Platinum Care Cheshire Ltd

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Inspection report

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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

This inspection of Platinum Care took place on 31 May 2018. The provider was given 48 hours' notice of our plans to complete an inspection. This was because the service provided a domiciliary care service and we needed to be sure that someone would be available at the office to assist with our inspection.

Platinum Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community in Cheshire. It provides a service to older adults and those with a physical disability or sensory impairment. Not everyone using Platinum Care receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

Platinum Care registered with the CQC on the 30 March 2016 and had previously operated from a different location before moving to its current location in July 2016. This was the first inspection of Platinum Care. At the time of our inspection, the service was providing personal care to 76 people living in their own homes in the community.

There was a manager in post at the service who was appointed in April 2018 but was not yet registered with the Care Quality Commission. 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.

All of the people we spoke with told us the support they received from staff enabled them to feel safe and secure whilst living independently. Risk management plans had been completed in areas such as moving and handling, medication and the environment to help protect people from the risk of harm and guide staff on how to mitigate identified risks.

Systems were in place to support people with their prescribed medicines. People received their medication from staff who had received the appropriate training and this was documented accurately. Medication audits and observations were completed regularly to ensure staff were competent in this process.

Robust recruitment procedures were in place to ensure that staff appointed were suitable to work with vulnerable people. Staff had received training in safeguarding and knew how to recognise and report abuse to local partner agencies.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The service operated within the principles of the Mental Capacity Act 2005 (MCA). People told us that staff always asked for their consent before delivering any care and support. Staff demonstrated a clear understanding of the need to ensure that people were involved in making decisions about their care. The manager provided

evidence of their plans to further develop the documentation in respect of this.

People using the service were supported by staff and external health care professionals to maintain their health and wellbeing. Staff maintained effective communication and adopted a multi-disciplinary approach to meeting people's needs. This included regular liaison with professionals such as social workers and occupational therapists.

Staff had the necessary skills and knowledge to provide care in an effective way and had a good understanding of the individual needs of the people using the service. Staff told us they felt well supported in their role and the training matrix showed they received regular training, supervisions and observations.

People told us that staff were 'kind', 'considerate' and 'caring' and spoke about the positive rapport they had developed with them. Comments included, "I would recommend them one million percent, they are absolutely excellent" and "I think they do a wonderful job, the carers that come to me are smashing." People confirmed that staff treated them with respect and preserved their dignity when providing personal care.

Care plans contained detail in respect of people's routines and preferences to enable staff to gain a good understanding of the person they were supporting and provide person-centred care.

People had access to a complaints procedure and knew how to make a complaint. However, people told us they had no cause to complain and if they did have an issue, they resolved this informally. Comments included, "If we have a problem, we just call the office and it's sorted."

Systems were in place to assess and monitor the quality of the service provided. This included audits in areas such as medication, care plans and recruitment, in addition to regular spot checks and staff observations to assess staff performance.

People who used the service were able to provide feedback about the quality of the care being delivered. Quality assurance surveys were issued to both people and staff to improve and develop the service.

The manager had notified the Care Quality Commission (CQC) of events and incidents that occurred at the service in accordance with our statutory requirements. This meant that CQC were able to monitor risks and information regarding the service.

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.

Risk assessments were in place for people who needed them and contained sufficient detail to guide staff on how to mitigate identified risks.

Safe recruitment practices were in place which ensured suitable staff were employed. Staff received training in safeguarding vulnerable adults.

There were effective systems in place to provide people with their medicines as prescribed and in a safe manner.

Is the service effective?

Good

The service was effective.

Staff followed the principles of the Mental Capacity Act (2005) and there was evidence of consent recorded in files.

Staff understood people's individual needs and received the relevant training to support them in their roles.

Staff supported people to maintain good health through on-going monitoring and liaison with external healthcare professionals.

Is the service caring?

Good

The service was caring.

People spoke positively about the relationships they had developed with staff and described staff as kind, friendly and considerate.

People's privacy and dignity was respected. Staff had received training in equality and diversity.

People were involved in decisions about their care and staff offered people choice to encourage their independence.

Is the service responsive?

Good

The service was responsive.

People's care records contained personalised, relevant and up-to-date information about the support they required.

People and their families were involved in the assessment and planning of their care and support.

A process was in place for managing complaints and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

There were processes (checks) in place to help monitor and improve the quality of the service provision.

There was a process in place to gather and analyse the feedback of people and their relatives in the form of an annual questionnaires.

The manager had notified the Care Quality Commission (CQC) of events and incidents that occurred at the service in accordance with our statutory requirements.

Platinum Care Cheshire Ltd

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.

Prior to the inspection we contacted the local authority commissioning team to seek their views about the service. They raised no concerns about the care and support people received and considered their last visit in November 2017 to be positive. We also considered information we held about the service, such as notification of events and incidents which occurred at the service which the registered provider is required by law to send to CQC. We used all of this information to plan how the inspection should be conducted.

The inspection was carried out by an adult social care inspector. The registered provider was given 48 hours' notice before our site visit and advised of our plans to carry out a comprehensive inspection of the service. This is because the location provides a domiciliary care service and we needed to be sure that someone would be in the office to assist with the inspection.

As part of the inspection, we visited the office and met with the manager for the organisation, the office assistance and a senior carer. We spoke with 10 people who used the service and seven relatives on the telephone. We spoke to six members of care staff. We also looked at eight care plans for people who used the service, five staff personnel files, MAR records for five people, staff training and development records as well as information about the management and quality assurance systems at the service.

Good

Is the service safe?

Our findings

People told us they felt safe when receiving support from staff. Comments included, "Oh yes, I absolutely feel safe" and "I have no fears at all, they are great." Relatives told us, "I trust them completely. When I go out, I know [relative] is safe with them" and "It's very reassuring to have such lovely people supporting [relative], I don't know what I'd do without their back-up."

People told us that sufficient staff were employed to meet their needs. They told us that staff had sufficient time to complete tasks and the majority of people told us that staff were dependable and punctual. Comments included, "They stick to the times allocated", "They are reliable. I thought they'd missed me once, I rang the office, they had an emergency and sent someone straight away" and "They are usually on time, it is very rare if they are late."

There were four seniors employed and 28 members of care staff to meet the needs of the 76 people receiving a service. We reviewed a series of staff rotas and saw that these were well-organised; however, we noted there was no provision for travel time in between visits. People were generally satisfied with the timeliness of their calls and the manager assured us that visits were grouped in close proximity to one another in individual boroughs reducing the need for travel time. Staff spoken to confirmed that 'runs' (which is a term used to describe visits close to one another) were manageable and now organised more effectively to promote punctuality of visits. One staff member told us, "One route was not working well due to the crossover traffic in the morning, I raised it and it was addressed, the route was changed and split differently among the staff."

We checked how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We reviewed five personnel files of staff who worked at the service and saw there were safe recruitment processes in place including; photo identification, references and Disclosure and Barring Service (DBS) checks. DBS checks are carried out to ensure that staff are suitable to work with vulnerable adults in health and social care environments and enable employers to make safer decisions about the recruitment of staff. All recruitment files were audited to ensure that all appropriate documentation had been received.

Staff had received training in safeguarding vulnerable people and were able to describe what course of action they would if they felt someone at the service was being abused or neglected. We saw evidence that the registered provider attended strategy meetings and worked with other local partners to ensure people were protected from suspected harm.

Staff had received medicine management training to ensure they had the skills and knowledge to administer medicines safely to people. Each staff member completed a medication 'workbook' which was used to assess their knowledge in respect of medication policies, recording, storage and terminology.

People's medical conditions, current medication and allergies were clearly documented on each care file. Medication assessments were in place to guide staff as to processes around administration and any

associated risks. A staff signature list was in place to ensure legibility of recording. There were records in place to guide staff on the use of topical preparations (creams) and body maps which outlined the areas of the body the cream was to be applied to.

People who received support with their medication were happy with how this was managed. Comments included, "They give me my medication morning, noon and teatime and leave my night meds for me to take later", "They help me with my medication and make sure I've had it" and "Staff always get my medication out of the blister pack for me."

We reviewed Medication Administration Records (MARs) for five people and saw these were completed accurately to evidence when medication had been administered. A two tier audit system was in place to check MAR's on a monthly basis which involved checks by both senior staff and the manager to promote more effective and robust oversight. When errors were identified, remedial action was taken which included disciplinary measures for staff involved or discussion within staff meetings to prevent re-occurrence. Three monthly medication observations were also completed to assess staff competencies in this area as part of the on-going development of the service and to ensure that any lessons to be learned were identified promptly.

Staff completed risk assessments in respect of areas such as people's living environment, fire safety, medication and moving and handling. These assessments were sufficiently detailed and included guidance on how to mitigate risks. For those people who had moving and handling needs, 'complexity of lifting' assessments were completed to inform staff intervention. This included measures to reduce the risk of back injuries for staff such as the support of a second member of staff. Additionally, each assessment considered whether there were any alternative measures which would reduce the risk.

Environmental assessments were completed on each person's home during the initial assessment process to highlight any potential hazardous working conditions for staff. These explored the safety and suitability of the environment and any risks to staff such as access to the premises, electrical equipment and fire hazards. Further assessments were completed of any moving and handling equipment in use which explored the suitability for equipment, such as hoists, to ensure they were in an adequate state of repair.

Records showed that fire safety, infection control, first aid and health and safety training was provided for all staff as part of the induction and updated on an annual basis. Staff had access to personal protective equipment (PPE) such as gloves, and people confirmed this was worn when delivering care to promote good hygiene and infection control.

Good

Is the service effective?

Our findings

People told us that staff were well trained and had the appropriate skills and knowledge to support them effectively. Comments included, "Staff know what they are doing. They empty my colostomy bag and take care of my catheter", "Staff are trained and know how to support me" and "The senior staff are very good, they have had some new staff start and the seniors come out with them and show them what to do." Relatives told us, "Staff are well trained, they know how to hoist [relative] and manage it well."

We reviewed the staff training matrix and certificates within staff recruitment files which showed staff had training in areas such as moving and handling, medication, communication, care planning and emergency first aid. Some staff had also received specialist training in respect of supporting individuals with their Percutaneous Endoscopic Gastrostomy (PEG) and non-invasive ventilation. The registered provider's records showed the vast majority of staff, had achieved, or were working towards, an NVQ level 2 or above. This helped to ensure that people were cared for by staff that had the necessary skills to support them safely. The manager provided evidence of their efforts to secure further training for staff to start on 4 June 2018 to include mental health awareness and end of life care.

Staff reported feeling well supported in their role through induction, regular training, observations and supervisions. We reviewed the registered provider's supervision schedule and saw that all staff had regular themed observations and supervisions. Supervision sessions between care staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs. These were held at six and 12 weekly intervals following staff appointment.

During this inspection we checked to see if the service was working within the legal framework of the Mental Capacity Act (MCA) 2005. The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People and their relatives told us that staff sought consent before providing care and encouraged people to be involved in decision-making. People's relative told us, "[Relative] has dementia, they offer her choice about what she would like to eat because they do her meals" and "We completed the [care planning] documents at the start of the package and [relative] was involved as much as possible up until she could no longer participate."

People signed consent documents within their files for decisions such as the administration of medicines and for the provision of services outlined within the care contract. Staff were able to give a summary of how capacity should be taken into account and how the best interests of people could be determined in their support. A copy of Lasting Power of Attorneys was retained within people's individual care files alongside supporting documentation. We discussed how the registered provider's own mental capacity assessments could be incorporated into the documentation to ensure staff have the necessary information when

supporting people with cognitive difficulties. This was because we identified two cases whereby people noted to have memory problems through an external assessment signed their own consent documents and it was not clear whether they had the capacity to do so. Following our inspection, the manager sent us a new template they planned to introduce to better evidence their assessments of people's capacity which would be rolled out across the service.

People told us staff worked together with other agencies to provide effective care. Comments included, "I have been advised to have specialist equipment, the Occupational Therapist is coming today and the senior will come too, so we can have discussions. They are very good" and "If my medication has not turned up from the pharmacy, the staff will chase it up for me." People's relatives told us that staff were alert to any deterioration in people's health. Comments included, "We have had to call the GP a few times, staff won't leave [relative] until the nurse or GP has arrived" and "On one or two occasions, staff had slight concerns about [relative], they alerted me straight away and I got the doctor out, it was reassuring to see they used their own initiative." Staff also assisted people on a practical basis to ensure any samples were sent to the GP when required.

Staff attended strategy and multi-disciplinary meetings to discuss people's needs and there was evidence of good liaison with social work professionals. For example, staff worked with other professionals to support a person when deterioration in their arm movement was noted. This included implementing guidance from other professionals in respect of assisting the person to exercise their hand and shoulders.

People were supported by staff to have their nutritional and hydration needs met. Comments included, "I have to be careful what I eat, the staff know this, and they prepare me food which is suitable with my bowel problems", "Staff make me breakfast, it's up to me what I have and they prepare it for me" and "Staff ensure I am well hydrated, they always leave a flask of hot drinks for me on each visit." We reviewed the daily logs which showed that staff had recorded what assistance staff had provided to people in respect of their nutritional intake each day. For example, '[Person] had vegetable soup for tea as they had a big dinner' and 'Person had pork pie for dinner and I peeled an orange. I saw [person] eat the pie- ate the meat mainly.'

Good

Is the service caring?

Our findings

People spoke positively about the staff team who supported them. Comments included, "I'm over the moon with them, they are very, very caring", "The girls are very good company", "I'm happy, I have one regular carer and she is brilliant", "Staff are very caring, they always ask if there's anything they can do before they leave" and "Each and every one of them is so kind, we have a laugh together." These comments were also echoed by people's relatives. One relative told us, "[Relative] is very, very keen on the staff. The girls have even popped in when they are not working from time to time to say hello."

Staff we spoke with demonstrated a good understanding of how to protect and promote people's dignity. Staff were able to provide examples of how they preserved people's dignity, which included asking people's permission before offering support and maintaining privacy when providing personal care. People we spoke with confirmed this. Comments included, "I have four regular girls, they shave me, wash me and yes they do this whilst maintaining my dignity. I was asked if I was comfortable with a particular staff member who I knew previously" and "The carers treat me with respect, they cover me when taking off my nightie and keep me dignified."

People and their relatives told us staff encouraged them to be independent. People told us, "They are very helpful when showering, I can dress myself but they encourage me" and "We work it between us, I do what I can do and staff support when I need it." People's relatives told us, "If I tell them [relative] can do that, they will encourage him, for example, to do things like wash his own face" and "[Relative] lacks motivation, staff will encourage her but don't impose on her either, if she doesn't want to do something because she's tired they respect that." This focus on maintaining independence and involving people in decisions was reflected in discussions we held with staff and within people's care records. For example, one care file instructed staff to encourage the person to exercise choice, 'Ask me if I would like shower or bath and ask me what I would like to wear for the day.'

Staff had received training in communication, values, and working relationships and told us how they encouraged people with sensory impairments to be involved in decision making. One staff member described how they supported someone who had a vision impairment and ensured that they utilised tools such as magnifying glass, lights and placing documentation within the person's line of vision to assist them.

The manager told us they were not currently supporting anyone with specific equality and diversity needs however they, and their staff, shared a commitment to treating all people equally and with fairness. This was echoed in the organisation's statement of purpose which outlined the company's priorities and included a pledge to ensure that each client's values and needs were respected in matters of religion, culture, race or ethnic origin, disabilities and impairments. All staff had received training in equality and diversity and understood how to apply this in practice. Each care plan had an 'important information' section whereby 'cultural needs' were documented which showed this was considered as part of the assessment process.

Personal records containing sensitive information were stored in office areas and staff kept secure information in locked boxes when travelling. This meant that people could be confident that personal

information was only shared to those directly linked to their care. Staff had received training in confidentiality. The manager had an awareness of new legislation which had come into force regarding the storage of people's personal data and were in the process of seeking advice in respect of how to ensure compliance with this. Records showed this new legislation around data protection was discussed in the last senior staff meeting.

Good

Is the service responsive?

Our findings

Care records showed that staff had consulted with the individual or their relatives and other professionals to develop a plan outlining how people needed to be supported. The care files we reviewed contained assessments of people's needs around personal care, mobilisation, cognition, behaviour and nutrition. These plans were sufficiently detailed to guide staff on how to support people effectively. Any changes were clearly recorded such as changes to people's call times or support needs. For example, one review form documented that a new stair lift was in place for someone at risk of falls which alerted staff to the new equipment in use.

People told us they had involvement in the care planning process and on-going reviews and people signed their own plans to support their inclusion in this process. Staff also completed daily records to provide an on-going account of care provided to each person and any key issues that affected their well-being. Comments included, "They write everything down and the book is left here, I can look at it if I want to" and "They asked me about the support I needed and do reviews every so often." Relatives told us, "The care plan was drawn up with what we wanted and the hours we wanted. Recently we cut the hours, Platinum Care were responsive and tried to adapt their hours to suit us."

Through our discussions with people using the service, their relatives and staff, it was evident that staff knew the people they supported well and delivered a person centred service. Care plans were person centred and contained an 'About me' document which was completed with the person regarding their desired outcomes and how they wanted to be supported. This document also contained information about people's individual routine and what tasks they would like carers to do on each call. We reviewed a care file for someone who had very specific support requirements in terms of infection control due to a compromised immune system. We saw that a meeting was held with staff to discuss this person's needs and how tasks, such as meal preparation, were to be carried out in a manner which would alleviate distress to the person. We spoke to a senior carer regarding this person, and they were able to recount this person's individual needs with accuracy, as reflected in the written documentation.

People had access to a complaints procedure and complaints were dealt with in accordance with the registered provider's policy. People who used the service and their family members told us they knew who to speak to if they had any concerns or complaints and had the office number. People told us, "I'd speak to [senior] if I had concerns", "I'd ring the office number on my red book" and "I can't fault them but if I had any issues, I'd speak to [senior] who manages the girls in this area."

The registered provider's records showed that only one formal complaint was received in December 2017 and they had not received any further. We saw that a record of investigation was held and appropriate action had been taken in response to this complaint. Preventative action was implemented which included disciplinary action for the staff member involved. A record of compliments and thank you cards were kept whereby people wrote to show their appreciation of staff and commended staff on their hard work and approach.

The service was not currently supporting anyone who received palliative care but had given consideration as to their processes in respect of people at the end of their lives. The manager had made links with a local training provider and had enrolled all staff on an end of life training course and was aware of their obligations in relation to this. Care records contained information in respect of whether people had completed 'Do Not Attempt Resuscitation' (DNAR) forms.

Good

Is the service well-led?

Our findings

All the people we spoke with told us they were happy with the staff and service in general. Comments included, "I'm quite happy with everything I get", "This is the third company I've had and these are brilliant, I would recommend them to anyone" and "They are a very good team, the office are easy to deal with."

There was a new manager in post who had been appointed in April 2018 and was not yet registered with the Care Quality Commission but had begun the process of doing so. 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. We discussed the need for consideration to be given to registration changes for the service given the last registered manager was also the responsible individual for the service. Following our inspection, we received confirmation that this had been addressed.

Some people told us they were aware of the new arrangements because the new manager had visited them in their own homes to introduce themselves. One relative told us, "I know [manager]; they visited last week to introduce themselves because I understand she is in the process of taking over." The manager had circulated a letter to all people using the service to inform them about the new management changes and people we spoke with confirmed they had received this.

The recently appointed manager was open to feedback during the inspection and demonstrated that they were committed to using this to further improve the service. The manager spoke enthusiastically of their new role and had a clear vision for the service. The manager has previously worked as a carer and therefore spoke about their commitment to staff well-being and further training and development for staff. They told us how they had already implemented changes to the rota system to improve staff satisfaction, the timeliness of calls and consistency of carer. Staff told us this had a positive impact on their role. One staff member commented, "The rotas are better organised now, [manager] knows the 'runs' in the area so it's easier for us." The manager recognised their own areas for personal development which included the compliance aspect of the management of the service and told us how they were seeking out local resources to address this.

Staff told us they felt well supported in their role and enjoyed working for organisation. Staff described a period of unsettlement following the loss of their last registered manager but described the new manager as 'fantastic', 'supportive' and 'approachable'. One staff member commented, "[Manager] is quite down to earth because they have worked as a carer before and understand the issues we have." Employee satisfactions surveys were completed in 2017 and showed that all respondents felt well supported in their role. Feedback regarding training was addressed and actioned.

Staff meetings were held regularly for both care staff and senior staff and minutes showed discussion was held regarding medication, paperwork and client updates. Information about any changes to people's needs was discussed at these meetings, for example, information was shared that one person had a new

profile bed in place. One staff member said, "I feel like we're kept in the loop, we have regular staff meetings and [management] keep in touch with us."

We reviewed documentation which showed that senior care staff completed regular themed observations and spot checks to assess the quality of care being delivered by care staff. These three monthly checks of practice assessed staff in respect of their performance, friendliness, use of PPE and medication administration. We saw that action was taken following these observations to improve practice, for example, staff were spoken to regarding any areas for improvement noted. In addition, good practice was acknowledged and recognised, such as, 'staff member gaining confidence, well done' and 'lovely manner used to client'.

Quality assurance procedures were in place and audits were completed regularly and in a wide range of areas to monitor and review the quality of service people received. Audits were completed in respect of medication, employee recruitment files, environmental assessments, staff supervision and care plans. Quarterly audits were completed in respect of areas such as health and safety and people's progress records. We saw that these were effective in identifying areas for development, for example, one care plan audit identified missing information in files and action was recorded to address this, which was signed off once completed.

There was evidence that people's views had been sought through the distribution of a quality assurance service survey. At the time of our inspection, the 2018 survey had not been circulated. We reviewed the results from 2017 and saw that the responses were positive to the majority of questions such as those in respect of staff punctuality and staff conduct. Isolated comments of low satisfaction were dealt with on an individual basis.

The service worked in partnership with other organisations to make sure they were following current practice, and providing safe, effective and compassionate care. These included social services, healthcare professionals and community groups. Feedback received from people and their relatives indicated that this multi-disciplinary approach had resulted in good outcomes for people using the service.

The manager was aware of their obligations to notify the Care Quality Commission (CQC) of events and incidents that occurred at the service in accordance with our statutory requirements. This means that CQC are able to monitor risks and information regarding the service.