# Inspection Report

## 22 September 2022

# Kimberley House Supported Living Service

Type of service: Domiciliary Care Agency
Address: 45 Abbey Road, Newtownards, BT23 8JL
Telephone number: 02891810003

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>Praxis Care<br><br>**Responsible Individual:**<br>Mrs Alyson Dunn | **Registered Manager:**<br>Miss Nikki McMullan<br><br>**Date registered:**<br>5 December 2019 |
| **Person in charge at the time of inspection:**<br>Miss Nikki McMullan | |
| **Brief description of the accommodation/how the service operates:**<br><br>Kimberley House Supported Living Service is a domiciliary care agency, supported living type. The agency provides 24 hour care and support to nine service users who have a range of complex needs; seven of the service users reside in individual apartments within a shared facility and two in a house located adjacent to the service. There are approximately 17 staff employed by the domiciliary care agency and the service also use agency staff not employed by the Praxis Care organisation. | |

## 2.0 Inspection summary

An unannounced inspection took place on 22 September 2022 between 10.00 a.m. and 4.30 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), Service user involvement, Restrictive practices, Dysphagia management and Covid-19 guidance was also reviewed.

Two areas for improvement were identified which related to the provision of formal supervision for agency staff members working in the setting and the outstanding annual review of one identified service user.

Good practice was identified in relation to service user involvement. There were good governance and management arrangements in place.

Kimberley House uses the term 'tenants' to describe the people to whom they provide care and support. For the purposes of the inspection report, the term 'service user' is used, in keeping with the relevant regulations.

## 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.

Having reviewed the model "We Matter" Adult Learning Disability Model for NI 2020, the Vision states, 'We want individuals with a learning disability to be respected and empowered to lead a full and healthy life in their community'.

RQIA shares this vision and want to review the support individuals are offered to make choices and decisions in their life that enable them to develop and to live a safe, active and valued life. RQIA will review how service users who have a learning disability are respected and empowered to lead a full and healthy life in the community and are supported to make choices and decisions that enables them to develop and live safe, active and valued lives.

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

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

During the inspection we spoke with a number of service users and staff members. There were no relatives visiting their family member.

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

Comments received included:

**Service users' comments:**

- "I like living here and I love my flat. The staff are kind and help me when I need it. I can talk to them whenever I need."

- "We receive support from staff that help us. I like going out with my friends and staff and I don't have any concerns."
- "Staff are good to us, they encourage me to be independent and I've learned a lot since coming to live here. I feel safe here."
- "This is my home, I've made friends here and I like talking with the staff in Kimberley."

**Staff comments:**

- "Our manager is approachable, supportive, hands on and takes action when she needs to."
- "There's good teamwork here and I feel there are good working relationships with the service users."
- "I've worked here for many years and I enjoy my work a lot."
- "I receive formal supervision every 2 months and we support each other, communication is good."

None of the staff (or visiting professionals) responded to the electronic survey. There were no returned and completed RQIA questionnaires received from service users or their relatives after the inspection.

## 5.0 The inspection

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

The last care inspection of the agency was undertaken on 14 December 2021 by a care inspector. One area for improvement was identified. This was approved by the care inspector and was validated during this inspection.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 14 December 2021</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for Improvement 1<br><br>Ref: Standard 12<br><br>Stated: First time</td><td>The registered person shall ensure that staff are trained for their roles and responsibilities.<br><br>This relates specifically to Dysphagia training.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:<br>Inspector confirmed Dysphagia training records were made available and up to date at the time of inspection. All staff have received training in Dysphagia.</td></tr>
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## 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. 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 was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

Staff were provided with training appropriate to the requirements of their role. Where service users required the use of specialised equipment to assist them with moving, this was included within the agency's mandatory training programme.

A review of care records identified that moving and handling risk assessments and care plans were up to date. Where a service user required the use of more than one piece of specialised equipment, direction on the use of each was included in the care plan. A review of the agency's moving and handling 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.

Apart from two outstanding service user's annual review of their placement, care reviews had been undertaken in keeping with the agency's policies and procedures. There was also evidence of regular contact with service users and their representatives, in line with the commissioning trust's requirements. The manager confirmed by email approximately a week

after the inspection that the outstanding annual reviews for the two identified service users had been requested, a date was provided for one outstanding care management annual review. One service user's care management's annual review remains outstanding. This is an identified area for improvement.

All staff had been provided with training in relation to medicines management. A review of the policy relating to medicines management identified that it included direction for staff in relation to administering liquid medicines. If an oral syringe was used to administer medicine to a service user, this was clearly noted in the daily care records. The manager confirmed a competency assessment was undertaken with staff before they commenced administering this medication.

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 Mental Capacity Act (MCA).

Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The person in charge reported there were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had had their capacity considered and, where appropriate, assessed. Where a service user was experiencing a deprivation of liberty, the care records contained details of assessments completed and agreed outcomes developed in conjunction with the HSC Trust representative.

There was a system in place for notifying RQIA if the agency was managing individual service users' monies in accordance with the guidance.

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

From reviewing service users' care records and through discussions with service users, it was good to note that service users had an input into devising their own plan of care. Service users were provided with easy read reports which supported them to fully participate in all aspects of their care. The service users' care plans contained details about their likes and dislikes and the level of support they may require. Care and support plans are kept under regular review and services users and /or their relatives participate, where appropriate, in the review of the care provided on an annual basis, or when changes occur.

It was also good to note that the agency seek the views of service users' on a regular basis, the manager stated most of the service user's prefer to meet individually with staff rather than larger group meetings, however several service users like to meet up in small groups with staff. This arrangement was confirmed via discussions with service users during this inspection. Service users enjoy going to the pub in small groups; a disco, Leisure Centre's, shopping, swimming, gym, charity shops, cinema, Nutts Corner Market, bowling and a chess club.

It was important that service users/individuals with learning disabilities are supported to maintain their relationships with family, friends and partners during the Covid-19 pandemic.

Service users were provided with an information leaflet/easy read document to explain Covid-19 and how they could keep themselves safe and protected from the virus. Where individuals with learning disabilities continued to experience anxiety about the pandemic, the agency was aware of the resources available from NI Direct, HSC websites and local organisations to support service users.

### 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. 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 also implemented the specific recommendations of the SALT to ensure the care received in the setting was safe and effective.

Staff demonstrated a good knowledge of service users' wishes, preferences and assessed needs. These were recorded within care plans along with associated SALT dietary requirements. 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?

A review of the agency's staff recruitment records confirmed that all pre-employment checks, including criminal record checks (AccessNI), were completed and verified before staff members commenced employment and had direct engagement with service users. Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC) or the Nursing and Midwifery Council (NMC) or any other relevant regulatory body. There was a system in place for professional registrations to be monitored by the manager. 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.

A review of the records relating to staff that were provided from recruitment agencies also identified that they had been recruited, inducted and trained in line with the regulations.

The agency has maintained a record for each member of staff of all training, including induction and professional development activities undertaken; this included staff that were supplied by recruitment agencies.

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 confirmed she has discussed the post registration training requirement with staff and ensures that all staff are compliant with the requirements. Discussions with staff also conclude they comply with NISCC's post registration training requirements.

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

There were monitoring arrangements in place in compliance with Regulations and Standards. A review of the reports of the agency's quality monitoring established that there was engagement with service users, service users' relatives, staff and HSC Trust representatives. The reports included details of a review of service user care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

The Annual Quality Report was reviewed and was satisfactory.

No incidents had occurred since the agency's previous inspection that required investigation under the Serious Adverse Incidents (SAIs) or Significant Event Audits (SEAs) 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.

There is a system in place that services should have an operational policy, procedure or protocol that clearly directs staff from the Agency as to what actions they should take to manage and report such situations in a timely manner. In addition to written direction, it is essential that all staff (including management) are fully trained and competent in this area.

Discussions with the manager and staff concluded formal supervision is taking place in accordance with Minimum Standards for staff employed by Praxis, however Kimberley House Supported Living Service is currently not formally supervising agency staff consistently working with service users. This is an identified area for improvement.

## 6.0 Conclusion

Based on the inspection findings, one area for improvement was identified. Despite this, RQIA was satisfied that this agency was providing services in a safe, effective, caring and compassionate manner and the service was well led by the manager and management team.

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

Findings of the inspection were discussed with person in charge as part of the inspection process and can be found in the main body of the report.

An area for improvement has 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 |
|---|---|---|
| **Total number of Areas for Improvement** | 0 | 2 |

The areas for improvement detailed in the QIP were discussed with Miss Nikki McMullan, Registered Manager 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 Minimum Standards (revised) 2021** | |
| **Area for improvement 1**<br><br>**Ref:** Standard 13.3<br><br>**Stated:** First time<br><br>**To be completed:**<br>from the date of inspection and ongoing | The registered manager shall ensure that all agency staff working with service users in the domiciliary care setting receive recorded formal supervision meetings in accordance with procedures. This should be commensurate with their roles and responsibilities. The Agency responsible for employing the staff member must be informed if there are any issues arising or recurring from the formal supervision meetings.<br><br>Ref: 5.2.6 |
| | **Response by registered person detailing the actions taken:**<br>This has now been actioned- there are x4 identified agency staff who work regularly in scheme and have received formal supervision during the months of September/ October on Praxis Care supervision records. They will be supervised every 3 months thereafter as per RQIA standards. |
| **Area for improvement 2**<br><br>**Ref:** Standard 6<br><br>**Stated:** First time<br><br>**To be completed:**<br>30 March 2023 | The registered manager shall ensure that the identified service user receives an annual review of their supported living placement with the responsible referring HSC Trust and staff in the agency.<br><br>Ref: 5.2.1 |
| | **Response by registered person detailing the actions taken:**<br>CMR has been organised for su678 for 20/12/22 following further prompt to care manager w/c 21/11/22 |

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