2010/2011 INSPECTION YEAR

DOMICILIARY CARE AGENCIES

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1. Background

In April 2009 RQIA introduced a revised approach to inspections of day care settings, domiciliary care agencies, nursing homes and residential homes. The methodology built on existing inspection practice by introducing a number of new elements.

For 2010 - 2011, this approach has been further developed taking into account practice learning during 2009 - 2010.

This document provides guidance about the values underpinning RQIA's inspection approach and gives direction about how staff and providers should use RQIA inspection tools in practice.

RQIA staff should read this guidance in conjunction with the Policy and Procedure for the Inspection of Establishments and Agencies within the Regulated Sector (2008).

2. Principles Underpinning Inspection

RQIA's approach to regulation reflects our 2009 - 2012 Corporate Strategy. This strategy sets out our value proposition:

"RQIA provides independent assurance about the quality, safety and availability of health and social care services in Northern Ireland, encourages continuous improvements in those services and safeguards the rights of service users.

RQIA has identified four core activities to support our vision of being a driving force for positive change in health and personal social services in Northern Ireland:

- **Improving Care:** we encourage and promote improvements in the safety and quality of services through the regulation and review of health and social care.

- **Informing the Population:** we publicly report on the safety, quality and availability of health and social care.

- **Safeguarding Rights:** we act to protect the rights of all people using health and social care services.

- **Influencing Policy:** we influence policy and standards in health and social care.

Consistent with our strategic approach, a number of principles that are characteristic of good regulatory practice have been identified[1]. These lead to the following practice recommendations:

2.1 Focus on Outcomes

Inspection should consider "service delivery to the end users of the services rather than concentrating on internal management arrangements".

This means that, for example, policies and procedures can only be considered to be fully in place when:

(a) the policy or procedure clearly states the desired service user outcomes of the policy or procedure,

and

(b) inspectors are able to access evidence to show how the policy or procedure impacts on the service provided to users.

The criteria in each Minimum Standard often focus on the processes necessary to achieve good outcomes. It is important that inspection staff take steps to identify outcome-based evidence to validate compliance with the standards. The possibility of overlooking outcomes when considering statements such as those within the criteria has been clearly described:

"The risk is that attention becomes focused primarily on minimum standards, inputs and processes, rather than regulation promoting improved outcomes and encouraging the sector to strive for improved standards." [2]

2.2 User Perspective

Inspection should "focus on the experience of those for whom the service is provided, as well as on internal management arrangements".

This recommendation builds on the first point, making it clear that inspectors should place significant emphasis on the directly reported experience of service users. This experience can validate the authenticity of apparent operational arrangements and, where it can be accessed, should be cited in reports as strong evidence of the degree of compliance with standards. This will mean that Inspectors will seek to identify how compliance with a particular criterion should affect service delivery and will then seek verification from users. Comments

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[1] Better Regulation Task Force (2003), Principles of Good Regulation.
[2] Duncan (2007) Journal of Care Services Management, vol. 2, no.1, pp. 17-27, Inspecting for Improvement.

used by users about relevant parts of service delivery should then be quoted or summarised within the report.

2.3 Self-assessment

Service providers are responsible for the quality of care provided and for demonstrating that quality of care. Therefore, it is important to note that it is the responsibility of the provider to demonstrate on the self-assessment how they are meeting both the standard and criteria.

Self-assessment by providers is a key part of the inspection process. It is important that evidence is established to underpin the self-assessment, whether this is cited by the provider in their self-assessment, or identified by the inspector during the inspection.

The practice requirement “inspectors should challenge the outcomes of managers’ self-assessments” makes it clear that, in all instances, inspectors should seek to find evidence that either confirms, or refutes, the provider's self-assessment. Such evidence should be specified in reports.

2.4 Evidence

Reports should specify the evidence that has been taken into account in reaching judgements.

Evidence to underpin the inspector's judgement should be identified during the inspection, and should be cited in the report. The “evidence, whether quantitative or qualitative, should be validated and credible”.

The credibility of evidence can be established primarily by validation - the process of triangulation or corroborating evidence by information from a different source. Credible and validated evidence that a policy on training, for example, is in place could be sought from:

- training records and curriculum
- discussion with staff that indicates that they are appropriately knowledgeable or skilful discussion with service users that indicates the relevant task is being carried out competently.

2.5 Follow-Up Evidence from Previous Requirements and Recommendations

An inspection will commence with the inspector requesting evidence that requirements and/or recommendations from a previous report have been met to the inspector's satisfaction. Thus, it is important for the provider to ensure they are prepared and are able to evidence how these requirements/recommendations have been met in full.

2.6 Core Criteria

RQIA is responding to feedback that assessment of large numbers of criteria and the associated issues of inspection time committed to desktop checking reduce time for getting user/resident feedback.

This has led to the risk of taking too narrow a focus because of time constraints. Accordingly, we have reviewed selected standards for each service type and, where appropriate, have identified a number of core criteria in order to assist the process of the inspection and to ensure sufficient time is available to gather and validate the experience of service users. This approach will also ensure that inspectors take time to review the overall operation of individual services alongside detailed assessment against identified criteria.

The core criteria for announced inspections will be clearly identified in advance to service providers. The criteria will then be used thus:

- Providers will continue to complete self-assessment documents for all criteria for report inclusion
- Inspectors will assess all core criteria on inspection. On the basis of the self-assessment return made, or on the basis of their judgement during the inspection, they may select other criteria against which they will inspect if necessary. This may occur if, for example, it is deemed by the inspector that elements of the core criteria have not been achieved.

Criteria which have **not** been identified as core criteria will contribute further to the evaluation of the service from the service user's perspective.

3. Levels of Achievement

3.1 General

The model used by RQIA asks both service providers and inspectors to rate the inspected service's level of achievement for each criterion within the inspected standard. It is important that inspectors make sure that their selected levels are based on evidence.

Guidance for use of these levels can be found in section 5. The assessment should also consider the achievement level that appears appropriate before any possible regulatory action is taken into account.

3.2 Regulatory Action

Normally, where a criterion is not fully achieved, full achievement would be desirable.

For this reason, the following practice should be followed:

- In situations where a criterion is assessed by the inspector as neither "not applicable" nor "fully achieved", in most circumstances either a recommendation or requirement, as appropriate, will be made.

- In a few situations where a criterion is found by the inspector to be neither "not applicable" nor "fully achieved " and where the inspector judges that it would not be appropriate to make a recommendation or requirement, the reasons for deciding not to take regulatory action should be stated in the relevant part of the report.

Regulatory action taken will vary according to the nature and content of each individual Minimum Standard and decisions about enforcement must be reached on an individual case basis.

4. Maturity Matrix

The model requires both service providers and inspectors to provide an overall summation of the service's performance against the Maturity Matrix for each Minimum Standard. Guidance on the terms used within the Maturity Matrix can be found in section 5.

4.1 Relationship between Achievement Levels and Maturity Level

Inspectors must bear in mind that the criteria used are to be considered as indicators of compliance with the relevant standard, but not as a checklist which, if complete, proves compliance.

It is also important to recognise that the Maturity Level is not simply an averaging out of achievement levels for each of the criteria. At the same time, evidence of significant degrees of non-compliance with the criteria must impact on consideration of the service's achievement against the standard statement as a whole.

The following points should be considered:

- When one or more criteria are assessed at "partially achieved" or below, services should generally be assessed as "aware", "responding" or "developing" against the overall standard.

- Where there is reason to assess outside the suggested range, the relevant section of the report must contain a clear statement explaining why this decision has been taken.

5. Guidance - Levels of Achievement

Level of Achievement	Definition	Guidance Note	Resulting Action in Inspection Report
Not applicable	The criterion is not applicable to this service setting.	A reason must be clearly stated in the assessment contained within the Inspection Report.	A reason must be clearly stated in the assessment contained within the Inspection Report.
Unlikely to be achieved	The criterion is unlikely to ever be achieved.	A reason must be clearly stated in the assessment contained within the Inspection Report.	A reason must be clearly stated in the assessment contained within the Inspection Report.
Not achieved	The criterion is unlikely to be achieved in full prior to end of March 2011. For example, the service has only started to develop a policy and implementation will not take place until after March 2011.	The definition states that implementation will not occur before end of March 2011. This level should be used in all instances where a plan showing service user impact of the necessary actions by that date cannot be convincingly demonstrated to the inspector.	In most situations this will result in a requirement or recommendation being made within the Inspection Report.
Partially achieved	Work has been progressing satisfactorily and the service is likely to have achieved the criterion prior to end of March 2011. For example, the service has developed a policy and will have completed implementation by end of March 2011.	The definition states that implementation is likely to occur before end of March 2011. This level should be used in instances where a plan showing service user impact of the necessary actions by that date can be convincingly demonstrated to the inspector.	In most situations this will result in a requirement or recommendation being made within the Inspection Report.
Substantially achieved	A significant proportion of action has been completed to ensure the service performance is in line with the criterion. For example, a policy has been developed and implemented but a plan to ensure practice is fully embedded has not yet been put in place.	At this level, the service user impact of the policy/procedure can be demonstrated across the service. However, processes to systematically review the user impact are not yet in place.	In most situations this will result in a requirement or recommendation being made within the Inspection Report.
Fully achieved	Action has been completed that ensures the service performance is fully in line with the criterion. For example, a policy has been developed, implemented, monitored and an ongoing programme is in place to review its effectiveness.	At this level, processes for monitoring, review and reformulation of the necessary actions on the basis of user impact can be demonstrated.	In most situations this will result in an area of good practice being identified and being made within the Inspection Report.

Guidance - Maturity Matrix

Level of Maturity	Definition	Guidance
Aware	The service is aware of the issues to be addressed but are unable to demonstrate decisions/actions to address them.	For the overall standard there is little evidence of a coherent approach to dealing with the practice area.
Responding	The service recognises the key issues and has identified options that are prioritised, although there is no evidence of strategic direction.	A plan has been developed addressing this area, but there is no evidence of service impact of the plan.
Developing	The service is taking steps to address the key issues through the development of strategic plans with evidence of good practice across the organisation.	Across this standard area, a plan is being taken forward with evidence from practice of the impact of policy.
Practising	The strategic agenda is being progressed and monitored by the service with significant evidence of continuous improvement across the organisation.	Good practice in this standard area is being monitored, evaluated, and revised according to the needs of service users.
Leading	The service is leading the strategic agenda through the implementation of innovative practice that is shared across and beyond the organisation to others, enabling realisation of long term sustainability.	In addition to the good practice evident at Practising level, the service is developing innovative practices that can be shown as being made available to other services.

Guidance - Standards

Standard 8: Management and Control of Operations Inspection

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
8.1	• Review of management flow chart and Statement of Purpose; reflected in observation of practice.	• Management flow chart. • Statement of Purpose.
8.3 and 8.4	• Policy and procedure manual. • Evidence of staff training and updates. • Evidence of staff having received a copy of NISCC Code of practice and training in the application of the code. • Evidence of action taken if staff do not meet expected standards of conduct. • Staff awareness of the above. • Evidence of policy implementation: – Infection Control – Listening to service user's views – Management of risks associated with service users	• Policy and procedure manual. • Evidence of staff training and updates. • Evidence of staff having received a copy of NISCC Code of practice and training in the application of the code. • Evidence of action taken if staff do not meet expected standards of conduct. • Evidence of policy implementation.
8.5	• Absence of Manager policy. • Example of RQIA being informed of an absence.	• Absence of Manager policy. • Example of RQIA being informed of an absence.
8.6, 8.7 and 8.8	• Statement of Purpose. • Evidence of review and any amendments, every 3 years. • Notification to RQIA of any changes. • Evidence of services delivered in accordance with the Statement of Purpose i.e. care/support plans, discussion with users and staff.	• Statement of Purpose. • Evidence of review and any amendments, every 3 years. • Notification to RQIA of any changes. • Evidence of services delivered in accordance with the Statement of Purpose i.e. care/support plans.
8.9	• Service User Guide • Evidence of review and any amendments, every 3 years. • Notification to RQIA of any changes.	• Service User Guide • Evidence of review and any amendments, every 3 years. • Notification to RQIA of any changes.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
8.10, 8.11 and 8.12	• Operational policy, Quality Improvement Policy • Auditing tools - i.e. service user feedback, monitoring of practice, staff surveys, complaints/compliments, accidents and incidents. • User awareness of audit activity. • Staff involvement in audit activity. • Evidence of monthly quality monitoring by the registered person. • Annual quality report and action plan.	• Operational policy, Quality Improvement Policy • Auditing tools - i.e. service user feedback, monitoring of practice, staff surveys, complaints/compliments, accidents and incidents. • Evidence of monthly quality monitoring by the registered person. • Annual quality report and action plan.
8.13 and 8.22	• Registration certificate. • Insurance and public liability certificate.	• Registration certificate. • Insurance and public liability certificate.
8.14 and 8.15	• Service user agreement - signed by service user/manager. • Records of amounts paid by service users. • User awareness of agreements.	• Service user agreement - signed by service user/manager. • Records of amounts paid by service users
8.16	• Reporting mechanisms to the registered person. i.e. changes in the service user's needs, untoward incidents / accidents / near misses, equipment, Vulnerable adults. • Reports made to Trust professionals, NISCC, ISA, NMC.	• Untoward incidents/accidents/near misses, equipment, Vulnerable adults. • Reports made to Trust professionals, NISCC, ISA, NMC.
8.17	• Training record of the registered manager in past 18 months.	• Training record of the registered manager
8.18	• Confirm agency is aware of the Trust's procedure for checking and maintaining equipment it provides. • Evidence of the agency referring to the Trust if equipment is defective. • Records.	• Confirm agency is aware of the Trust's procedure for checking and maintaining equipment it provides. • Evidence of the agency referring to the Trust if equipment is defective.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
8.19 and 8.20	• Policy on whistle blowing. • Evidence of staff having read examples of any reports. • Mechanisms for supporting staff reporting concerns. • Staff describing awareness of whistleblowing approach.	• Policy on whistleblowing. • Evidence of staff having read examples of any reports. • Mechanisms for supporting staff reporting concerns.
8.21	• Already covered in inspection year 2009/2010. • Evidence as per Regulation 13 Schedule 3.	• Already covered in inspection year 2009/2010. • Evidence as per Regulation 13 Schedule 3.

Standard 13 : Supervision and Appraisal

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
13.1 and 13.6	• Agency policy and procedures. • NISCC guidelines. • Content of the training. • Qualifications of the trainer (NVQ 3 or higher from 2007) • Supervision and appraisal records. • Staff demonstrate understanding of these processes.	• NISCC guidelines. • Content of the training. • Qualifications of the trainer (NVQ 3 or higher from 2007) • Supervision and appraisal records.
13.2	• Policy. • Best practice. − Formal one to one basis with the line manager quarterly and written records kept on the content and outcome of each meeting. − One of these meetings should incorporate direct observation of the care worker providing care to a service user. − Regular meetings are also held at least quarterly with peers and/or other team members. • Records. • Linkages with observed practice and need for service improvement. • Staff Questionnaire feedback. • Discussion with staff.	• Policy. • Best practice: − Formal one to one basis with the line manager quarterly and written records kept on the content and outcome of each meeting. − One of these meetings should incorporate direct observation of the care worker providing care to a service user. − Regular meetings are also held at least quarterly with peers and/or other team members. • Records.
13.3 and 13.4	• Supervision records. • Minutes of serious and/or recurring issues - evidence of action taken and follow up. • Staff Questionnaire feedback. • Staff discussions.	• Supervision records. • Minutes of serious and/or recurring issues - evidence of action taken and follow up.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
13.5	• Agency policy and procedures. • NISCC guidelines. • Agency's appraisal and personal development plan documentation measured against the job description. • Appraisal records. • Personal development plans show links with needs of the service.	• Agency policy and procedures • NISCC guidelines • Agency's appraisal and personal development plan documentation measured against the job description. • Appraisal records. • Personal development plans. • Review of effectiveness of training.

NB 13.2 - Best practice statements derived from English Standards for Domiciliary Care.

Standard 15: Complaints

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
15.1, 15.2, 15.3, 15.4, 15.6, 15.9, 15.10, 15.11 and 15.17	• Complaints procedure • Publication of complaints - Service User Guide • Role of RQIA • Role of Ombudsman • Complaints records • Staff and users able to describe complaints approach.	• Complaints procedure • Publication of complaints - Service User Guide • Role of RQIA • Role of Ombudsman • Complaints records
15.5	• Staff training records • Frequency of updates as required and at least every 3 years. Staff awareness of policy demonstrated.	• Staff training records • Frequency of updates as required and at least every 3 years.
15.7	• Information on Independent Advocacy services. • Users describe awareness of this possibility.	• Information on Independent Advocacy services.
15.8	• Training for managers in the investigation of complaints. • Managers and staff able to describe role in procedures. • Indication that manager or responsible person reviews complaints records.	• Training for managers in the investigation of complaints. • Indication that manager or responsible person reviews complaints records.
15.12	• Records of any complaints referred to RQIA demonstrating a breach in regulation. • Evidence of process of screening complaints to determine what should be referred to RQIA.	• Records of any complaints referred to RQIA demonstrating a breach in regulation. • Evidence of process of screening complaints to determine what should be referred to RQIA.
15.13 and 15.18	• Evidence of referrals to social services (Child protection), PSNI, NISCC, NMC, ISA	• Evidence of referrals to social services (Child protection), PSNI, NISCC, NMC, ISA
15.14	• Evidence of referrals to social services (Adult Services) PSNI, NISCC, NMC, ISA	• Evidence of referrals to social services (Adult Services) PSNI, NISCC, NMC, ISA

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
15.15	• Records and summary if required by RQIA	• Records and summary if required by RQIA
15.16	• Quality Improvement Plan - reference to complaints and action taken/learning. • Individual examples of changes made to service following complaints.	• Quality Improvement Plan - reference to complaints and action taken/learning. • Individual examples of changes made to service following complaints.

Standard 16: Safe and Healthy working practices

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
16.1	• Policy and procedures re health and safety covering the 4 areas specified. • Staff and managers demonstrate familiarity with the policies and procedures.	• Policy and procedures re health and safety covering the 4 areas specified.
16.2	• Record of training received by staff - signature of staff. • Content of training. • Qualifications of the trainer. • Processes for dissemination of information to staff ie faulty equipment. • Staff describe receiving information as needed.	• Record of training received by staff - signature of staff. • Content of training. • Qualifications of the trainer. • Processes for dissemination of information to staff ie faulty equipment.
16.3 and 16.5	• Health and safety information given to staff, training records, supervision records, monitoring of staff re: 8 areas specified in 16.3	• Health and safety information given to staff, training records, supervision records, monitoring of staff re: 8 areas specified in 16.3
16.4	• Identification of a member of staff responsible for receiving NIAIC notifications and reporting to NIAIC. • Evidence of reports received and reports made to NIAIC. • Accident prevention training records. • Policy on Protective clothing and equipment. • PPE equipment issued to staff. • Training records in the use of PPE in conjunction with 16.2. • Staff are able to describe their understanding of these areas.	• Evidence of reports received and reports made to NI Adverse Incident Centre. • Policy on Protective clothing and equipment. • Training records in the use of PPE in conjunction with 16.2. • Records of PPE received by care workers.
16.6	• Decontamination Policy and procedure in line with DHPSS guidelines. • Training records/content of training - frequency of updates. Staff are able to identify reusable devices.	• Decontamination Policy and procedure in line with DHPSS guidelines. • Training records/content of training - frequency of updates.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
16.7	• Policy and procedure re: occupational health services. Referral systems - private statutory. • Record of policy read by staff. • Evidence of referrals made.	• Policy and procedure re: occupational health services. • Record of policy read by staff. • Evidence of referrals made.

6. Inspection Process

6.1 Six weeks prior to the inspection date

A member of the admin staff will contact the Registered Manager to confirm the Agency's email address, as well as the Agency's service user and staffing numbers.

An email then will be sent to the confirmed address containing the notification letter and self assessment document. If the Agency does not have an email address, the above documentation will be sent to the Registered Manager in hard copy.

The Registered Manager will also receive a package which will include the Agency's staff and service users questionnaires as well as guidance regarding the distribution of the questionnaires.

A hard copy of the notification letter will also be sent to the Registered Provider so that they are aware of the inspection date.

A Trust questionnaire will be emailed to the Designated Person to be completed and returned to the Agencies team 2 weeks prior to the inspection.

6.2 Two weeks prior to the inspection

Please return the self assessment document to the Agencies team by the date stated on the notification letter to allow time for the Inspector to prepare for the inspection.

6.3 Day of Inspection

During the inspection, the Inspector will be validating the Agency's completed self assessment document. Please have copies of any evidence stated in the self assessment available on the day of inspection.

The Inspector will ask the Registered Manager to complete a questionnaire regarding the inspection process to be returned to the Agencies Team.

6.4 Post inspection

It is the aim of the Authority to issue the draft report within 4 weeks of the inspection date to the Registered Manager and Registered Provider.

Please complete the Quality Improvement Plan completing the actions taken by the Registered Provider section, in detail, and return to the Agencies Team, preferably by email, by the date stated on the letter.

If no amendments are received in writing by the date stated, the report will be considered as final and will be made available to the public if requested.

7. Frequently asked questions

Q: Can word count and spell check be used in the self assessment document?

A: Due to the limitations of Microsoft Word, word court and spell check cannot be used in the self assessment document when drop downs are being used. If you wish to use these facilities, it is possible to copy information from a word document into the self assessment document.

Q: How do you complete the self assessment document?

There is a grey text box inserted in the Provider's self assessment box for each criterion as shown below.

PROVIDER'S SELF-ASSESSM Please outline (in no more than 200 words) how yo
Criterion Assessed: 10.1 Staff have knowledge and understanding of each individual resident's usual c of communication. Responses and interventions of staff promote positive outcome
Provider's Self Assessment:
Please enter the establishment's evidence for the above criterion here.
Inspection Findings: FOR RQIA INSPECTORS USE ONLY

Drop down menus have been inserted for the achievement levels for each criterion and maturity matrix for the four standards as shown below:

ACHIEVEMENT LEVEL
Not Applicable
Not Applicable
Unlikely to be Achieved
Not Achieved
Partially Achieved
Substantially Achieved
Fully Achieved

Inspection No
MATURITY LEVEL
Aware
Aware
Responding
Developing
Practising
Leading

Q: The inspection date on the notification letter does not suit.

A: If the inspection date does not suit, please contact the Agencies Team administrative staff on (028) 9051 7500 as soon as the problem arises. It may be possible to reschedule the inspection with agreement from the Inspector.

Q: I am unsure what evidence to record in the self assessment document for each criterion.

A: Guidance regarding the evidence RQIA are looking for under each standard is contained in section 3 of the guidance booklet, however if you are still unclear please contact the Inspector carrying out the inspection or the Duty Inspector.

Q: I am having problems completing the documentation on line or emailing the returns to RQIA.

A: Please contact the Agencies Team administrative staff on (028) 9051 7500 to discuss your problems. If necessary the documentation can be returned on paper.

Q: I am unable to complete the self assessment document by the date stated on the notification letter:

A: RQIA ask for the self assessment document to be returned 2 weeks before the inspection to allow time for pre-inspection preparation. If you cannot return the completed document by the stated date, please contact the Agencies Team administrative staff on (028) 9051 7500 to arrange a new deadline for the documentation.

Q: Contact details for the Agencies Team

A: AGENCIES TEAM EMAIL ADDRESS - Care.Team@rqia.org.uk
AGENCIES TEAM TELEPHONE NUMBER - (028) 9051 7500