with the care and support that a person received and felt the care worker was very involved and had provided support above and beyond their role to meet their needs. They highlighted that they had raised concerns if the person's health and wellbeing had changed.

Although they felt the provider could possibly report more often about the level of support and findings from visits, they felt the service worked well with the person and had no concerns.

At the last comprehensive inspection the registered provider was still in the process of implementing monthly audits of people's daily logs and medicine administration records (MARs). At this inspection we saw that improvements had been made and people's MARs were being returned on a more regular basis. An audit checklist was in place and issues and concerns that had been identified through the monthly audit had been followed up with the relevant staff. For example, a MAR audit for one person in February 2018 found gaps in the MAR and the corresponding days in the daily log book. We saw that the care worker involved had been invited in for supervision and issued with a written warning within 48 hours of the audit being completed. Another audit highlighted that a person's MARs were not always completed correctly which prompted a home visit to check the current records that were in place. A relative said, "[Care coordinator] is around much more and they come and check the records more frequently. That support is very helpful." A care worker said, "We are getting reminders sent out about the MAR sheet and the importance of completing them. I have to say, when [care coordinator] addresses any issues that they find, it isn't done in an embarrassing way and is very professional."

Improvements were also seen in the level of detail recorded in three out of the four samples of people's daily logs we reviewed. Daily logs for one person had improvements from the December 2017 entries to the March 2018 entries in relation to repositioning and skin integrity checks. A care worker said, "They have told us in meetings that it is very important to complete the daily logs and record all the tasks that we have done." However we did highlight to the registered manager that when the daily logs were returned there was no audit checklist in place as there were for people's MARs. For example, we could only view one person's daily logs up to 22 January 2018 as records after this date had not been returned to the office. The level of recording was less detailed and examples of ineligible entries had not been picked up. The registered manager said that as the person only had two visits a day, it took longer for the log book to be completed.

All of the staff we spoke with told us they felt well supported in their roles and we received many positive comments about the management of the service. Comments included, "I really like working here. It's rewarding and I really enjoy it. I get good support from the office", "I'm really happy with the support I get. When I speak with the office staff, they are very respectful and give good advice", "It's a good service and I feel we provide quality care. If there are issues we can contact the office and they always deal with it" and "It's a good agency. They always answer the phone and get back to us." Staff also spoke positively about the registered manager. Comments included, "I'm pleased with the support I receive from the [registered] manager. I'm always listened to and she is very kind and gentle" and "I think she is well organised and it is well managed. We are provided with the right information and it is explained well."

We saw the provider had drafted an action plan after the last inspection to highlight the areas where improvements needed to be made. We saw a new communication booklet was in place and meetings arranged for care workers who had been identified as not completing records in line with policy and procedure. A care worker meeting had been held which discussed key points that had been highlighted at the last inspection. The main agenda item focused on people's MARs and log books and how recording needed to be improved. Demonstrations on completing MARs were given to care workers along with a discussion on why it was important for records to be detailed to reflect the visit. For example, it highlighted that external organisations such as the local authority or the CQC might need access to people's records. We also saw disciplinary measures and possible actions that could result from not following policies and procedures were discussed and reiterated in supervision meetings. Care workers spoke positively about the meetings they had and how it was important to be reminded about their responsibilities.

Systems were still in place for the provider to monitor the quality of service being provided. Monthly telephone monitoring calls were completed and the most recent monitoring report showed that 14 people had no issues or concerns, with the majority being positive responses. Only one concern had been highlighted which was being followed up at the time of the inspection. If people did not answer, contact was made with the care worker to get an update. When spot checks were carried out it highlighted if records were checked to see if they had been completed in a factual and concise manner with an appropriate level of detail for the visit.

All of the staff we spoke with felt the management team had focused on making improvements since the last inspection. Comments included, "They are friendly, relaxed and have been more receptive towards us. They listen and respond to us, and are quick to act", "It's a good place to work. They are making sure we understand everything and are giving us feedback" and "I feel that they are well organised and manage everything well. It really helps that they are understanding towards us and help us improve."