Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Gold Hill Homecare

Graham House, Criss Grove, Chalfont St Peter, SL9 9HG

Tel: 01753890844

Date of Inspections: 18 September 2013
10 September 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Complaints	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Gold Hill Housing Association Limited
Registered Manager	Miss Claudia Sumner
Overview of the service	Gold Hill Homecare provides a domiciliary care service to people in their own homes. They do not provide a service for children.
Type of service	Domiciliary care service
Regulated activity	Personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 10 September 2013 and 18 September 2013, talked with people who use the service and talked with carers and / or family members. We talked with staff and talked with other authorities.

What people told us and what we found

We spoke with four people who used the service, three members of staff and the registered manager. People said they were happy with the care and support they received. They made positive comments about the care staff, and about the office staff. One person said "The carers are always on time, and are kind and friendly." Another person told us "The carers are reliable, and they turn up when they are meant to. The people in the office are friendly and efficient." A relative told us she was pleased with the service given. She felt she could rely on the staff to deliver a good service to her relative.

People told us they had signed general consent forms for information about them to be shared appropriately. Each file we reviewed confirmed this had been done, and consent had been correctly documented.

Staff told us that there was enough detail in the care support plans to be able to assist each person.They said they always read the information and checked verbally with people that nothing had changed.

We heard there had been very few complaints about the service. We reviewed the complaints file and saw they had been dealt with efficiently and in a timely manner.

There was a recruitment process in place to ensure that staff had the right skills and qualifications to work with vulnerable people.

Records were usually accurate and fit for purpose. They were securely stored and the provider had a policy for retention and destruction.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. People told us they had signed general consent forms for information about them to be shared appropriately. This was done in order to provide information to other health care providers, such as general practitioners, dieticians and district nurses. One person told us they were asked at length about providing consent, and she was surprised about this because "I thought the nurse knew everything anyway." The other people we spoke with confirmed that these conversations had taken place, and they were happy to have signed the consent after a full explanation was given. Each file we reviewed confirmed this had been done, and consent had been correctly documented. This meant that people could be sure their personal information would only be shared with appropriate individuals, after their consent had been gained.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. This meant that, if necessary, a relative may have been asked to provide consent if a person was unable to do so for themselves.

People told us that carers asked for their permission before delivering personal care. They ensured the person knew what would be done, and had agreed to it. Care plans clearly described personal care procedures to be undertaken, and where these were changed, the care plan had been appropriately updated to reflect the changes. Staff told us they always checked the care plan before providing any support or personal care. If a person refused care, the reasons had been sought, and time taken to ensure the person understood the consequences of refusing care on that visit. This had been documented and the agency manager informed.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. People we spoke with told us they were happy with the care and support they received. They confirmed someone from the agency had visited to determine their personal requirements, before any care began. We read five care plans. In each of them, we saw that an assessment of needs had been carried out. This was agreed with the person or their relatives, before appointments for care were set up.

People told us the carers were polite and respectful, and they "almost always" saw the same carer(s). They said they found the carers attentive to their needs, and that they stayed for the full allotted time of the appointment. We heard that people or their relatives had been involved in the planning of care. In the agency office, we read communications from a family member, requesting changes to planned care, and for things to be done in a very specific way. The care records demonstrated that this had happened in accordance with the expressed wishes.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. The care plans contained consent for information sharing, and clear demonstration that people had been consulted when the care plan was written. Information in the initial needs assessment was used to inform the care plan.

The deputy manager told us that risk assessments were completed on an individual basis, and this was evident in the care plans we viewed. Where people lacked the capacity to make informed decisions about aspects of their support and care needs, best interest meetings had been held. This involved consulting with family and other agencies or professionals who may have been involved directly in care or treatment. This meant that care and support required was accurately tailored to the individual, even where they lacked capacity to speak for themselves. The care plan documented that care delivered met individual, and changing, needs.Most of the care plans had been recently updated.

Visit records were maintained, detailing all care that had taken place. If care was refused, the reasons were appropriately documented, and the staff in the office had been informed. Records were kept in people's homes, and then transferred into files at the office.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

People told us they felt safe with the carers who looked after and supported them. They said they thought the staff were well-trained and kind.

We reviewed six staff files and saw the job application, interview records, selection and induction process were usually well documented. There was a new check list so any outstanding documentation could be seen at a glance. This meant that the manager could be assured that the recruitment process had all of the relevant documentation in place.

Appropriate checks were undertaken before staff began work. The agency policy was for all staff to have a Criminal Records Bureau (CRB) check, two references and a full employment history. In five out of six files we saw they had records of CRB checks and a full employment history, however one person only had one reference. We also saw one file where the checks of the documents received was not of a sufficiently robust standard to pick up some errors on it. We addressed this with the agency manager. As the file was of a staff member who had joined many years ago, she was unaware of the facts required. The provider may wish to note there had been no formal documentary review process until recently.

We also discussed this with the Chief Executive of the agency. They immediately set up an internal enquiry to understand how this error had not been picked up previously. This meant that the people using the agency could now be assured that all documentation undergoes rigorous checks.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People were made aware of the complaints system. This was provided in a format that met their needs. People we spoke with said they knew how to make a complaint, although none of them had done so. One person told me the complaints procedure was written into the documentation supplied by the agency. We saw a copy of the information sent to people, and confirmed this information was within the pack. Two other people told us that staff who worked in the office would listen to "little worries", and they were confident these would be addressed.

The manager told us there had been very few complaints about the service. We asked for and received a summary of complaints people had made and the provider's response. We reviewed the complaints file and saw there was one complaint made during the last year. It had been dealt with efficiently and in a timely manner, and the records clearly documented the satisfactory outcome. This meant that people could be assured they would be able to make a complaint, and have it fully investigated and resolved, where possible, to their satisfaction.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

People's personal records were accurate and fit for purpose. We read five care and support plans and saw they were complete. The plans had been reviewed regularly and within the last year, or before, if considered necessary. We noted that the person who used the service, or their relative, had been involved in the process.

Records were usually clearly written, and signed. The provider may wish to note that written records of visits should include not just the time of arrival, but also the time of departure. Signatures should also be clear and full, not just the first name of the person delivering the care.

Staff records and other records relevant to the management of the services were accurate and fit for purpose. We looked at six staff files and saw that these were mainly complete. A new audit system was being implemented to ensure compliance with all necessary records being on file. This was substantially complete.

Records were kept securely and could be located promptly when needed. Electronic records had been kept private by the use of a personal password, and paper records were filed in a cabinet within a locked office. This meant that people could be sure that their personal information was kept in a private and secure manner, and accessed only by those with a legitimate reason to read them.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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