Goldsmith Personnel Limited

Goldsmith Personnel Limited (East London)

Inspection report

98 Hoe Street
Walthamstow
London
E17 4QS

Tel: 02085093766

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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

Goldsmith Personnel Limited (East London) is a domiciliary care agency. It provides personal care to people living in their own flats and houses in the community. At the time of this inspection 75 people were receiving personal care and support.

This inspection took place on 22 and 23 May 2018 and was announced. At the last inspection in March 2016, the service was rated as overall Good but we found one breach of the regulations because recruitment processes were not robust. During this inspection, we found improvements had been made.

There was a registered manager at the service. 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 2008 and associated Regulations about how the service is run.

Staff were knowledgeable about safeguarding and whistleblowing procedures. The provider had safe recruitment processes in place to ensure staff were suitable to work with people. The provider used a call monitoring system to ensure visits to people were not missed. Risk assessments were carried out to mitigate the risks of harm people may face. There were systems to manage people's medicines. People were protected from the risks associated with the spread of infection.

People had an assessment of their needs to ensure the provider could meet their requirements. New staff received induction training at the start of their employment and staff were offered regular training opportunities. Staff were supported with regular supervisions to ensure they could deliver care effectively. People were supported to eat a nutritionally balanced diet and to maintain their health. The provider and staff knew about their responsibility to obtain consent from people before delivering care.

Staff described how they developed caring relationships with people they supported. People and their relatives were included in decision making about the care that was delivered. Staff were trained in equality and diversity. People's privacy and dignity was promoted and their independence was maintained.

Care records were personalised and contained people's preferences. Staff understood how to deliver a personalised care service. The service had a complaints procedure and complaints were dealt with appropriately. People and their relatives knew how to make a complaint if they were not happy with any aspect of the service. The provider kept a record of compliments made to the service.

People and their relatives spoke positively about the service. The provider had a system to obtain feedback from people and their relatives about the quality of the service in order to make improvements where needed. Staff had regular meetings so they could contribute to the development of the service. The provider carried out spot checks and quality assurance checks of the work of staff to monitor the quality of the service being delivered. The provider worked with other agencies to share good practice and find ways to

make improvements to their service.

We have made one recommendation about specific health conditions. Further information is in the detailed findings below.

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 improved to Good. The provider had safe recruitment processes in place. People and relatives told us they felt safe using the service. Staff knew what actions to take if they suspected a person was at risk of harm.

Risk assessments were carried out to mitigate the risks to people's safety. The provider used a call monitoring system to ensure visits were not missed.

People received their medicines as prescribed. The provider had systems in place to protect people from the risk of the spread of infection. The provider worked jointly with other agencies to learn from incidents that occurred.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Goldsmith Personnel Limited (East London)

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 checked 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 22 and 23 May 2018 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure someone would be in. One inspector carried out this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the evidence we already held about the service including notifications the provider had sent to us. A notification is information about important events which the service is required to send us by law. We also contacted local authorities who used the service to obtain their view about the service.

During the inspection we spoke with the registered manager, reviewed six people's care records including risk assessments and care plans and reviewed seven staff records including recruitment and supervision. We looked at records relating to how the service was managed including staff training, medicines, policies and procedures and quality assurance documentation. After the inspection we spoke with five people who used the service, one relative and three care staff.

Good

Is the service safe?

Our findings

At the last inspection in March 2016, we found the provider's recruitment processes were not robust. During this inspection, we found improvements had been made and relevant checks were carried out before someone was employed to ensure they were suitable to work with people. For example, staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and had been given written references. New staff had criminal record checks to confirm they were suitable to work with people and the provider had a system to obtain regular updates. This meant a safe recruitment procedure was in place.

People and relatives told us they felt safe with the staff in the service. Responses included, "Yes I'm certainly safe", "Yes definitely [safe]" and "The [staff] do everything to keep me safe."

The provider had safeguarding and whistleblowing policies which gave clear guidance to staff on the actions to take if they suspected abuse. Staff had received training in safeguarding adults. One staff member told us, "If I see anything that is wrong, then I have to report to my office, explain the kind of abuse and write it down." Another staff member said, "As far as I'm concerned, the first person I would call is my manager and we take it from there. If you see something which is not appropriate, it depends on what it is, we involve the police, social services, CQC." A third staff member told us, "If you see something that is not right you have to report it to your manager, the police or CQC." This meant the provider had systems in place to keep people safe.

People had risk assessments as part of their care plans regarding their care and support needs. Risk assessments included clear actions for staff to mitigate the risks. People's risk assessments included self-neglect, skin integrity, mobility and falls, breathing, nutrition and financial. For example, one person's breathing risk assessment indicated they were at risk of fainting, exhaustion, exertion and tiredness. The risk management plan stated, "Carer to give time to carry out task and walk. Carer to give [person] time to mobilise safely. [Person] is able to administer inhaler." Another person's mobility risk assessment stated, "Carer to ensure clear path way. Carer to give [person] time to mobilise safely.[Person] to use wheelchair or walking aids when going out. [Person] not able to go out on [their] own." This meant the provider had taken steps to mitigate the risks that people may face.

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people who used the service and their assessed needs. Records showed that no visits were missed. The service used electronic call monitoring to ensure visits were not missed. The call monitoring required staff to log in when they arrived for a visit and when they left. The system alerted the office staff if care staff were late so this could be followed up and appropriate action taken. This showed the provider had taken reasonable steps to ensure people received their planned visits.

Each person who needed support with their medicines had a medicine risk assessment which detailed the level of support they required. Records showed medicines were given to people by appropriately trained and competent staff. The provider had a medicines policy which gave clear guidance to staff about their responsibilities regarding medicines management.

We reviewed medicine administration record (MAR) charts which had been returned to the office at the end of each month for auditing. These showed appropriate arrangements were in place for recording the administration of medicines. Medicines contained in blister packs were listed individually on the MAR charts. Staff had signed to indicate the medicines had been administered. There were no gaps in signatures indicating people had received their medicines correctly. The registered manager told us that if issues were identified during the MAR audits, these would be discussed with the relevant staff member during supervisions.

Each person who needed support with their medicines had a medicine risk assessment which detailed the level of support they required. Records showed medicines were given to people by appropriately trained and competent staff. The provider had a medicines policy which gave clear guidance to staff about their responsibilities regarding medicines management. Training records showed that staff had received up to date medicines training. This meant the provider had systems in place to ensure people's medicines were managed safely.

The provider had an infection control policy which gave guidance to staff on how to prevent the spread of infection. Records showed that staff had received training in infection control. People told us staff cleaned up after themselves before leaving the visit. Staff told us they were provided with sufficient personal protection equipment (PPE) including gloves, aprons and shoe covers. One staff member told us, "We get too much [PPE]. Goldsmith provides enough. They don't limit you."

The registered manager described an incident where lessons had been learnt. A person who used the service had asked their staff member to take money out of the cashpoint on their behalf. This person was not well enough to go to the cashpoint themselves at this time and had no money or food. The service had a finance policy which gave guidance to staff to contact the office if a person who used the service had no money. However the staff member wanted to help the person but had not followed the correct procedure.

The registered manager explained how lessons were learnt from the above incident. An arrangement was set up with the local authority that if a person lacked funds, social services would put a financial process in place so that essential items could be purchased for the person. All staff were asked to watch a safeguarding video, there was a discussion around safeguarding and each staff member was given a written guidance. This showed the provider was willing to learn when things go wrong and worked jointly with other agencies to find solutions to safeguarding people.

Good

Is the service effective?

Our findings

People and relatives told us the service was effective and staff had the skills needed to work with them. One person told us, "Yes [staff] have the skills needed." Another person said, "[Staff member] only does what I want her to do."

People had a care needs assessment before they began to use the service to ensure the provider could meet their needs. Information gathered during the assessment included whether the person could answer the front door, medical history, medicines, current care needs, relationships, culture and religion. For example, one person's care needs assessment detailed that members from their place of worship visited them weekly for bible study.

Staff confirmed they had access to regular training opportunities. One staff member told us, "I'm always interested in learning more." New staff completed a five day induction at the head office where they were given information about the organisation and completed training in moving and handling, health and safety, medicines, safeguarding, dementia and food hygiene. As part of the induction, new care staff shadowed more experienced care staff between one day and one week, depending on their former experience.

Records showed staff were required to complete the Care Certificate. The Care Certificate is training in an identified set of standards of care that staff are recommended to receive before they begin working with people unsupervised.

Training records showed staff were up to date with safety-related training including moving and handling, first aid, food hygiene, and health and safety. Staff had also received training in the Mental Capacity Act (2005), communication and dementia. Records showed where appropriate, staff received training relevant to their role and the people they cared for such as learning disability, epilepsy and diabetes. This meant people were provided with a service from staff who had the knowledge and skills to provide them with care.

Records showed staff received supervision every three months or more frequently if needed in line with the provider's policy. Staff told us they found these useful. One staff member said, "It's useful because we can point things out to them [supervisor]." Topics discussed in individual supervisions included electronic call monitoring, teamwork, timekeeping, handling people's money, medicines, record keeping, effective communication, mental capacity and people's well-being.

The provider used group supervision sessions to provide refresher training in certain areas. We reviewed the records of group supervisions held in July, October and November 2017. Topics discussed included lone working, confidentiality, the reporting procedure, medicines, communication and dignity and respect.

Records showed staff received an annual appraisal which looked at what aspects of the job the staff member performed well and what they could do to make further improvements to their strengths. The appraisal also looked at what aspects of the job could be done better and what was needed to overcome

any difficulties. Each staff member was given a rating to indicate how well they were performing.

Staff confirmed people were supported with their nutritional needs and had choices of the food they ate. The registered manager told us, "[People] are given a choice at the assessment stage so they can tell us what they like or what they don't like to eat." A staff member told us, "Different people like different kinds of food so I have to ask them what food they like."

One person's care plan stated, "[Staff] support with food shopping and to carry the shopping." Another person's nutrition care plan stated, "I am able to verbalise my wants. I am very conscious of what I eat." A third person's care plan stated, "[Person] is not able to prepare food. Requires the carer to prepare breakfast and sandwiches for lunch. [Family member] will support [person] for the rest of the day."

Care plans showed the service worked jointly with people's GPs and district nurses. Records showed that appropriate referrals were made to occupational therapists when a person had poor mobility or falls and needed equipment such as mobility aids or a hospital bed.

People had information sheets on their specific health conditions contained in their care files which gave clear guidance to staff on supporting the person to manage their health. Information sheets included asthma, high blood pressure, learning disability, high cholesterol and strokes. However although we found the information sheet for diabetes contained lots of information about the condition, it did not list the symptoms of hypoglycaemia (low blood sugar) which staff should be aware of. We recommend the provider seeks advice and guidance from a reputable source about supporting people with specific health conditions.

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 had signed their care plan and consent to care forms to indicate their agreement to receiving care. Where people were not able to sign for physical reasons, the reason why was indicated on the form.

Staff gave examples of the circumstances when they sought consent from people. One staff member told us "I need to ask when I am going shopping for the person, ask if they want to have a drink or something to eat. When I am leaving, I ask if they want me to leave something near them like a drink." Another staff member said, "I have to ask for everything I do. Get permission for everything." This meant the provider was working within the principles of the MCA.

Good

Is the service caring?

Our findings

People and relatives told us staff were caring. One person told us, "I am happy with the carers. [Staff member] is a good carer and good company." Another person said, "I wouldn't change them [the agency]. I'm very happy. I've had the same [staff member] for nearly five years." A relative told us, "They are ok. We have no problem with them."

Staff described how they became familiar with people's care needs and how they got to know people. One staff member told us, "First I introduce myself. Then I read all their information about the care they need. By talking to them, making conversation." Another staff member said, "What I do is I ask my care co-ordinator what needs to be done. I introduce myself and I am a very friendly person. I get on with [people who use the service]. I know how to approach [person] and communicate and get on with them.

People and their relatives were included in making decisions about the care. A relative told us, "We [family member and person using the service] both make the decisions." The registered manager told us they included the person using the service and families in the initial assessment. The registered manager said, "We have a Christmas party every year for people and their families. We send Christmas and birthday cards." One staff member told us, "When the care co-ordinators go out to assess, [people who use the service and families] are included. They play a major part in decisions and choices."

The registered manager told us how they supported people with their relationship needs, "We don't discriminate regardless of their sexuality. It's incorporated in the training. We offer emotional support to people when they are grieving a lost spouse or partner. We will support people to access opportunities to form friendships if it is part of the care plan." The provider had an equality and diversity policy which gave clear guidance to staff about providing a fair and equal service to people without discrimination. Staff confirmed they received equality and diversity training. One staff member told us, "I have to be nice to everybody. I can't behave badly with people." Another staff member said, "Everyone is equal. You have to accept people for who they are. You cannot change them."

The provider had a dignity and respect policy which gave clear guidance to staff about what was expected of them when delivering a service to people. Staff demonstrated they were knowledgeable about promoting people's privacy and dignity. One staff member told us, "I make sure nobody else is there to see them; I have to close the curtains." Another staff member said, "It is part of the training. Whatever happens in work stays at work. It's confidential. I don't go to any other place and talk about the person." A third staff member said, "[People] have their rights. We allow them to make choices. If I am helping someone to dress and a family member is present, I think I should ask the family member to be excused. I close the door and the curtains."

Staff confirmed they promoted people's independence. One staff member told us, "First I make sure they can do for themselves. I let them if they can do for themselves. If not then I will help them." Another staff member said, "Allow them to feed themselves or give them the flannel and say, "You can wash your face." This staff member gave an example of how they encouraged a person who remained in bed to sit up and feed themselves.

Good

Is the service responsive?

Our findings

Records showed that staff had received training in providing person centred care. Staff were knowledgeable about providing personalised care. One staff member told us, "I work differently with different kinds of people because people are different and don't want their care the same." Another staff member said, "We have to do everything that will support the person in the way that they want."

Care plans were detailed, personalised and contained people's preferences. For example, one person's care plan stated, "The TV keeps me up to date with what is happening. Please make sure the TV remote is close to me before you leave. I love listening to the news on BBC. I love the company of my children." The provider also asked people to complete and sign a gender preference form to indicate if they preferred to receive care from female or male staff or if they did not mind.

Care plans indicated the activities people enjoyed participated in. This gave guidance to staff about conversation topics. For example, one person's care plan stated, "I attend choir practice twice a week and I really enjoy it. Have been doing this for years. I like reading books. I enjoy painting." This care plan detailed that support was not needed from staff for activities because the person was supported by a family to attend them. This meant the provider delivered care in line with people's preferences.

Providers must evidence they record, flag and meet the accessible communication needs of people using their service. Care plans for people with learning disabilities were pictorial to help them to understand the content. One person's care plan stated, "Ensure [person] is wearing her hearing aid. Carer to ensure that [person] has her hearing aid on whilst talking and ensure the hearing aid is functioning properly. Carer to speak loud and clear when communicating and ask [person] if she understands what is being communicated." This meant the provider had taken reasonable steps to meet the communication needs of people who used the service.

Records showed the provider reviewed people's care plans every six months or more frequently if their needs changed. Care plan reviews indicated whether an increase or decrease in support hours were needed and flagged up with the relevant local authority. This meant the provider responded appropriately to people's changing needs.

People and their relatives told us they knew how to complain but had not needed to complain. One person said, "If I had got a complaint I would just ring the office and they would sort it." Another person told us they had made a complaint some time ago and they were happy with how the complaint was dealt with.

The provider had a complaints policy which gave clear guidance to staff about how to handle complaints. Records showed the service had received four complaints since the last inspection. We saw these had been handled appropriately and in line with the policy. For example, one person who was supposed to receive three daily visits complained that one visit was being missed each day. The provider investigated and realised the person was expecting to see three different staff each day but one staff member was completing two of the daily visits so they were only seeing two staff daily. The outcome was the person was receiving the

correct number of visits for the correct amount of time. This was explained to the person who was satisfied with the explanation.

The provider kept a record of compliments. These included, "I would like to compliment the services by the carers and GPL [Goldsmith Personnel Limited]", "The carers are very helpful and patient with [person]. They are thorough with what they do. The [person] is very pleased with the carers" and "They look after [family member] very well."

The provider had an end of life policy which gave clear guidance about advance planning and end of life care. At the time of this inspection one person was at the end of their life and had been discharged from hospital to spend their last days at home with their family. Records showed this person had signed a DNACPR form. A DNACPR form is a medical decision record which indicates that it is not in a person's best interests or the person does not wish to receive resuscitation if their heart or breathing stops. The doctor signs the form and also the person and their representative will sign if they agree to the decision. We found the DNACPR form had been correctly completed. This person had also signed an advanced decision to refuse specific medical treatment and this was clearly marked at the front of their care file and throughout their care records.

Good

Is the service well-led?

Our findings

There was a registered manager at the service. People told us they thought the service was managed well. One person told us occasionally different carers came if their regular carer was away but it was always carers who had been before. This person said, "So that's alright." Another person told us, "[Registered manager] rings me just to check everything is ok. She's very nice." A third person said, "I quite like [registered manager]." A relative told us, "[Registered manager] is quite helpful."

Staff told us they felt supported to do their job. One staff member told us, "Our manager is very good." Another staff member said, "[The management and staff] are very good. Very friendly. They treat everybody [staff and people using the service] equally." A third staff member told us, "[Registered manager] is okay. Any situation we can reason with her. She's approachable."

The provider had several systems to obtain feedback about the service. Care records contained telephone monitoring sheets and showed people and their relatives were satisfied with the service with comments including, "[Staff member is very good with me" and "Absolutely brilliant. [Family member] has a regular carer."

Records showed that feedback was obtained during the person's care plan review every six months. Comments during reviews included, "[Person] is really pleased with the carer and the service Goldsmith Personnel is providing. [Person] commends the carers", "[Staff member] is fantastic. [Person] is happy with her services" and "Happy with the carers and services provided."

People were asked to complete an annual survey. We reviewed the analysis of the survey completed in 2017 and saw that overall people were satisfied with the service they were receiving. The analysis showed 5% of people were not informed when there was a change in care staff or if their care staff was running late. The service responded to this by increasing their telephone spot checks and unannounced observations of staff and by introducing electronic call monitoring so that lateness can be dealt with directly with staff. This meant people's feedback could be used to make improvements to the service.

Staff confirmed they attended regular meetings and they found them useful. One staff member told us, "We get to raise and air our views and get to know the others [staff] more." We reviewed the minutes of the meetings held in January, February and April 2018. Topics discussed included mental capacity, report writing, medicines, policies and procedures, dignity and respect, punctuality, safeguarding, lone working, training and recruitment. Staff were required to sign to confirm attendance at meetings. Minutes of meetings were available for staff who were unable to attend. This meant the provider kept staff updated on good practice. The provider also kept staff updated on expectations about their conduct by issuing written directives. Each staff member was required to sign to indicate they had read and understood the message in the written directive.

The provider had various systems of auditing the quality of the service provided. The registered manager showed us a provider quality audit completed in November and December 2017 which looked at whether

the service was safe, effective, caring, responsive and well led. This audit checked records about health and safety, understanding safeguarding, staff rotas, supervision and training, nutritional and health support, people's dignity and privacy being respected, inclusion of people's wishes in decision-making, compliments and complaints, personalisation of care plans and feedback from people. We saw no concerns were identified during this audit.

Audits included carrying out unannounced direct observations of staff. These checks included the timeliness and presentation of care workers, their communication and how well they performed their tasks. We reviewed six of these checks and saw no areas for improvement were identified.

Office staff carried out care file audits when they were returned to the office each month. The registered manager told us they preferred these audits to be done in the presence of the staff member so that any issues identified could be dealt with at the time. We saw file audits done on 5 February and 5 March 2018 noted that staff were writing detailed reports but identified an issue with how the care record was completed. It was noted that the action completed was this was raised with the relevant staff members during supervision.

The provider worked in partnership with other agencies. The registered manager told us they offered one week or two week work placement opportunities to students from a school in Hackney and they had one student from France for three months. The registered manager told us they attended the quarterly registered manager's meeting which was useful for sharing ideas about good practice. Attendees at this meeting had started a consultation page on 'What's App' which could be used to ask for or give advice in between meeting dates. What's App is a mobile phone application where groups can set up a page to support each other through text messages.