Goldsmith Personnel Limited

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Inspection report

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Date of inspection visit:
23 October 2018

Date of publication:
20 November 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Goldsmith Personnel Limited on 23 October 2018. The inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. Our last inspection took place on the 23 and 28 June 2017 and we found one breach of regulation in relation to safe care and treatment. At this inspection we found improvements had been made.

Goldsmith Personnel Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. Not everyone using Goldsmith Personnel Limited receives 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. At the time of the inspection it was providing a service to 90 people.

There was a registered manager at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission 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 and associated Regulations about how the service is run.

People told us they felt the service was safe, staff were kind and the care received was good. We found staff had a good understanding of their responsibility with regard to safeguarding adults.

Risk assessments were in place which provided guidance on how to support people safely. There were sufficient numbers of suitable staff employed by the service. Staff had been recruited safely with appropriate checks on their backgrounds completed. Medicines were managed safely.

Staff undertook training and received regular supervision to help support them to provide effective care. Staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA). MCA is legislation protecting people who are unable to make decisions for themselves. People and their relatives told us staffing treated them with dignity and respect.

Person centred support plans were in place and people and their relatives were involved in planning the care and support they received.

People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The provider had a complaint procedure in place. People and their relatives knew how to make a complaint.

At the time of our inspection the service did not have any people receiving end of life care. The service had an end of life policy in policy. Staff received end of life care training.

Staff told us the registered manager was supportive. People and their relatives felt the service was well led and had a good relationship with office staff. The service had various quality assurance and monitoring mechanisms in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns.

Risk assessments were in place which set out how to manage and reduce the risks people faced.

People felt supported with medicines. Medicines were managed safely.

Staff were recruited appropriately and adequate numbers were on duty to meet people's needs.

People were protected by the prevention and control of infection.

Is the service effective?

Good

The service was effective. Staff undertook regular training and had one to one supervision meetings.

The provider met the requirements of the Mental Capacity Act (2005).

Staff were aware of people's dietary preferences. Staff had a good understanding about the current medical and health conditions of the people they supported.

Is the service caring?

Good

The service was caring. People that used the service told us that staff treated them with dignity and respect.

People were involved in making decisions about the care and the support they received.

The service promoted people to live as independently as possible.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and care was planned in line with the needs of individuals. People were involved in planning their own care.

People and their relatives knew how to make a complaint.

Staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The service had end of life training and policies in place.

Is the service well-led?

Good

The service was well-led. The service had a registered manager in place. Staff told us they found the registered manager to be approachable and open.

The service had various quality assurance and monitoring systems in place.

Goldsmith Personnel Limited

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.

This inspection took place on 23 October 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection team consisted of two inspectors.

Before we visited the provider's office we checked the information we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placed people with the service, and the local borough safeguarding adult's team. We reviewed the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with the registered manager, the care manager, a manager who worked for the provider, the human resources officer, the field care supervisor and four support workers. After the inspection we spoke to one support worker. We also spoke to 14 people who used the service and nine relatives. We looked at eight care files which included care plans and risk assessments, five staff files which included supervision records, appraisal records and recruitment records, quality assurance records, five medicine records, training information, and policies and procedures.

Good

Is the service safe?

Our findings

At our last comprehensive inspection on the 23 and 28 June 2017 we found that the provider had not consistently assessed risks to people's health and wellbeing, and detailed plans on how to mitigate risks were not always in place. The service was in breach of Regulation 12. During this inspection we checked to determine whether the required improvements had been made. We found the service had made sufficient improvements thereby meeting the regulation.

The provider identified, assessed and mitigated risks associated to people's health, care and mobility needs. People's risk assessments included falls, moving and handling, medicines, finances, internal and external environment, personal care, equipment, self-neglect, nutrition and accessing the community. People with risks specific to their health and medical conditions had risk assessments and guidelines in that area for example, with depression, epilepsy and diabetes. Since the last inspection the provider had reviewed and updated people's risk assessments to ensure they provided sufficient information to staff to meet people's individual needs safely. For example, one person was assessed at being at risk with their mobility. Their risk assessment stated, "[Person] is at risk of falls due to restricted mobility resulting from arthritis in her knee and hands and breathlessness which affects her balance sometimes. Carer to give her time to mobilise slowly at home with her walker. She uses a wheelchair when accessing the community." Care records showed that people at risk with specific conditions had information fact sheets available to staff. For example, we saw information fact sheets on depression, high blood pressure, cataracts, hearing impairment, arthritis, and pacemakers. Staff we spoke to demonstrated a good understanding of the risks to people they supported and the procedures they followed to mitigate those risks. This meant the risk assessment processes were effective at keeping people safe from avoidable harm.

People and their relatives told us they felt the service provided was safe. One person said, "Yes, I feel safe." Another person told us, "[Staff] make me feel safe. They just make sure I'm clean and take my medication on time." A relative said, "I am sure [relative] feels safe. She would certainly say if she didn't." Another relative told us, "Yes, [relative] is absolutely safe."

There was a safeguarding policy in place which made it clear the responsibility for reporting any allegations of abuse to the local authority and the Care Quality Commission. Staff had undertaken training about safeguarding adults and had a good understanding of their responsibilities. One member of staff said, "I would quickly report it to my coordinator. If they didn't get back to me I could whistle blow to social services, the police and CQC." Another staff member said, "I would speak to my line manager. If nothing done I would go the police and social services." The service had a whistleblowing procedure in place and staff were aware of their rights and responsibilities with regard to whistleblowing. However, some staff we spoke with did not have an understanding of whistleblowing. After the inspection, the registered manager told us they would give the provider's whistleblowing policy to all staff and discuss the procedure in their next supervision sessions.

The registered manager told us there had been two safeguarding incidents since the last inspection. The registered manager was able to describe the actions they would take when reporting an incident which

included reporting to the Care Quality Commission (CQC) and the local authority. Records confirmed this. This meant that the provider was aware how to report safeguarding concerns appropriately so that CQC would be able to monitor safeguarding issues effectively.

Accident and incident policies and procedures were in place. Accidents and incidents were documented and recorded and we saw instances of this. We saw that incidents were responded to and outcomes and actions taken were recorded. This meant the service learned from incidents and put procedures in place for prevention.

The provider followed safe recruitment practices. Staff recruitment records showed relevant checks had been completed before staff worked unsupervised at the service. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records. This meant the provider had done all that was reasonable to ensure people were suited to work in the caring profession.

Through our discussions with staff and people who used the service, we found there was enough staff to meet the needs of people who used the service. Staffing levels were determined by the number of people using the service and their needs, and could be adjusted accordingly. People told us staff generally arrived on time. One person told us, "[Staff] turn up on time. They're not late. If one has a problem, they let me know. On the whole, they're on time." Another person said, "[Staff member] always at the right time. A few weeks ago, [staff member] was on holiday. They sent a lady to me who I know." A relative commented, "The [staff] are on time. Sometimes there may be traffic and they're 10 to 15 minutes late. If there's traffic, either they phone or I phone them." Another relative said, "If [staff are] gonna be late, they give a quick call. Overall, they're good at that."

People were supported with medicines and the support required was clearly detailed in their care plans and medicines risk assessments. People and their relatives told us they were happy with medicines support. One person said, "[Staff] remind me to take my medication [because] I sometimes forget." Another person commented, "[Staff member] puts [medicines] together for me in the morning. I take them once a day." A relative told us, "Overall, [relative] gets her medications at the right time." People's medication administration record (MAR) charts detailed names and dosage of medicines, and timing of medicines administration and codes when medicines were refused or not taken. People's MAR charts showed that staff recorded medicines appropriately. One staff member said, "I prompt medicines. If [person] can't reach medication I put in little cup and give to them. I have to record on the medication chart." MAR charts were audited monthly and any identified issues during were addressed with staff. Records confirmed this. Staff received medicines training. Staff we spoke with and records confirmed this.

Staff were trained in infection control and were given sufficient personal protective equipment to prevent the spread of infection. Staff comments included, "You wash your hands. [Provider] gives you [hand] gel, wear an apron and gloves" and "I have my hand gel with me and put that on before personal care. I have gloves and apron. I get from the office every week."

Good

Is the service effective?

Our findings

People and their relatives told us staff were supportive and knowledgeable in their jobs. One person said, "[Staff] are so good. They look after me. They've arranged for my flu jab today. The nurse is coming soon." A relative told us, "It's really very good team work. We all work together."

Before using the service a pre-admission assessment was undertaken to assess whether the service could meet the person's needs. The assessment looked at medical history, medicines, nutrition, toileting, communication, mobility, behaviours, finances, religious and cultural needs, social needs, personal care, and daily living skills. A relative told us, "At the beginning, someone from Goldsmith came and talked to [relative]. Assessed what he wants and doesn't want."

Staff were trained and supported to have the right skills, knowledge and qualifications necessary to give people the right support. A staff member told us, "They do a lot of training here. You can call them or they check if you need training." Another staff member said, "You have training on premises and online. Each [staff] member is trained on communication skills, how they dress, how they talk to the clients and all things you need as a care worker. Every few months people have training. If you are not good you go back on training. You are well trained and mentored." Staff we spoke with confirmed that they had received all the training they needed to meet people's needs effectively. The training records and staff files we looked at confirmed that staff had received training for their role which would ensure they could meet people's individual needs. This included training in topics such as infection control, health and safety, food hygiene, fire awareness, nutrition and hydration, pressure sores, manual handling, safeguarding, equality and diversity, whistleblowing, medicines, dementia, end of life care, and the Mental Capacity Act 2005 (MCA).

New staff joining the service completed the care certificate. The care certificate is a recognised qualification that ensures that staff have the fundamental knowledge and skills required to work in a care setting. When new staff joined the service, they completed an induction programme which included shadowing more experienced staff. This enabled them to gain a better understanding of people's needs and how they liked to be supported.

Staff had regular one to one supervision meetings with a senior member of staff. One staff member said, "I always do [get supervision]. It is a very demanding [role] and it is important to get [supervision]. They ask how you are getting on with the [people who used the service]." Another staff member told us, "I get supervision. We talk about personal care, safeguarding and health and safety." Records showed supervision included discussions about health and safety, duty of care, record keeping, safeguarding, and personal development.

People were supported with their nutrition and hydration needs and told us their needs were met. One person said, "[Staff] encourages me to eat and drink. [Staff member] puts food in the oven for me." Another person told us, "[Staff member] does what I ask. I buy the food and then [I] say what I want." A third person said, "[Staff member] wakes me up in the morning and gets my breakfast. She leaves the kitchen tidy and clean." One staff member said, "I have worked with a [person] who was [culturally specific]. He had a

preference for [culturally specific] food. I was able to prepare that meal for him." This showed people's individual dietary needs and preferences were met by staff who were knowledgeable about people's needs.

The service supported people when requested to make healthcare appointments and liaise with healthcare professionals to deliver effective care. People and relatives we spoke with confirmed this. A relative said, "One of his carers will always attend his hospital appointments with me, they come along so they have a good understanding of any changes to his needs and feed that back to their colleagues." People's care files had records of healthcare professionals' appointments and correspondence in relation to people's needs. The provider kept clear records of healthcare professionals' recommendations and ensured staff followed them to support people with their individualised needs. Records confirmed this.

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 Act 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.

We checked whether the service was working within the principles of the MCA. People's care files had power of attorney documents that were accessible to staff for people who could not make their own decisions. Records showed people signed consent forms agreeing to their care and support. People's care files recorded when people using the service had capacity to make choices about their day to day life.

People told us staff gave them choices, asked their permission and encouraged and supported them to make decisions. Staff we spoke to knew their responsibilities in promoting people's right to choice and asked their permission before supporting them. A relative said, "[Staff] take him out. It's always [person's] decision." Another relative commented, "[Staff member] explains what he's doing, [for example] shaving him or giving him a shower." A third relative said, "[Staff] do not tell [relative] what to do. They encourage rather than tell him. They know if they tell him to do something he will refuse. [Relative] can be quite challenging, but they know how he works." One staff member said, "You have to ask consent. You have to ask permission because you don't live in that property. It is their home." Another staff member told us, "I have to ask if [person] wants a bath or a cup of tea."

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind, caring and helpful. One person said, "I can talk to my carers and have conversations with them. They're quite nice. I'm very happy with them. We have a laugh. They always say goodbye and hello." Another person told us, "I like both my carers. They're like friends. They're really good." A third person said, "[Staff] really good. Absolutely lovely. They're like my mum. My carer really looks after me. She's so lovely. All my family love her. I say I love her and my family love her." A relative said, "Not only do [staff] do a wonderful job with [relative], they keep me company and ask me how I am." Another relative told us, "[Staff member] is very caring. She genuinely enjoys her job and loves coming to visit [person]."

Staff spoke in a caring way about people they supported and told us that they enjoyed working for the service. One staff member said, "It is like my extended my family. I treat [people who used the service] like my children and family."

Support plans contained information about people's communication needs and preferences. This helped give staff the information they needed to build rapport with people in order to establish positive relationships with them. For example, one support plan stated, "I go out daily and visit friends and enjoy purchasing cultural foods. I purchase a paper daily and enjoy watching television." People had a preference for care workers of a specific gender and people told us this was respected. A relative said, "[Relative] is happy to have a male carer. He wants the choice of a man. [Relative's] happy with him. I like him."

People and their relatives told us their privacy and dignity were respected. One person said, "They [staff] respect that it's our home and they don't boss me around." Another person told us, "All of the carers are kind and respect my home." A relative told us, "They [staff] fit into our family environment. They never disrespect my home and always knock before entering." Staff we spoke with gave examples about how they respected people's privacy. One staff member told us, "I have a [person] who doesn't like me to wash his private parts. So, I respect what he wants. I let him do that in private." A second staff member said, "Treat [people] with respect and dignity. What I do is knock on the front door. First thing I say is 'good morning'. It is very important." The same staff member told us, "People should be treated with dignity. Confidentiality is so important with my clients. It is the most important thing."

The service promoted people to live as independently as possible. Staff gave examples about how they involved people doing certain aspects of their own personal care to help them become more independent. This was reflected in the support plans for people. For example, one support plan stated, "I would like my carer to assist me with a shower every day. I am able to do most of my personal care, and I would like to remain as independent as possible." One staff member told us, "I help [person] to go out and shop. It helped him with independence with choosing what shop he wanted to go and what food he wanted to eat."

Good

Is the service responsive?

Our findings

People and their relatives told us the service was responsive to people's needs. One person told us, "I told [staff member] what I want and what I like. I didn't have to tell her again. Her standard is very high. I'm very particular. I don't have to say nothing, [because] she knows what to do. She does things exactly how I like." A relative said, "[Relative] can be quite challenging. He will refuse to do things, but [staff] really do work with us and encourage. It's all really positive, which is what [relative] needs. [Staff] are very attentive." Another relative told us, "[Staff member] does whatever's needed."

Support plans contained detailed information and clear guidance about all aspects of people's health, social and personal care needs, which helped staff to meet their individual needs. The support plans covered personal care, medicines, nutrition, finances, home health and safety, continence care, mobility, daily living, social/religious/cultural needs, and activities. The support plans were person centred. For example, one support plan detailed how someone wanted to be supported with nutrition. The support plan stated, "My support worker ensures I have breakfast of my choice every morning. I normally have a roll and tea. I prefer my lunch visit to be combined with the morning as I am never home for lunch. During the day I eat out."

People's care and support was planned proactively with them and the people who mattered to them. Relatives were fully involved, where appropriate, in identifying people's individual needs, wishes and choices and how these should be met. They were also involved in regular reviews of each person's care plan to make sure they were up to date. Records confirmed this. One person said, "The [support] plan was organised between me and the agency. There are yearly reviews. The co-ordinator comes and checks that I'm happy with the carers." A relative told us, "When they come and do reviews, they talk to [relative] as well [as me] and I interject." Another relative commented, "Sometimes the office people come. They make a [support] plan and then review it. They ask, how's it going? Is everything ok?" Detailed support plans enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

People's cultural and religious needs were respected when planning and delivering care which included specialised food preparation. One staff member told us, "I have had [specific religion] clients [people who used the service]. You have to understand you are going into a home with a different culture. You have to be aware of it and be very humble. I have to respect their religion and culture. Make sure I am dressed appropriately."

Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "It needs to be person-centred. We would listen on how they want to be cared for and what they require for us." A staff member told us, "I would treat them with the same respect as everybody." Another staff member said, "I have no problem with anyone's sexuality. I believe we are all human beings. We should all be given equal rights. I am there to do a job. It is based on the quality of your work." However, the service did not explore people's sexuality in the assessment and support planning stages. After the

inspection the registered manager showed us the service had updated their needs assessment and profile information documentation to reflect people's sexuality and how to meet their needs.

The provider had a system in place to log and respond to complaints. There was a complaint procedure in place. This included timescales for responding to complaints and details of who people could escalate their complaint to if they were not satisfied with the response from the service.

People and their relatives were aware of how to make a complaint. One person told us, "Would feel happy to pick up the phone if I had any complaints." Another person said, "I have no complaints. If I had, I would speak to the manager." A relative told us, "If I see something wrong, I let them know. I speak to [office staff member]. She's been as helpful as she can be." Records showed the service had received three formal complaints in the last 12 months. We found the complaints were investigated appropriately and the service had provided a resolution for the complaint in a timely manner.

At the time of our inspection the service did not have any people receiving end of life care. The service had an end of life policy for people who used the service. The policy was appropriate for people who used the service. The service always provided end of life care training for staff.

Good

Is the service well-led?

Our findings

People who used the service and their relatives told us they thought the service was well managed and had a good relationship with the office staff. Most people and their relatives did not know who the registered manager was but felt comfortable calling the office. The registered manager told us she had recently returned from long term leave and therefore people and their relatives were not always familiar with her.

There was a registered manager in post. They were aware of their responsibilities as registered manager and of the need to notify CQC about reportable incidents. They had current policies and procedures in place to run the service.

Staff spoke positively about the registered manager and working for the service. One staff member told us, "Yes, [registered manager] is good. She listens to you and gives advice." A second staff member said, "I can call [registered manager] anytime I want and I have her email if I have any concerns. I like working here as they have helped me with [my university studies]." A third staff member commented, "[Registered manager] cares about her staff and cares about what she is doing. I have worked for other agencies and they don't have the compassion [registered manager] has. Not only for the [people who used the service] but also the staff. We can go to her anytime if we have a problem. She asks how you are and if you are ok. She cares."

Staff meetings were held regularly. Records confirmed this. Topics of meetings included record keeping, risk assessments, medicines records, dignity, safeguarding, supporting people in extreme weather conditions, spot checks and training. One staff member said, "They do [staff meetings]. They talk about spot checks, how to care for people in the winter time and things like that. If you have any concerns you can express it." Another staff member, "Yes we do have [staff meetings] once a month. Talk about the care and solutions, and how to make things better."

The service involved people and their relatives in various ways and sought feedback on the service provided. This included regular reviews with people and relatives, and an annual survey. Spot checks included visiting people in their home and telephone calls to people and their relatives. Records confirmed this. One relative told us, "The office do check how things are going on a regular basis." The spot checks topics included punctuality, appearance of the staff member, care records, medicines records, moving and handling, infection control and any other feedback. A staff member told us, "One of the office staff does spot checks. They first thing they asked to see your ID card, how you are handling the [person], things like that. They are doing pretty frequent."

The quality of the service was also monitored through the use of annual surveys to get the views of people who used the service and their relatives. The last annual survey had been conducted for this year. Overall the results were generally positive. The annual survey had been analysed by the service and they found some people and their relatives felt they were not always informed if their care worker was running late. The service had an action plan to address this which included increased telephone monitoring, increasing the number of field care supervisors and more unannounced direct observations of care workers. The registered manager also told us the service had introduced an additional observation tool for staff called "Direct

Dignity Challenge Observation for Care Staff." This focused on observations around respect, communication and any other feedback people and their relatives would want to share.

The service worked in partnership with key organisations to support care provision, service development and joined-up care. For example, the registered manager told us the service had worked with the local authority, social services, pharmacies, district nurses, tissue viability nurses, occupational therapists, other domiciliary care agencies, and the local clinical commissioning group.