# Inspection Report

## 9 March 2023

# Platinum Support and Care Services Ltd

Type of service: Domiciliary Care Agency
Address: 5a Ann Street, Ballycastle, Antrim,
Telephone number: BT54 6AA

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

## 1.0 Service information

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| **Organisation/Registered Provider:**<br>Platinum Support and Care Services Ltd<br><br>**Responsible Individual:**<br>Mr Shaun Patrick Joseph McCook | **Registered Manager:**<br>Mrs Mary Gillan<br><br>**Date registered:**<br>18 December 2015 |
| **Person in charge at the time of inspection:**<br>Mrs Mary Gillan | |
| **Brief description of the accommodation/how the service operates:**<br><br>Platinum Support and Care Services Ltd is a domiciliary care agency based in Ballycastle which provides a range of services including personal care, practical and social support and sitting services. Service users have a range of needs relating to dementia, mental health, learning disability and physical disability. Services are commissioned by the Northern Health and Social Care Trust (NHSCT). | |

## 2.0 Inspection summary

An unannounced inspection took place on 9 March 2023 between 11.20 a.m. and 5.00 p.m. The inspection was conducted by a care inspector.

The inspection examined the agency's governance and management arrangements, reviewing areas such as staff recruitment, professional registrations, staff induction and training and adult safeguarding. The reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS), restrictive practices, Dysphagia and Covid-19 guidance was also reviewed.

Areas for improvement identified related to training of staff, the annual update of care plans, the inclusion of accurate Speech and Language Therapist (SALT) recommendations within care plans and the monthly quality monitoring reports.

Two areas for improvement identified at the previous inspection in relation to recruitment and service users' daily logs were assessment as partially and not met.

Good practice was identified in relation to service user involvement.

## 3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

In preparation for this inspection, a range of information about the service was reviewed. This included any previous areas for improvement identified, registration information, and any other written or verbal information received from service users, relatives, staff or the Commissioning Trust.

As a public-sector body, RQIA has a duty to respect, protect and fulfil the rights that people have under the Human Rights Act 1998 when carrying out our functions. In our inspections of domiciliary care agencies, we are committed to ensuring that the rights of people who receive services are protected. This means we will seek assurances from providers that they take all reasonable steps to promote people's rights. Users of domiciliary care services have the right to expect their dignity and privacy to be respected and to have their independence and autonomy promoted. They should also experience the individual choices and freedoms associated with any person living in their own home.

Information was provided to service users, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included questionnaires and an electronic survey for staff.

## 4.0 What did people tell us about the service?

During the inspection we spoke with a number of service users, service users' relatives and staff members.

The information provided indicated that there were no concerns in relation to the agency.

Comments received included:

**Service users' comments:**

- "They were very good. Really lovely carers."
- "I am very happy."
- "Very professional and very caring. They treat me as a person and not just a job. I have a good relationship with the carers."
- "All the timings are good."

**Service users' relatives' comments:**

- "I am 110% happy."
- "They are very caring and very considerate. They do what they need to do and also go over and above for her."

- "Absolutely delighted."
- "We have had other services and it's like night and day. They are very thorough, diligent and very friendly. I cannot say enough about them. Even the Director of the company has visited my relative to introduce herself."
- "The office staff are very courteous."

**Staff comments:**

- "The induction was great. You need to be out there to learn."
- "Great company to work for. Very accommodating."
- "I am aware of the procedure to follow if I can't get access to a service user's home."
- "There is always someone at the end of the phone for support. The manager is always doing spot checks. I get regular supervision."
- "Management are very sincere and very good to their staff."

No questionnaires were returned.

No staff responded to the electronic survey.

## 5.0 The inspection

## 5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

Due to the coronavirus (Covid-19) pandemic, the Department of Health (DoH) directed RQIA to continue to respond to ongoing areas of risk identified in services. An inspection was not undertaken in the 2021-2022 inspection year, due to the impact of the first surge of Covid-19.

The last care inspection of the agency was undertaken on 23 November 2020 by a care inspector. A Quality Improvement Plan (QIP) was issued. This was reviewed by the care inspector and was partially validated during this inspection.

| **Areas for improvement from the last inspection on 23 November 2020** | | |
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| **Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007** | | **Validation of compliance** |
| **Area for Improvement 1**<br><br>**Ref**: Regulation 13(c)(d) Schedule 3<br><br>**Stated:** First time | The registered person shall that no domiciliary care worker is supplied by the agency unless-<br><br>(c) he is physically and mentally fit for the purposes of the work which he is to perform; and<br>(d) full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 3. | **Partially met** |

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| | This relates to gaps of employment being explained, references and a statement of fitness by the registered provider or the registered manager. | |
| | **Action taken as confirmed during the inspection**:<br>We reviewed a sample of staff recruitment records and gaps in employment remained for two staff members.<br><br>This area was partially met and has been stated for the second time. | |
| **Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021** | | **Validation of compliance** |
| **Area for Improvement 1**<br><br>**Ref**: Standard 5.2<br><br>**Stated:** Second time | The registered person shall ensure that the record maintained in the service user's home details (where applicable):<br><br>• the date and arrival and departure times of every visit by agency staff | **Not met** |
| | **Action taken as confirmed during the inspection**:<br>A sample of service users' daily logs were reviewed and it was noted that they had not been fully completed and the deficits had not been identified during the audit.<br><br>This area has not been met and has been stated for the third and final time. | |
| **Area for improvement 2**<br><br>**Ref**: Standard 5.6<br><br>**Stated:** Second time | The registered person shall ensure that all records are legible, accurate, up to date and signed and dated by the person making the entry. They are kept in a safe place in the service user's home, as agreed with the service user, or where appropriate his or her carer/representative. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The agency was compliant with this standard. | |

## 5.2 Inspection findings

### 5.2.1 What are the systems in place for identifying and addressing risks?

The agency's provision for the welfare, care and protection of service users was reviewed. The organisation's adult safeguarding policy and procedures were reflective of the Department of Health's (DoH) regional policy and clearly outlined the procedure for staff in reporting concerns. The organisation had an identified Adult Safeguarding Champion (ASC). The agency's annual Adult Safeguarding Position report was reviewed and found to be satisfactory.

Discussions with the manager established that they were knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting and managing adult safeguarding concerns.

Staff were required to complete adult safeguarding training during induction and every two years thereafter. It was noted from reviewing the staff training records, that a number of staff had outstanding training in relation to adult safeguarding, medicines management and moving and handling. An area for improvement has been identified.

Staff who spoke with the inspector had a clear understanding of their responsibility in identifying and reporting any actual or suspected incidences of abuse and the process for reporting concerns in normal business hours and out of hours. They could also describe their role in relation to reporting poor practice and their understanding of the agency's policy and procedure with regard to whistleblowing.

The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. A review of records confirmed that these had been managed appropriately.

Service users said they had no concerns regarding their safety; they described how they could speak to staff if they had any concerns about safety or the care being provided. The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any concerns.

RQIA had been notified appropriately of any incidents that had been reported to the Police Service of Northern Ireland (PSNI) in keeping with the regulations. Incidents had been managed appropriately.

The manager reported that none of the service users currently required the use of specialised equipment. They were aware of how to source such training should it be required in the future. A review of the policy pertaining to moving and handling training and incident reporting identified that there was a clear procedure for staff to follow in the event of deterioration in a service user's ability to weight bear.

The manager advised that no service users required their medicine to be administered with a syringe. The manager was aware that should this be required, a competency assessment would be undertaken before staff undertook this task.

The Mental Capacity Act (MCA) provides a legal framework for making decisions on behalf of service users who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, service users make their own decisions and are helped to do so when needed. When service users lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff who spoke with the inspector demonstrated their understanding that service users who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the MCA.

Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The manager reported that none of the service users were subject to DoLS. Advice was given in relation to developing a resource folder containing DoLS information which would be available for staff to reference.

### 5.2.2 What are the arrangements for promoting service user involvement?

From reviewing service users' care records, it was good to note that service users had an input into devising their own plan of care. The service users' care plans contained details about their likes and dislikes and the level of support they may require. A review of care plans noted that they had not been reviewed on an annual basis or when changes require. An area for improvement has been identified.

### 5.2.3 What are the systems in place for identifying service users' Dysphagia needs in partnership with the Speech and Language Therapist (SALT)?

New standards for thickening food and fluids were introduced in August 2018. This was called the International Dysphagia Diet Standardisation Initiative (IDDSI). A number of service users were assessed by SALT with recommendations provided and some required their food and fluids to be of a specific consistency. Upon reviewing service users' care plans, it was noted that one care plan had not been updated since July 2020 and a SALT assessment had been completed on 5 January 2023. Another service user had a SALT assessment on 28 June 2022 and the care plan dated 11 August 2022 did not make any reference to this assessment. The omission of this information has the potential to place service users at a risk of harm. An area for improvement has been identified.

A review of training records confirmed that staff had completed training in Dysphagia and in relation to how to respond to choking incidents.

Discussions with staff and review of service users' care records reflected the multi-disciplinary input and the collaborative working undertaken to ensure service users' health and social care needs were met within the agency. There was evidence that staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate.

Staff demonstrated a good knowledge of service users' wishes, preferences and assessed needs. Staff were familiar with how food and fluids should be modified.

### 5.2.4 What systems are in place for staff recruitment and are they robust?

We reviewed a sample of the agency's staff recruitment records and they were not compliant with Regulation 13, Schedule 3 of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007. Whilst references and a statement of fitness by the registered manager had been completed, there remained deficits in the recruitment process. There were gaps in employment in two staff files which had not been discussed as part of the selection and recruitment process. This area for improvement was identified at the previous inspection and will be stated for the second time.

Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC) and the Nursing and Midwifery Council (NMC). There was an appropriate system in place for professional registrations to be monitored on a weekly basis by an appointed person within the office. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

There were no volunteers working in the agency.

### 5.2.5 What are the arrangements for staff induction and are they in accordance with NISCC Induction Standards for social care staff?

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care, to ensure they were competent to carry out the duties of their job in line with the agency's policies and procedures. There was a robust, structured, three day induction programme which also included shadowing of a more experienced staff member. Written records were retained by the agency of the person's capability and competency in relation to their job role.

The agency has maintained a record for each member of staff of all training, including induction and professional development activities undertake. A number of training for staff were outstanding and an area for improvement has been identified for this in 5.2.1.

All registrants must maintain their registration for as long as they are in practice. This includes renewing their registration and completing Post Registration Training and Learning. The manager was advised to discuss the post registration training requirement with staff to ensure that all staff are compliant with the requirements.

### 5.2.6 What are the arrangements to ensure robust managerial oversight and governance?

We reviewed a sample of the monthly quality monitoring reports which were available on the day of inspection. From reviewing the records retained by the agency, it was noted that they were not robust and a number of areas were not being reviewed by the monitoring officer. There was no evidence of any reviews of NISCC registrations of staff, staff recruitment files, service users' records, supervision/appraisal of staff or staff training. There was also no evidence that the action plans identified during the monitoring visits was reviewed at the next

visit therefore no assurance was provided that improvement was being driven and achieved by the service. These reports should identify any deficits in staff records, service user records and provide an analysis of any patterns or trends contained within all the information. An area for improvement has been identified.

The Annual Quality Report was reviewed and was satisfactory.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAIs) procedures.

The agency's registration certificate was up to date and displayed appropriately along with current certificates of public and employers' liability insurance.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Where complaints were received since the last inspection, these were appropriately managed and were reviewed as part of the agency's quality monitoring process. In some circumstances, complaints can be made directly to the commissioning body about agencies. This was discussed with the manager. Advice was given in relation to updating the complaints policy about how such complaints are managed and recorded.

There was a system in place to ensure that records were retrieved from discontinued packages of care in keeping with the agency's policies and procedures.

Where staff are unable to gain access to a service users home, there is a system in place that clearly directs staff from the agency as to what actions they should take to manage and report such situations in a timely manner. It is essential that all staff (including management) are fully trained and competent in this area. Following discussions with the manager it was reported that there is a clear system in place including a policy and procedure which all staff are aware of and adhere to.

## 6.0 Quality Improvement Plan (QIP)/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007 and The Domiciliary Care Agencies Minimum Standards (revised) 2021.

| | Regulations | Standards |
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| **Total number of Areas for Improvement** | 4* | 2* |

* the total number of areas for improvement includes one regulation that has been stated for the second time and one standard that has been stated for the third and final time.

Areas for improvement and details of the QIP were discussed with Mrs Mary Gillan, Registered Manager and Mr Shaun McCook, Responsible Individual, as part of the inspection process. The timescales for completion commence from the date of inspection.

## Quality Improvement Plan

| Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007 | |
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| **Area for improvement 1**<br><br>**Ref:** Regulation 13(d) Schedule 3<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>31 May 2023 | The registered person shall ensure they have a robust recruitment process which ensures all gaps in employment are explained.<br><br>Ref: 5.1 and 5.2.4 |
| | **Response by registered person detailing the actions taken:**<br>The application form has been amended to record that any gaps in employment have been checked and the reasons for such gaps in employment. Another member of the management team shall sign off the application form. The process is not considered complete until this check has been completed. |
| **Area for improvement 2**<br><br>**Ref:** Regulation 15(3)(b)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>31 May 2023 | The registered person shall ensure that every service user's care plan is kept under review. This should be completed on an annual basis or if the service users' needs change.<br><br>Ref: 5.2.2 |
| | **Response by registered person detailing the actions taken**:<br>Care plans are kept under review and a live spreadsheet has been created which will flag when updates are required. A member of staff has been assigned the task of reviewing the spreadsheet each week. Where there is any change in the service users needs the named worker shall be informed and an updated care plan requested. |

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| **Area for improvement 3**<br><br>**Ref:** Regulation 15(2)(a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>31 May 2023 | The registered person shall ensure that the risk assessments and care plans are reflective of the International Dysphagia Diet Standardisation Initiative (IDDSI), as indicated on the Speech and Language Therapist (SALT) care plan.<br><br>Ref: 5.2.3 |
| | **Response by registered person detailing the actions taken**:<br>All risk assessments and Care plans are now checked to ensure that they reflect the International Dysphagia Diet Standardisation Initiative (IDDSI) as indicated on the Speech and Language Therapist (SALT) care plan. The risk assessments and Care plans shall be checked every 3 months and a record kept of the checks. Named workers are advised of any changes to the services users needs and the requirement to update the risk assessments and care plans. |
| **Area for improvement 4**<br><br>**Ref:** Regulation 23(2)(a)(4)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>31 May 2023 | The registered person shall ensure that the information contained in the monthly quality monitoring reports is robust and a full review of records is undertaken. The reports are to contain action plans of any improvements the monitoring officer identifies and these actions are to be reviewed at the next monitoring visit to ensure improvement is being driven and embedded into practice.<br><br>Ref: 5.2.6 |
| | **Response by registered person detailing the actions taken**:<br>We are now using the new format of the monthly monitoring reports which ensures that a full review of records is undertaken. Action plans will be provided to ensure that improvement is being driven and embeded. |

| Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021 | |
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| **Area for improvement 1**<br><br>**Ref:** Standard 5.2<br><br>**Stated:** Third time<br><br>**To be completed by:**<br>31 May 2023 | The registered person shall ensure that the service users' daily logs are fully completed and should include dates, times or arrival and departure and contain both staff members' signatures where applicable.<br><br>Ref: 5.1 |
| | **Response by registered person detailing the actions taken:**<br>Staff have all been informed of informal process followed by a formal disciplinary process for those who do not complete documentation to the required standard. Management are auditing completed documentation and staff have been made aware of this process. All staff to be trained by the Nurse Manager on full and accurate completion of documentation and the training shall be recorded. All staff to complete the online documentation training and certificates will be retained. |
| **Area for improvement 2**<br><br>**Ref:** Standard 12.3<br><br>**Stated:** First time<br><br>**To be completed by:**<br>31 May 2023 | The registered person shall ensure that all staff have completed the mandatory training.<br><br>Ref: 5.2.1 |
| | **Response by registered person detailing the actions taken:**<br>A process has been introduced where a weekly update of training needs is provided for the Operations Manager. Staff are advised of their training needs and the escilation process which includes disciplinary action and the possibility of the withdrawal of shifts. A review of progress on training needs shall be included in the monthly monitoring reports. |

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