Golden Key Support Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Golden Key Support Ltd is a domiciliary care agency providing care and support to children and adults under direct payment arrangements in several East London boroughs. At the time of our inspection there were 32 people using the service.

People's experience of using this service
The provider did not always consider how best to meet people's nutritional needs in line with their preferences and recording did not support this. There was a lack of detailed plans for how to support people with health conditions and sudden changes to their health. Care workers received suitable training and supervision to carry out their roles but not always to respond to changes in people's health conditions, and managers observed and assessed their practice.

People's basic care needs were assessed and care plans were followed. The service responded to changes in people's care needs and checked regularly to see if any changes were needed. Care workers understood how to meet people's choices and preferences but recording did not always support this. People knew how to complain and complaints were responded to appropriately.

There was not always detailed planning for how to support people with their end of life care. The service was not meeting the accessible information standard to provide information for people in a format relevant to them. People were not supported to have maximum choice and control of their lives and did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People told us they were treated with dignity and respect by care workers. People's cultural needs were met and understood by care workers but care planning processes did not always ensure this took place. Care workers gave us examples of how they supported people to make choices and maintain their independence. Care workers worked well with families to deliver care to people.

Processes safeguarded people from abuse and improper treatment. Risks to people's safety and wellbeing were considered, but sometimes there were not assessments in place to support people when they became upset or agitated or unwell. Care workers were recruited safely.

People's medicines needs were assessed but sometimes it was not clear how people were to be supported with creams or rescue medicines. There were not enough checks on medicines records to ensure that issues would be addressed promptly.

There was a new manager in place who had applied to be the registered manager. They had identified their immediate priorities for assessing the performance of the service to develop a suitable action plan. Some audits and checks were not being carried out and staff meetings were not taking place, which the manager

was planning to address. People and staff told us managers were accessible and helpful. The service had the capacity to deliver learning but did not always promote reflective practice which would help the service to improve.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection:
The last rating for this service was good (published 7 June 2018).

Why we inspected
The inspection was prompted in part due to concerns received about the management and quality of the service. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches of regulations in relation to the management of medicines, management of risks, person centred care and good governance.
We issued a warning notice requiring the provider to be compliant with regulations concerning the management of risks and medicines by 4 March 2020.
Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Golden Key Support Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by an inspector and an assistant inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.
The service did not have a manager registered with the Care Quality Commission. A registered manager is a person who is legally responsible for how the service is run and for the quality and safety of the care provided. It is a requirement of the provider's registration that they have a registered manager.
The service had a manager who had recently started in post and subsequently began the process of registering.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service, including serious events the provider is required to tell us about. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.
We used all this information to plan our inspection.

During the inspection
We spoke with the director, branch manager and care co-ordinator. We looked at records of care and support for seven people and records of recruitment, training and supervision for six care workers. We

reviewed records relating to the management of the service, such as training records, audit and development plans.

After the inspection
We made calls to one person who used the service and three family members of people who used the service. We spoke with four care workers.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Care workers were able to give medicines safely. Staff had received training in medicines administration and told us they felt confident administering medicines.

● People's medicines needs were not fully assessed. The provider had recorded the levels of support people required and people's ability to manage their medicines. Sometimes information was not consistent. For example, one person's plan for being escorted out in the community said they did not require medication, but another care plan stated they had rescue medicines in the event of a seizure. This meant that if the person was being escorted out in the community, they may not have had access to their required medication in the event of a seizure. Often it was not clear what people took medicines for. Where people had prescribed creams, it was not always clear how often these needed to be applied or where on the body.

● Medicines were not always suitably recorded. Medicines administration was recorded on charts, however sometimes medicines, including creams were not included on these. Medicines charts were not always brought back to the office or audited promptly; some people's charts had not been audited for six months.

Assessing risk, safety monitoring and management

● Risks to people's safety were not always assessed. The provider had generic risk assessments which highlighted risks from neglect, the environment and people's mobility. However, assessments did not always cover the risks from health conditions and when people had behaviour which may challenge.

● There were not always suitable risk management plans for particular circumstances. For example, when people became agitated, plans sometimes did not include useful information about the interventions and precautions care workers needed to take. There was not always information on the equipment people used. When a person had diabetes there was no information on how to recognise the signs of hypoglycaemia and how to respond.

The above paragraphs constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were safeguarded from abuse and poor treatment. Care workers had received training in safeguarding adults and were confident in describing types of abuse and how to report these. People and their relatives told us they felt safe when staff members visited.

● The provider had suitable safeguarding procedures. These outlined people's responsibilities to report abuse and included details of where these needed to be reported to. Where issues of concern had been noted, including abuse or poor practice by third parties, these had been reported promptly to the local

authority.

Staffing and recruitment

● There were enough staff to meet people's needs. People told us that their care workers came on time and stayed for the entire call. Care workers were allocated in such a way that they could attend calls as required.

● The provider operated safer recruitment measures. Managers had verified staff identification and the right to work in the UK. The provider had obtained references, including evidence of satisfactory conduct in previous health or social employment and had carried out a check with the Disclosure and Barring service (DBS). The DBS provides information on people's backgrounds, including convictions, to help providers make safer recruitment decisions. The provider had systems in place to repeat DBS checks every three years.

Preventing and controlling infection

● People were protected from infection risks. Care workers had received training on infection control and gave us examples of how they used personal protective equipment supplied by the provider. Care workers had also received training in food safety.

Learning lessons when things go wrong

● The provider had a process for reporting incidents and accidents. Care workers described how they would respond to an incident, including reporting this to the office and giving an account of what had happened.

● There had not been any serious incidents that may require a review of processes. However, there were not processes for monitoring when people had become distressed or agitated to look at way of reducing their occurrence. The provider's process did not include checking whether a serious incident needed to be reported to the CQC or the local authority and whether risk assessments needed to be changed as a result.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

- The provider carried out assessments of people's needs. These included information how what people could do for themselves and areas of daily living where people required support.
- People's assessments were clear about who was responsible for each area of care. For example, when people received specialist nutritional support or were supported with medicines by a family member this was clearly recorded on care plans.
- Sometimes assessments lacked detail on people's choices. There was not always information about how people liked to receive their personal care or the types of foods people preferred to eat. There was not always information about people's cultural or religious needs relating to food or care.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support

- People told us their nutritional needs were met but there were not always enough records to show this had taken took place. The provider assessed the support people required with nutrition and hydration and where necessary this formed part of people's support plans. Daily logs did not always show that people had received the right support and there was a lack of detail to show how people received balanced diets.
- The provider obtained information on people's health conditions. There was information available for care workers on particular conditions on how these may affect the person.
- There were not always consistent plans on how to support people with conditions. In some cases information was available on the clinics and health services that people accessed. However, there was not always information on how to support people with long term conditions such as diabetes, what the person's individuals needs were relating to that condition and how care workers should respond in an emergency.

Ensuring consent to care and treatment in line with law and guidance

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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● When children used the service, the provider sought appropriate consent to care from parents or those with parental responsibility. Processes did not always support obtaining parental consent as these were designed with adults in mind. For example, a child's plan stated they did not have mental capacity, but in other cases said they were able to make decisions for themselves.

● Processes were not always followed when people were thought to lack capacity. For example, one person's plan said that they lacked capacity and their family member made decisions on their behalf. It was not clear which decisions this was referring to, there was no assessment of the person's capacity and the provider had not obtained proof that the family member had legal authority to make decisions on the person's behalf.

● Consent to care was obtained when people were able to do so. The provider recorded people's understanding of aspects of care and people had consented to their plans.

Staff support: induction, training, skills and experience

● Care workers received a suitable induction into their roles. This included an opportunity to shadow more experienced colleagues and to complete the care certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. The provider told us they did not have access to staff workbooks, which meant these could not form the basis of staff development.

● Care workers had not always received sufficient training to carry out their jobs. People told us they felt their care workers had the right skills to do their jobs. The provider had assessed mandatory training for staff and there was evidence staff had attended these. However, care workers had not always received training regarding health conditions which could pose a risk to the people they supported, such as when they provided care to people living with diabetes or epilepsy. Managers carried out checks of staff competency when providing care. Care workers told us they received adequate training from the provider and that they found these useful.

● Care workers received regular supervision from the provider. These were used to give staff feedback about their performance and set targets for staff. Supervisions were not always used to devise a development plan for staff. Sometimes basic targets were set for care workers, such as to complete logs accurately or attending calls on time, but it was not clear if this was setting management expectations or indicating a problem with the staff member's performance.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were well treated and supported. People told us they felt well treated by their care workers. The provider regularly spoke with people and their families to make sure they were treated with respect. A family member told us "[my relative] has dementia, and they have a lot of patience with [him/her]."
- People benefitted from having consistent care workers. In most cases the same care worker attended the same people's visits each day, and people who used the service confirmed this with us. Care workers told us the people they supported had requested they be supported by people of the same gender, and this was always respected.
- The provider assessed people's spiritual and cultural needs. Sometimes this information was brief and did not consider how these needs affected how people received care. However, care workers gave us examples of how they supported people with their spiritual needs, for example preparing people for Friday prayers. People told us they benefitted from having care workers that spoke their language.

Supporting people to express their views and be involved in making decisions about their care

- The provider assessed people's communication needs. This included whether people were able to read or write or required the use of glasses or hearing aids. People told us their care workers communicated clearly with them.
- Staff knew how best to communicate with people. Care workers gave us examples of how they supported people to make choices and understood the importance of talking to people during care.

Respecting and promoting people's privacy, dignity and independence

- People were treated with dignity and respect. People told us that their care workers spoke appropriately and gently with their family members. Care workers gave us examples of how they preserved people's dignity, such as keeping people covered and ensuring doors were kept closed when providing care.
- People's independence was respected, but this was not always planned in a way that helped people to develop and maintain skills. Plans sometimes lacked detail on what people could do for themselves and care workers had not recorded what people had done independently and the level of support they had offered. Care workers described how they encouraged people to carry out tasks for themselves.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider was not meeting the AIS. There were not alternative formats to help people understand the contents of the care plans. Family members told us that they read these and understood their contents.
- The provider did not routinely provide information about the service in a format applicable to people. We did not see examples of policies or guidance in other languages or easy-read formats.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's basic care needs were planned. There was information on the support people required to maintain personal hygiene and continence needs. Care plans were reviewed to make sure they still met people's needs. The provider regularly spoke with people and their families to see if any changes were needed.
- Sometimes systems did not support responsive care. There was very limited personalised information about how people liked to receive their care and what approaches worked best with people. We found care workers relied on their own experience of the person to provide this.
- Care workers recorded when there were more serious issues with people's packages of care, such as when more time was needed, and managers acted on this. Care workers recorded basic information about the tasks they had carried out, but did not keep details of how the person was or what challenges they had faced in providing care. This made it harder for managers to monitor the delivery of care or make the case when more care hours were required.

End of life care and support

- The service did not always follow best practice in planning for end of life care. Where a person was considered to be at end of life there was information on how they worked with palliative care services and family members to provide care. However, there was no more detailed planning based on the person's life expectancy or how to respond to a sudden change in the person's wellbeing.
- Where people were not at end of life there was a lack of planning for the future. Care plans did not routinely consider what people's wishes for their end of life care were or what may be important for the person following their deaths.

The above paragraphs constituted a breach of regulation 9 of the Health and Social Care Act 2008

(Regulated Activities) regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People received support to access the community and attend places of worship. People using the service told us they were happy with the support they received with this.

● Recording of community access was not always clear. The provider did not always have plans in place to describe the places people liked to go and how best to support them with this. Care workers did not record where they went with people or what the person's experience of this was.

Improving care quality in response to complaints or concerns

● The provider had processes for responding to complaints or concerns. People told us they knew how to make a complaint and who to speak with. People we spoke with told us they had no complaints about their care.

● The provider had responded appropriately to the single complaint that had been made. This included speaking with the complainant, investigating the complaint and commencing a full investigation. The provider had an action plan in place to ensure that appropriate action was taken.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was not a registered manager in place as the previous manager had deregistered in July 2019. The service had appointed a new manager who had recently started in post and we received an application to become registered manager shortly after this inspection.
- The manager had clear priorities to assess the performance of the service. We saw a plan of checks planned between the co-ordinator and manager for their first days working together. This included high priority issues such as audits of medicines and checking staff files were up to date. The manager told us they would use this to develop an action plan to improve the quality of the service, but there was no clear development plan at this time.
- The provider was behind schedule with some audits. There were clear systems in place for checking the administration of medicines but this had not taken place for some months. Other audit systems were yet to be developed or implemented. Daily records were not routinely checked to ensure recording was of a sufficiently high quality to monitor the delivery of the service, nor were care plans checked for accessibility, person centred detail or end of life planning.

This constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

- The provider notified the CQC about significant events as required to by law. Managers submitted notifications when people had died and when allegations of abuse had been made and when people had died.

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

- Care workers told us that managers were approachable. Comments included "[they are] very kind and helpful" and "They have an open door policy." Care workers told us they were kept informed of serious issues and any changes to people's care needs.
- People and their families told us that managers of the service engaged well with them. Comments included "[the director] always makes a phone call to get updates" and "It is easy to contact the office."

● Senior members of staff carried out regular checks with people and their families to monitor the quality of care. This involved speaking with people by phone or visiting them at home, and identifying if there were any concerns or changes required to people's care.
● Team meetings had not been taking place regularly. The last meeting had taken place in April 2018. The new manager had identified team meetings as a high priority.

Continuous learning and improving care; Working in partnership with others
● The service worked in partnership with people's families to develop care. Care workers were clear about where responsibilities lay between them and people's family members.
● The service communicated with local authorities when required. This included when to report concerns about people's care and when changes to people's care packages were required.
● There was a learning culture, but not always reflective practice. The service had detailed and good quality training packages available for their staff team which were kept updated in line with changes to legislation. There were limited opportunities to reflect on areas where practice could be developed to improve the quality of care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not design care with a view to achieving service users' preferences and ensuring their needs were met or provide the relevant person with the information they would reasonably need for the purposes of this 9(3)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality and safety of the services, assess monitor and mitigate the risks relating to the health and safety and welfare of service users or to maintain securely an accurate, complete and contemporaneous record of the care provided to the service user. 17(1)(2)(a)(b)(c)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always assess risks to the health and safety of people using the service or do all that was reasonably practicable to mitigate any such risks; or ensure the proper and safe management of medicines 12(2)(a)(b)(g)

The enforcement action we took:

We issued a warning notice