Golden Key Support Ltd

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Inspection report

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Date of inspection visit:
18 May 2018

Date of publication:
07 June 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 carried out this inspection on 18 May 2018.

At our last comprehensive inspection in April 2017 we found breaches of regulations regarding staff recruitment and the management of medicines. We carried out a focussed inspection in September 2017 where we found the provider was now meeting regulations concerning the management of medicines but was still not meeting regulations about staff recruitment.

At this inspection we found the provider had made the necessary improvements and was now meeting regulations. We have changed their rating from "Requires Improvement" to "Good".

Golden Key Support is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. At the time of our inspection there were 25 people using the service. These were primarily older people and people with physical disabilities. The provider had applied to provide support to children with disabilities, but had not started doing so at the time of this inspection.

The service had a registered manager. 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.

People's needs and preferences for their care and health needs were assessed before they started to use the service, and care plans were designed in order to meet these. Care plans were reviewed regularly to make sure they met people's needs, and we saw care was delivered in line with these, although we saw a small number of cases where there were discrepancies between what care was planned and what care staff had recorded had taken place. People received support in line with their cultural needs and were supported to have varied diets.

The provider obtained suitable consent to care and had assessed people's capacity to consent to care, but lacked procedures in the event they needed to document that they were providing care in people's best interests.

Risks to people using the service were assessed and there were measures to keep people safe. People were safeguarded from abuse, and when there were concerns staff were aware of their responsibility to speak up and had confidence in the manager's ability to address these. Processes were followed in order to investigate and address complaints and allegations.

The provider followed safer recruitment measures to make sure people were suitable for their roles. People told us that care workers were punctual and reliable, and that they felt treated with respect. People consistently received care from the same care workers, who could meet their cultural and language needs.

The provider had revised their policies regarding the management of medicines prior to their last inspection, and we saw that this improvement was sustained to ensure people received their medicines safely.

Staff told us they felt well supported by managers. Care workers received regular training and supervision to make sure that they had the right skills for their roles.

There were systems in place to make sure people were regularly consulted about their care, both by telephone and in routine home visits. These were used to make sure people were satisfied and whether any aspect of their care needed to change. There were consistently high levels of satisfaction with the service provided.

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.

There were procedures in place to protect people from abuse and avoidable harm.

Risks to people using the service were assessed with appropriate management plans in place.

People told us staff arrived on time for their calls. The provider operated safer recruitment processes to help ensure that staff were suitable for their roles.

Medicines were safely managed, and managers carried out regular checks to ensure that this continued.

Is the service effective?

Good

The service was effective.

There were comprehensive assessments carried out of peoples' needs and wishes for their care and how they may be affected by health conditions.

Staff received the right training and supervision to carry out their roles.

People received the right support to eat and drink and have a varied diet.

People's capacity to make decisions was assessed and consent to care was obtained.

Is the service caring?

Good

The service was caring.

People told us that their care staff were kind and treated them with respect.

People consistently received care from the same care workers, who could meet their cultural and language needs.

People's communication needs were assessed. People were given regular opportunities to discuss their care.

Is the service responsive?

Good

The service was responsive.

People received care which was in line with their plans. These were regularly reviewed to ensure they still met their needs.

Complaints were investigated by managers and appropriate actions taken.

Is the service well-led?

Good

The service was well led.

Staff told us they were well supported by managers.

There were processes in place to monitor the quality of care and people's satisfaction with the service.

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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 carried out this inspection as the provider had been rated "Requires Improvement" within 12 months of this inspection and was breaching one regulation concerning staff recruitment. The provider had recently informed us of an allegation of neglect and had shared the investigation they had carried out into this. We were not aware of any further concerns about the service.

Prior to the inspection we asked the provider to complete a provider information return. This is a document which asks providers to tell us what they think is working well in the service, what needs to improve and their plans to develop the service. We also reviewed notifications about incidents which the provider is required to tell us about by law, such as when people using the service had died. We checked the provider's registration with Companies House and made sure they were displaying the rating of their last inspection on their website.

This inspection took place on 18 May 2018 and was carried out by a single adult social care inspector. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

In carrying out this inspection we looked at records of care and support for four people using the service and records of medicines management for three people. We looked at records of recruitment and supervision for five staff. We also looked at staff rotas, staff training records, policies and records of team meetings. On the day of the inspection we spoke with the registered manager, administrator and care co-ordinator. Following the inspection, we made calls to two people using the service and two relatives of people who used the service. We spoke with four care workers.

Good

Is the service safe?

Our findings

People were protected from abuse as the provider had, and followed, a suitable policy for safeguarding adults and children. Staff had received safeguarding training and were able to describe how they would recognise signs of abuse. Comments from staff about the management of the organisation included "They do take [abuse] seriously, they take the necessary action" and "[my manager] did take it seriously".

We were aware of two allegations of abuse that had occurred in the last year. In both cases we saw that the registered manager had taken appropriate steps to report their concerns to the local authority and the Care Quality Commission and had carried out an appropriate investigation with recommendations. These included additional training for staff, and, where abuse was suspected by a member of staff who had been dismissed, the registered manager had referred the matter to the Disclosure and Barring Service (DBS) as required. There had not been any further incidents recorded since our last inspection, but the provider had a procedure for recording when incidents had occurred, which included the registered manager reviewing these and identifying any changes which needed to take place to prevent a recurrence.

People were protected from avoidable harm, as the provider had completed suitable risk assessments with plans to mitigate risks to people using the service. This included assessing the risks to people from hazards in their property, risks relating to falls, mobility and skin integrity. Where people required support to make transfers, the provider had assessed the safety of this and made recommendations, such as the number of staff required to make the transfer safely and any changes which may be made to make this safer. The provider had assessed the equipment which was in place to make transfers and checked that these were in good condition. Moving and handling risk assessments also included details on risks such as those relating to skin integrity, muscle mobility and behaviour which may challenge.

There were enough staff to safely support people using the service. When people required two staff to support them safely we saw that this was taking place. People using the service told us that staff arrived on time and stayed for the correct duration. Comments included "They arrive on time and stay" and "It's pretty much on time." Staff told us that they had enough time to travel between calls.

The provider told us they checked that staff had arrived for calls by requiring them to send a text message on arrival and on leaving. We confirmed this by talking to staff. Comments included "I've never missed a text" and "They do call if I'm running late. Sometimes you forget to text".

At our last inspection we found that the provider was not always operating safer recruitment measures to ensure that staff were suitable for their roles. At this inspection we found the provider was now meeting this regulation.

The provider carried out suitable checks on staff before they started work. This included obtaining proof of identification and a full work history. The provider was now using a form to verify that they had a complete work history for prospective staff and explored any gaps in this at interview stage. Interviews were also used to verify suitable information was obtained on staff and to assess personal qualities such as politeness and

personality.

The provider also obtained references which demonstrated, where relevant, evidence of satisfactory conduct in previous health or social care employment, which they verified by obtaining a company stamp and/or calling the referee. Where personal references were taken, the provider obtained proof of the referee's identify such as a driving licence. The registered manager told us "What we do now is to contact the employer or the person giving the reference to ensure that the reference is actually coming from them."

There were also records which verified candidate's identification, address and their right to work in the UK. Prior to starting work the provider also carried out a check with the DBS. The DBS provides information on people's backgrounds, including convictions, to help employers make safer recruitment decisions. The provider's policy was to repeat these every three years, and they maintained a record of dates for this purpose.

People were safely supported with medicines. At the time of our inspection the provider was supporting three people with medicines. At the previous comprehensive inspection we had found the provider was not keeping suitable records of medicines administration. We found that the improvements we had required had been sustained.

As part of the assessment process the provider obtained detailed information on the medicines people took, the reasons for these and the support they required to receive their medicines safely. This included assessing any risk factors such as the likelihood of a person refusing medicines or attempting to take them in a manner which may be unsafe. The provider checked that medicines were stored safely and whether a person was taking any homely remedies which may present a risk.

When staff administered medicines, this was appropriately recorded on a medicines administration recording (MAR) chart. The provider told us that wherever possible they obtained this from the person's pharmacy, but in one person's case they had decided it was more appropriate to do this themselves. We looked at three months' MAR charts for all three people, and saw that these were correctly completed by care workers. The registered manager carried out a monthly check of all MAR charts and verified that these were correctly completed and whether any issues were identified or action taken as a result.

The provider also had a suitable medicines policy which clearly outlined staff responsibility with regards to assessment and recording. There was a clear procedure for reporting and investigating any errors which had occurred, but we did not see any evidence of medicines errors taking place.

Risk assessments also covered infection control measures. This included the steps that carers needed to take to minimise the risks from infection such as wearing gloves and using hand gel. Where a person had a catheter, there was a clear procedure for staff to follow when emptying the catheter bag to ensure that good infection control practice was maintained.

Good

Is the service effective?

Our findings

People's needs and choices were assessed before they used the service. The provider had a detailed assessment process in place, which assessed people's needs with regards to daily living, including handing money, cooking, moving around and needs relating to continence and personal care. This also included assessing whether care workers working with the person would require any additional training.

Staff received appropriate training and supervision to carry out their roles. Care workers had obtained a Care Certificate as part of their induction. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. Care workers received a five-day induction which covered a wide range of subjects and then had the opportunity to shadow more experienced members of staff.

The provider had ensured that care workers received yearly training in key areas identified as mandatory. These included moving and handling, administering medicines, safeguarding adults and children, mental capacity, food hygiene, first aid, infection control and dementia. Care workers told us that they received suitable training to carry out their roles.

Additionally, the provider intended to provide support to children with additional needs. The registered manager told us "We are being very selective about who we are putting with them; we are doing training around global development delay and epilepsy". Training certificates showed that this was taking place.

Care workers told us that they received supervision every three months, which was supported by records of formal supervisions. This included discussing the challenges and barriers care workers faced, any concerns they had about their roles and additional training or support they may need. Managers used this as an opportunity to give care workers feedback about their performance. Additionally, the provider carried out supervision of care workers in people's homes to verify that the care they gave was safe and appropriate.

People received the right support to eat and drink. As part of the assessment the provider checked the support people needed in this area and checked who was responsible for this. Where care workers were required to help people with food, for example by reheating and serving food, this was reflected in care plans. Logs of daily care showed that people received this as needed. Care workers also documented what people had had for each meal, and this showed that people received varied diets.

There was also information on people's plans on any relevant health conditions they may have. This included information about the effect of the person's condition and any signs that this may be deteriorating. Care workers were also provided with information on common issues such as skin tears and pressure sores, and information on common conditions affecting people using the service such as stroke, diabetes or high blood pressure.

People had consented to their care. The provider had assessed whether people were able to make decisions. This included checking whether there were any conditions which may affect the person's

decision-making ability and whether they were able to retain information and make decisions regarding their daily care. This showed the provider was working in line with the Mental Capacity Act (2005) (MCA). The Act provides a legal framework for making 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 found that although appropriate consent was obtained to people's care, systems were not in place in the event that the provider needed to demonstrate that they were making a best interests decision about a person's care.

The provider had also developed information in line with the General Data Protection Regulations (GDPR). This included guidance on what the new regulations meant for people using the service, how they may hold and share information regarding the person and obtaining consent to hold people's information.

Good

Is the service caring?

Our findings

People told us the service was caring. Comments included "[My relative is treated] very kindly, she is so happy when [the carer] arrives" and "I'm very happy, they're very lovely."

People consistently received care from the same care worker. Rotas showed that the same care workers were allocated to the same person most of the time, and no one had different carers from day to day. One person told us "Usually it's the same lady, she's been working with [my relative] a year and a half, and there's another who covers when she's away".

People's preferences for their care were assessed and followed. This included checking the preferred gender of the care worker and required language skills. A care worker told us "In terms of language barriers, we try to get people who can speak each other's language." A relative said "[My relative] is quite happy with the service, because it's the same language speaking." The provider also assessed people's communication needs, such as whether they required glasses or hearing aids and whether they could communicate their needs verbally or by making phone calls or sending texts.

Where people had health conditions which affected their communication, plans clearly detailed the ways in which this could occur. For example, a person had a diagnosis of vascular dementia, and staff were made aware that this didn't affect their verbal communication but they could become confused at times, especially when the person was tired.

People's views on their care were sought regularly. This included monthly phone calls to people using the service and quarterly visits by a manager. The registered manager told us "We have regular calls to make sure that the clients are happy and that the carers are getting there on time." Everyone using the service had received a monthly call to check that they were happy with the standard of care and felt that they were treated with dignity and respect. We could see that these had been carried out monthly ever since the person started using the service.

Care workers also received training in equality and diversity to make sure that people's needs were met in an appropriate fashion. Care plans had examples of people's cultural needs, including language needs, preferred foods and religious needs and how these were met. For example, one person's plan required them to be supported to the mosque every Friday.

People told us that staff treated them with respect and maintained their dignity. One relative told us "They try to make sure that no one is around when they are changing [my relative], so they are quite aware of that." Care workers gave us examples of how they maintained people's dignity. One care worker told us "We talk to them and see if they are comfortable. We [provide care] in a way that they are comfortable with everything" and another said "I work with someone and consider them to be part of my family. How would I treat my family member? I do it like that."

Good

Is the service responsive?

Our findings

People received care which was responsive to their needs. This was because people's care plans were designed in a way that met their assessed needs and followed by care workers.

Care plans had clear information about the support people required on each visit. This included details of how this varied during the week. For example, one person's plan highlighted when visits were carried out at different times at weekends, and other plans highlighted different support such as shopping and cleaning that took place on different days.

The provider had a daily log system which required staff to tick tasks that they had done with the person each day. This included washing, dressing and support to use commodes or change a person's pad. This meant we could be sure that people received the right support on each visit, but these records contained limited information on the quality of the interaction and the way the person had presented each day. However, in one instance a person's plan indicated that they were to receive additional support on two days with tasks such as cleaning and accessing the community. We saw from timesheets that this was taking place, but care workers were routinely not recording visits which were outside what was planned on a daily basis.

In another case, we saw that a person received an additional visit in the evening which did not form part of the care plan. However, the plan was clear about the tasks that needed to take place on every visit, and we could see that this was taking place.

Plans were reviewed regularly to check that people's needs were still met. People received an annual review of their care and support, but quarterly monitoring visits were also used to highlight whether any changes were required to the person's care plan. For example, a person's plan had recently been updated to reflect changes to their medicines.

The provider had assessed any needs people had with understanding and reading information. Care plans were straightforward and easy to follow. This meant the provider was meeting the Accessible Information Standard.

Care workers told us they felt the care plans were of a sufficient standard to understand the support people required. Comments included "Definitely it's useful. It does have enough information to get information on how the person is, but now and then it's good if the family's around to check if they know anything else" and "When I go to a service user I go through the care plan and I understand what the person needs immediately. It's well understandable." The registered manager told us "Before we give [staff] a client we tell them to come to the office and make sure they are aware of the contents [of the care plan]."

People using the service told us they were confident they could speak with the registered manager if they had any complaints or concerns. The provider had a suitable process in place for recording and responding to complaints. This included obtaining details of the nature of the complaint and how the person would like

the service to put things right. We saw two examples of complaints having been received and evidence that the registered manager had carried out a suitable investigation. As part of the process, the registered manager recorded any actions which needed to take place because of the complaint and verified whether the person was happy with the way their complaint had been handled.

Good

Is the service well-led?

Our findings

People using the service told us that it was well led. Comments included "Someone in the office does a check to make sure you're OK", "The manager's quite nice, when he calls he's making sure [my relative] is happy and if there's anything he can do" and "They way they come across I'm sure they'll do their best to sort any issue out."

There were systems in place to ensure that people were satisfied with the care. On a monthly basis office staff called people or their relative to check whether they were satisfied with their care package and whether the care workers were doing all they should do. A member of the office staff said "I ask them how they are getting on and if they have any concerns and issues. The Reponses are mostly positive; there has always been good feedback because we monitor them regularly." In addition, the service carried out a monitoring visit every three months. This was used to obtain comments about the service and to check that daily logs and medicines records were appropriately completed, and whether any changes were required to the care plan. There was also a yearly review, in which a senior member of staff checked the person's satisfaction with the service, whether the person was happy with the number of care workers working with them and whether their confidentiality was maintained. This was also used to review and update risk assessments and the person's care plan.

The registered manager had implemented strong processes to make sure good practice was maintained. This included the detailed assessment and care planning procedure, good systems of recruitment and checking the suitability of staff and regular audits of medicines records. A care worker told us "They do check the daily log. They go through it and if there's anything they don't understand they give me a call."

Managers also carried out random spot checks on staff. These recorded whether the care worker had arrived on time and if they provided good quality care, for example by communicating well, following moving and handling procedures and encouraging the person to do things for themselves. Sometimes these lacked details on why the assessor had reached these conclusions, but in other cases we saw examples of good practice recorded. A co-ordinator told us "spot checks have so far been good, but sometimes I become aware that they are not wearing the correct clothing, so I will sit down with them and discuss the issue. As that could be a hazard. It's [things] like health and safety, or too much jewellery."

Staff told us they felt well supported by the managers. Comments included "They attempt to support staff", "He is supportive" and "He talks to carers sometimes in our own language." A member of staff told us how the manager had supported them to develop their skills and progress in their role. Managers also collected compliments they had received from people and their relatives about specific care workers. For example, the registered manager received an email from a family member to say their carer "Interacted as if [they] were a member of the same family." The registered manager had printed this out and highlighted it in the person's supervision and placed it on their personnel file.

Staff were also supported through monthly team meetings, which were taking place as planned and well attended by care workers. These were used to discuss areas of practice and to ensure that policies were

adhered to. For example, a team meeting was used to discuss how daily logs and timesheets should be completed, and in another meeting staff were reminded of their responsibilities to check people for sores and bruises. New regulations such as those affecting personal data were also discussed with care workers. The registered manager had also discussed with the staff team how they could build their confidence, and the importance of speaking up when necessary.