Positive Care Services Limited

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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

Positive Care Services Limited is a domiciliary care agency registered to provide personal care to adults living in their own homes. Not everyone using Positive Care Services Limited will necessarily receive a 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. At the time of our inspection there were eleven people using the service, all of whom were receiving personal care.

This was the first inspection of the service since it was registered in June 2017. The inspection was announced and took place on 1 August 2018 with follow up phone calls carried out on 3 and 6 August 2018.

At the time of inspection there was a registered manager in post who was also the registered provider. 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 and associated Regulations about how the service is run.

People felt safe using the service. Staff were aware of their safeguarding responsibilities and knew what to do to keep people safe. Staff were aware of the risks to people and how to manage risks to ensure people's safety and well being.

We made a recommendation about risk recording to ensure sufficient written guidance was available for staff to refer to.

People were supported to take their medicines safely by staff who had been trained and assessed as competent to administer medicines.

There were sufficient staff employed who had been safely recruited. Robust systems were in place to monitor people's visits to check that calls were not late, cut short or missed.

Accidents and incidents were recorded and analysed to monitor people's safety. Lessons had been learned and systems and processes adapted to improve the safety and quality of the service.

Staff received an induction, training and supervision to support them to be competent in their role. Staff felt well supported and were regularly observed to check their performance and identify any learning needs.

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. People's consent was sought before care and support was provided.

People were supported to have enough to eat and drink and received support to access treatment from healthcare professionals if their health needs changed.

Staff were kind and caring and listened to people. People were treated with dignity and respect and independence was supported and encouraged.

People's needs had been assessed and care plans formulated which described people's care and support needs. However, improvements were required to ensure written care records were 'person-centred' to reflect people's routines and preferences.

Staff had received training in end of life care and the service had formed links with the local hospice to provide additional guidance and support to staff if needed.

There were systems and processes in place to respond to complaints. People had access to the company's complaints policy and knew how to make a complaint. Feedback from people and staff was actively sought to drive improvements.

There was a registered manager in post who was supported by a care manager in the day to day running of the service. People and staff were positive about the management team who were 'hands-on' and visible within the service.

Quality assurance systems were in place to monitor the safety and effectiveness of the service. There was robust oversight of the service and clear lines of accountability at staff, management and provider level.

Further information is in the detailed findings below.

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.

Staff had received training in how to protect people from the risk of harm.

Risks to people had been identified and the information shared with staff so that staff knew what to do to keep people safe.

There were sufficient staff employed who had been safely recruited to meet people's needs.

Medicines were safely managed and good infection control practices were adhered to.

Is the service effective?

Good

The service was effective.

Staff received support and training to be competent in their role.

People were supported to have enough to eat and drink and access healthcare treatment if needed.

Consent was sought before providing people with care and support.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and treated people respectfully.

People's privacy was respected and their independence supported.

People were listened to and included in decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

Care records were task focussed however staff provided care to people the way they wanted to reflect a person-centred approach.

There were systems and processes in place to respond to complaints and people knew how to make a complaint if necessary.

Practices regarding supporting people with their end of life preferences required strengthening.

Is the service well-led?

Good

The service was well led.

The registered manager was visible and accessible within the service which meant that staff felt well supported.

There were systems and processes in place to monitor and improve the safety and quality of the service.

Feedback was sought from people and staff to include them in the running of the service and drive improvements.

Positive Care Services 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.

We completed a comprehensive inspection on 1, 8 and 6 August 2018 which was completed by one inspector and was announced. We gave the service 48 hours notice of the inspection visit because the location provides a domiciliary care service and we needed to be sure that they would be in.

Prior to the inspection we reviewed information we held about the service including statutory notifications submitted by the provider. Statutory notifications contain information about important events that happen at the service, which the provider is required to send to us by law. We also used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted external agencies who commission services from the provider to ask for their professional opinion of the service.

As part of the inspection we spoke with the registered manager, the care manager and two care staff. We also received written feedback from one member of staff and a commissioner. We also interviewed two people who used the service and one relative. We looked at three people's care records and four staff files. We also reviewed other documents relating to the management of the service such as quality assurance audits, supervision records and minutes of meetings.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. Staff wore uniforms and had ID badges and when new staff joined the service they were introduced to people first. This meant that people recognised the staff who came to their home which helped them to feel safe.

Staff had received training in how to protect people from the risk of abuse. Staff were aware of the signs to look for that someone might be being abused and knew how to report concerns to keep people safe. We spoke to a staff member who gave us an example of where they had reported a safeguarding concern which had resulted in the person being protected from the risk of abuse. This showed that the systems and processes in place to train staff and manage safeguarding concerns had been effective in ensuring people's safety.

Risk assessments were in place which identified individual risks to people and provided guidance to staff on how to manage those risks. However, we found there were some gaps in the risk recording process which meant that not all risks to people had been formally recorded. For example, where people had catheters in place, there was no risk assessment or management plan in place to provide guidance to staff. Nonetheless, we found this had not impacted on the safety or wellbeing of people. Staff we spoke with were aware of the risks to people including those associated with catheters and knew what to do to minimise the risk of harm. One staff member told us, "People with catheters are at risk of infection, we look for signs such as discharge or change in colour or urine or blood or the smell; also the catheter can block so we check this." We saw an example in a person's daily notes where a staff member had noticed a blockage in the catheter. This had been reported to the office and the district nurse had been called out to address the issue. This showed that staff were knowledgeable about risks to people and knew what to do to keep people safe.

We recommend that the provider review their systems and processes for recording risks to people to ensure sufficient written guidance is available for staff to refer to for people's safety and wellbeing.

Where required, staff supported people to manage their medicines. Medicine administration records (MAR) were kept in people's folders which staff signed to evidence that they had given people their medicines. We looked at copies of people's MAR and saw there were no gaps. This demonstrated that people had received their medicines as prescribed. Staff had received training in how to assist people with medicines and had their practice observed by the management team to ensure they were competent to provide support.

Lessons had been learned and the provider had improved their quality and safety monitoring by ensuring that their safety checks were properly documented. For example, when auditing people's MAR they had added an additional text box to record actions taken in response to any errors found. This meant that the provider was able to reliably monitor whether the necessary actions to improve the safety of medicine management had been completed.

Safe recruitment processes were followed. Records showed that applicants were subject to a series of checks before they started work at the service. This included a check carried out with the Disclosure and

Barring Service (DBS) and checks carried out with applicants previous employer/s. These checks helped the registered provider make safe recruitment decisions.

There were sufficient numbers of suitably qualified staff recruited to meet people's needs. The number of staff who attended people's homes was based on the person's individual needs. Records showed that people had received the care and support identified in their care plan at the right time by the right amount of staff. The service used an electronic GPS monitoring system to check that people had received their visits. A staff member told us, "If I haven't logged in to the system to show I have made my call they will chase me up to check that I have done visit and that I am ok." The registered manager told us that since the service registered in they had only had one missed visit. People we spoke with confirmed that they had not received any missed visits and that carers arrived within a half hour window of their allotted time.

Staff had received training in infection control and the service provided staff with aprons and gloves to maintain good hygiene practices and prevent the spread of infection. People told us that staff wore the appropriate protective clothing when providing personal care.

Good

Is the service effective?

Our findings

People told us that staff were competent in their role and that the service was meeting their needs. We received feedback from an external agency who commissioned services from the provider. They told us that they contacted people who had they had commissioned services and had received positive feedback. Comments from people had included; "The best ever." And, "Very good, timing good, kind and generous of thought." And, "Thorough with their duties."

People's needs were assessed prior to joining the service and the information gathered formed the basis of people's care plan which provided written guidance to staff on how to meet people's individual needs. However, we found that people's care plans lacked detail to provide sufficient written guidance to staff on how to effectively meet people's needs.

We discussed our concerns with the provider. They told us that staff were always given a verbal handover when a new person joined the service. Staff were then introduced to new people before providing care and support and worked alongside a senior member of staff who showed them what was needed for each person. Staff we spoke with confirmed that this happened in practice and were able to demonstrate a good awareness of people's needs. For example, one staff member told us, "When a new person comes on the books we get a call to let us know; we arrange for [registered manager] or [office manager] to come along and go through the care plan and everything they need; they take us there and explain things in more detail; we also read the care plan and we have to sign a page to say we have read it."

After the inspection the provider sent us an example of a new care plan template they had introduced. We saw that this provided a far more detailed written account of people's needs which would support staff should they need to refer back to the care plan for guidance.

When new staff joined the service they received an induction based on the care certificate standards. This represents best practice when inducting staff in the health and social care sector. The induction process also included a period of 'shadowing'. During this time the new staff were introduced to all of the people who used the service and worked alongside senior staff who provided guidance on how to effectively meet people's needs. During this time the management team also observed new staff to check their skills and competence. One staff member we spoke with described their induction experience. They told us, "I did shadowing with [named manager] for almost two weeks for all of the service users and once I was confident enough I could go out alone; [named manager] observed me and gave me feedback; after two weeks they did a review with me sat down and talked to me about what I needed and what I needed help in." This demonstrated that the provider was committed to supporting staff to have a thorough induction to help them be competent in their role.

Staff received regular supervision and observations of their practice to monitor their performance, provide feedback to staff and identify any learning needs. A staff member told us, "They [management] do spot checks on us all the time; they even talk with the clients to make sure what we do is ok and then they will call you into the office to tell you if you have done well or if you need to work on anything."

Ongoing training was provided to equip staff with the skills and knowledge to be competent in their job role. Both the registered manager and office manager were qualified as 'train the trainers' which meant they had the skills to deliver training to staff. The registered manager kept a record of staff training and we saw that staff training was up to date. The training provided was classroom based and involved watching DVDs followed by practical interactive sessions. Staff were required to take an exam to test their knowledge and this was sent to an external examiner for marking. Aside from the mandatory training programme which covered general aspects such as health and safety, infection control and moving and safeguarding. Additional training was provided which met the individual needs of the people who used the service. For example, where the service had been commissioned to provide people with leg care, training in leg hosiery had been organised with the district nurse.

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.

People's ability to make their own decisions and communicate their needs was assessed and recorded during the initial assessment. At the time of inspection, we were advised that all of the people using the service were able to make their own day to day decisions so no assessments of capacity had been completed.

Staff received training in the MCA to help them to support people who might have difficulty making choices. Staff we spoke with understood the importance of gaining people's consent and could describe how they would help people make their own choices. People we spoke with confirmed that staff asked their permission before providing care and support.

Where it was part of an identified need, staff assisted people to have enough to eat and drink which met their health needs and preferences. People we spoke with confirmed that staff always offered them a choice of food, snacks and drinks and before staff left they made sure that people had drinks within reach.

If people were observed to become unwell during a care visit, staff understood the importance of reporting any concerns to the provider. If necessary, the GP or paramedics were called to assess people's health needs. The registered manager told us that they would contact families to inform them of health concerns. If no family member or friend was available to support the person staff or a member of the management team would stay with the person until medical assistance arrived.

Good

Is the service caring?

Our findings

The service used values based interview questions when recruiting to check that potential new members of staff had a caring attitude and demonstrated positive values which would enable them to provide a caring service.

People told us that staff were kind and caring and that they were treated politely and with respect. One person told us, "They [care staff] are lovely girls." A relative said, "They [care staff] are always kind to [named family member]. All the people using the service that we spoke with told us that they felt comfortable and at ease with staff in their homes.

Staff were aware of the importance of respecting people's privacy and maintaining their dignity when providing personal care. One staff member told us, "We will make sure no one else is in room who doesn't have to be there; we shut the door and put a towel over people so not to let them feel exposed."

People's care plans showed that people had been involved in making decisions about the support that they received as they had signed to indicate their consent. Family members informed us that they had opportunities to express their views about the care and support their relatives received. Staff told us they listened to people so that people were in control of how they received their care and support. A staff member told us, "Listening to people is very important; they are the main focus; we listen and they explain what and how they want things done."

Care and support was delivered in a way that took account of people's individual needs and preferences and maximised their independence. People told us that staff promoted their independence and choice and encouraged them to be as independent as possible. One staff member described to us how they supported people to be independent. They said, "I always ask how much they can do, people can change so always check; give them choices, what they would like to wear, eat etcetera; we include people; if they able to do something for themselves we should let them; we just take over when they say they need help."

We looked at how the service recognised equality and diversity and protected people's human rights. Care records captured key information about people including any personal and religious beliefs. We saw that people who used the service could request a preference of gender of care worker and this was respected to help people feel comfortable and at ease with receiving care and support.

To strengthen its approach to equality, diversity and human rights, we recommend the provider consults the CQC's public website for further guidance entitled 'Equally outstanding: Equality and human rights - good practice resource.'

The service understood its responsibilities for data protection. We saw that personal information held about people was kept secure which meant that confidentiality was respected and maintained.

Good

Is the service responsive?

Our findings

The service involved people in the planning and delivery of their care and support. When new people started using the service they met with a member of the management team who completed an initial assessment. This was used to identify people's strengths and abilities, care needs and preferences.

We did find that the information recorded in people's care records was task focussed and lacked sufficient information to support staff to provide person-centred care. Person centred care means care tailored to meet each individual's specific needs and preferences. However, whilst the written records did not reflect a person-centred approach, in practice we found that staff knew people well and were providing care that was person-centred. People told us that staff knew them well and providing care the way they liked. For example, whether they liked tea or coffee and how many sugars people liked in their drink. One person told us, "The staff always try to do things the way I want them."

We discussed our concerns with the registered manager regarding their care recording which had failed to capture personalised information about people which would help staff to provide person-centred care. After the inspection we were provided with a copy of a new care plan template which had been designed. This was more person-centred in design as it gave a more complete picture of the person and included aspects such as people's preferred routines, wishes, likes and dislikes.

People were given information on how to make a complaint and all of the people we spoke with said they knew how to make a complaint but had not had to do so. People knew the name of the registered manager and office manager and told us they were accessible via telephone if required. We saw that there were systems and processes in place to manage formal complaints though we could not comment on their effectiveness as at the time of inspection there had been no complaints made. Compliments from people were also recorded and passed onto staff. We reviewed the cards and letters sent to the provider from relatives and people who used the service. Comments included; "To [named managers] and the team, thanks for doing a wonderful job." And, "Thank you to all of the carers who looked after [named person], they treated [named person] with such loving care and [named person] always looked forward to their smiling faces."

The service worked in partnership with the local clinical commissioning group (CCG) to provide care and support to people with palliative care needs. In these instances, the CCG provided the service with a care plan which contained guidance for staff to follow to meet people's particular needs. Staff had received training in palliative care to support their understanding when providing care to people at the end of their lives. The service had also formed links with the local hospice which provided additional support and training for staff. The registered manager told us that if people expressed particular end of life wishes then the service would support with this but these discussions had not been formally documented. Consequently, we found that people did not have preferred priorities of care (PPC) documentation in place. PPC provides a means of exploring and recording people's end of life wishes with the person or their relative, if appropriate.

We recommend that the provider seek independent guidance from a reputable source to ensure that people receive the necessary support to have their end of life wishes documented if this is their choice.

Good

Is the service well-led?

Our findings

There was a registered manager in post who understood their registration requirements including notifying us of significant events that affect the service. The registered manager was supported by a care manager and together they shared responsibility for the day to day running of the service.

The management team were committed to developing their knowledge and expertise and improving the service. They subscribed to industry related journals to keep up with best practice. The service had also formed links with local community organisations to help people access help and support that could not be provided through their care package.

The management team demonstrated good leadership, providing constructive feedback to staff regarding their performance through spot checks and supervision. This meant that all staff were clear about their roles and responsibilities. A staff member told us, "They [managers] do random observations to spot check that things are being done as they should be; they let us know if there's anything we need to improve upon."

There was good communication between staff and management which meant that staff were kept updated about any changes to people's needs or how the service was run. A staff member told us, "Compared to my previous manager, the new one is really good; I see them everyday and we get updates on people every day." We also received positive feedback about communication from a healthcare professional who worked in partnership with the service. They told us, "[registered manager] is always communicative and responds promptly to us; [registered manager] will always update me after they assess a person and discuss any issues."

Staff told us the management team were approachable and 'hands-on' working at the service and this helped staff feel supported. A staff member told us, "They [managers] are very visible within the service and we can always get hold of them by phone." The 'hands-on' approach of the registered manager meant that people knew who the manager was and could contact them if needed.

Quality assurance systems in place to monitor the safety and effectiveness of the service. We saw that a range of checks were completed by the management team including audits of care plans, daily notes and people's MAR sheets and spot checks of staff performance and practice. This meant that any mistakes or areas of improvement could be picked up on and addressed. We saw that these checks had been used effectively to drive improvement. For example, where a spot check had identified poor time-keeping by a member of staff, this was addressed with the staff member concerned and a further spot check was then completed a week later to make sure that the improvement was sustained.

Feedback from people was actively sought to develop the service and drive improvements. Informal discussions were held during spot checks of staff to check people's satisfaction levels. In addition, the registered manager regularly phoned people to check they were happy with the service they were receiving. Face to face meetings were also organised every six months or sooner if there were any concerns regarding the care package.

Staff were also included in how the service was run. An annual staff survey was sent out to staff to invite their feedback. Regular staff meetings were also arranged. A staff member told us, "If there is any decisions to be made about the company we all get to know what's going on."