J.C.Michael Groups Ltd

J.C.Michael Groups Ltd Basildon

Inspection report

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31 July 2023
10 August 2023

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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 Basildon is a domiciliary care agency providing personal care to people living in their own homes. 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 our inspection there were 86 people receiving personal care support.

People's experience of using this service and what we found
The provider's processes for reviewing the quality and safety of the service were not always effective in identifying concerns. The provider's safeguarding systems were not robust, and this meant it was not always clear what actions had been taken to address concerns. Statutory notifications had not always been submitted appropriately.

The provider had systems in place to recruit staff safely; however, not all checks were fully documented. Risks to people's safety were assessed; however, some information lacked detail. Feedback from people and their relatives highlighted concerns with the provider's management of medicines and oversight of people's care visits.

The provider sought feedback from people and relatives about the care provided; however, we received some mixed feedback about how well the provider communicated and shared information.

Despite these concerns, people and their relatives spoke positively about the kindness of the care staff and management team. 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 supported this practice. The provider worked in partnership with other health and social care professionals in order to meet people's changing support needs.

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 24 September 2019).

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

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for J.C.Michael Groups Ltd Basildon on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding and governance at this inspection. We have also made a recommendation about the provider's recruitment processes.

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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 Basildon

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 1 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

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

Inspection activity started on 31 July 2023 and ended on 10 August 2023. We visited the location's office on 31 July 2023.

What we did before the inspection
We reviewed the information we held about the service. We used this information to plan our 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.

During the inspection
We spoke with 4 people who used the service and 6 relatives about their experience of the care provided. We spoke with the branch manager and operations manager and received feedback from 7 care staff and 3 health professionals who have had contact with the service.
We reviewed a range of records. This included 9 people's care records, 4 staff files in relation to recruitment and a variety of records relating to the management of 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 our last inspection we rated this key question good. 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.

Systems and processes to safeguard people from the risk of abuse
- The provider's safeguarding processes were not always effective.
- The provider kept a safeguarding log for recording and monitoring concerns; however, information was not consistently recorded and lacked detail. For example, we found safeguarding concerns which had not been documented on the log. For some safeguarding concerns, it was not clear which authorities had been notified, what action had been taken to safeguard people or what the outcome was. This meant we could not be assured the provider had effective oversight of the safeguarding concerns raised.
- The provider had not always sent appropriate safeguarding notifications to CQC when required.

The provider did not have robust systems in place to protect people from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our feedback, the provider told us they would review their safeguarding processes to ensure information was correctly recorded including when notifications were raised and to which authorities. They told us this would enable them to have clearer oversight of the actions they had taken.

Staffing and recruitment
- The provider had recruitment processes in place to check staff were safely employed. However, not all checks had been documented appropriately. For example, we found staff did not always have a full employment history listed.
- Following the inspection, the provider responded promptly to confirm they were completing an audit of all staff files to ensure accurate information was recorded throughout.

We recommend the provider reviews their process to ensure staff are safely recruited

- We received mixed feedback about the timing of people's care visits, with some people and relatives telling us they had consistent visit times and others saying their visits were not always evenly spaced and they did not know when staff would arrive. Comments included, "We are not given a timetable of when the carers are supposed to come in, it can be 7:30am or it can be any time up until 10:30am", "It has happened that there has only been 2 hours from breakfast to lunch" and "I don't have a regular time for my calls."
- The provider had expanded the geographical area where they were providing support in the 12 months prior to this inspection and we found people's feedback about their visit times varied depending on where they lived.

● Staff told us they did not always feel there were enough staff available in some areas and this meant they were sometimes rushing. Comments included, "Sometimes I feel rushed", "Sometimes, the travel time is too little" and "We are often at a shortage of carers."
● The provider used an electronic system for monitoring the punctuality and duration of people's care visits. They told us this data was analysed on a monthly basis and adjustments were made as necessary. However, the feedback we received suggested people were not always able to have their care at their preferred times.
● The provider told us they were aware of the need to recruit more staff into specific areas and were continuously advertising for these roles.

Using medicines safely
● The provider had processes in place to support people with their medicines and used an electronic system to record what medicines people were prescribed and what support was provided. However, we received mixed feedback from people's relatives about how well the provider managed people's medicines. For example, some relatives told us people's medicines were not always consistently timed due to the variation in the times of their care visits. Other relatives told us people's medicines had not always been accurately documented or administered.
● The provider confirmed they had received several safeguarding concerns around people's medicines support and sent additional evidence about the actions they had taken in response. The provider told us they continued to monitor the administration of people's medicines closely and were alerted to any issues promptly via their live electronic call monitoring system. The provider completed monthly medicines audits to identify any errors and action needed.
● Staff had received medicines training and the provider had assessed their competency to administer medicines safely.

Assessing risk, safety monitoring and management; Learning lessons when things
● Risks to people's safety had been assessed. However, there was a lack of information about people's health conditions and the risks associated with these. Following the inspection, the provider responded promptly, confirming they had reviewed the relevant care plans and added additional information about people's health.
● Staff did not always have detailed guidance about how they should provide support to people who were experiencing distress. Information was sometimes vague, and this meant staff may not know how to respond appropriately to minimise the risk to the person or themselves.
● The provider had systems in place to record and review incidents and accidents. However, some incident forms had not been completed appropriately and lacked detail.
● The provider had shared lessons learnt with staff during team meetings and highlighted areas of improvement to minimise the risk of a reoccurrence.

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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal

authorisations were in place to deprive a person of their liberty.

Preventing and controlling infection

● People were protected from the risk of infection. Staff completed infection prevention and control training and appropriate personal protective equipment (PPE) was available to use.

● The provider had an infection control policy in place for staff to follow. Staff were kept informed about any updates to guidance.

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 requires improvement. The rating for this key question has remained 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; 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 provider's systems for monitoring the safety and quality of the service were not always effective. During the inspection we found concerns with the provider's oversight in number of key areas such as safeguarding, recruitment and medicines management. Feedback received during the inspection highlighted concerns with the provider's oversight of the timing and safety of people's care visits.
- The provider understood their responsibility to be open and honest with people, and those important to them, when incidents occurred. However, they had not always promptly submitted the relevant notifications to CQC.
- The provider told us they were aware of their regulatory responsibility to notify CQC when appropriate and evidenced where they had raised other notifications in a timely way. However, we found some notifications were delayed or submitted incorrectly. This meant we could not be assured the provider fully understood when a notification should be made.

The provider had not ensured effective processes were in place to monitor the safety and quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was absent from the service at the time of the inspection and the provider told us this had meant there had been some changes in the day to day management and oversight of the service. Following our feedback, the provider completed a review of their processes for identifying and submitting statutory notifications to ensure these were sent without delay.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We received mixed feedback from people's relatives about how well the provider communicated with them. Relatives told us information was not always accurately recorded in people's care documentation and communication between the management team and care staff did not always seem effective. Relatives told us they were not always able to easily contact a manager out of office hours.
- Despite these concerns, most people and relatives spoke positively about the care they received and the

friendliness of the staff and management team. One relative told us, "They appear to be very kind, caring and nothing is too much trouble for any of them to do, [person] has no complaints at all."

● Staff told us they felt supported in their roles and were able to give feedback and raise concerns. Comments included, "I believe the manager and team try to encourage staff to communicate with each other, promote togetherness and professionalism" and "I feel supported and comfortable speaking to my manager."

Working in partnership with others; Continuous learning and improving care

● The provider worked in partnership with a range of different health and social care professionals in order to support people's needs. Contact details for any health professionals involved in people's care were documented in their care plans.

● The provider sought feedback from people and relatives via regular phone calls and surveys. The provider used this feedback to identify areas for improvement within 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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have robust systems in place to protect people from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured effective processes were in place to monitor the safety and quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.