The Regulation and Quality Improvement Authority

Inspection Report

14 December 2021

Kimberley House Supported Living Service

Type of Service: Domiciliary Care Agency
Address: 45 Abbey Road, Newtownards, BT23 8JL
Tel No: 028 9181 0003

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

1.0 Service information

Organisation/Registered Provider: Praxis Care Group **Responsible Individual:** Mr Greer Wilson, acting	**Registered Manager:** Miss Nikki McMullan **Date registered:** 5 December 2019
Person in charge at the time of inspection: Team Leader	
Brief description of the accommodation/how the service operates: 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.	

2.0 Inspection summary

An unannounced inspection was undertaken on 14 December 2022 between 10.00am and 3.30pm by the care inspector.

The last inspection to Kimberley House SLS was undertaken on 9 February 2021, by a care inspector.

This inspection focused on staff recruitment, Northern Ireland Social Care Council (NISCC) registrations, adult safeguarding, incident reporting, complaints and whistleblowing. Other areas reviewed included Deprivation of Liberty Safeguards (DoLS) including money and valuables, restrictive practice, monthly quality monitoring and Covid-19 guidance.

Good practice was identified in relation to monitoring of NISCC registrations, and the agency's system in place of disseminating Covid-19 related information to staff.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the service was 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.

The inspection focused on:

- contacting the service users, their relatives, HSC Trust representatives and staff to obtain their views of the service

- reviewing a range of relevant documents, policies and procedures relating to the agency's governance and management arrangements.

Information was provided to service users, relatives, staff and other stakeholders to request feedback on the quality of service provided and this included questionnaires. In addition, an electronic survey was provided to enable staff to feedback to the RQIA.

4.0 What people told us about the service

No questionnaires were returned prior to the issuing of this report. There was no response to the electronic survey.

During the inspection we spoke to two service users and three staff. Comments received are detailed below.

Service users' comments:

- "I am happy. ***** (staff member) is good."
- "I like going out to the charity shop."
- "I do my shopping in the garage; staff go with me."
- "I go out with my family."
- "I like it here, would like to go out more on my own."
- "I am going to my mums for Christmas."

Staff comments:

- "I love it here, seniors are approachable. The service users are well looked after."
- "All staff including agency know that the needs of the service users are paramount."
- "Can be stressful at times due to the complex needs."
- "No concerns, no issues, really happy."
- "Very happy working here, no concerns."
- "Service users are well cared for and have choice."
- "The manager is so supportive."

5.0 The inspection

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

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 9 February 2021</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 23.-(1)

Stated: First time

To be completed by:
Immediate and ongoing from the date of inspection.</td><td>The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided.

Ref: 6.1</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
It was noted that a system had been implemented for evaluating the quality of the services which the agency arranges to be provided.

However it was identified that reports developed were required to include more detail of the matters reviewed and needs to reflect that matters identified on the action plan have been addressed.

This area for improvement was assessed partially met. An area for improvement with regard to the quality monitoring reports has been identified and is detailed within the QIP.</td></tr>
<tr><th colspan="2">Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 12.6

Stated: First time

To be completed by:
Immediate and ongoing from the date of inspection.</td><td>The registered person shall ensure that a robust system is in place for monitoring staffs' NISCC registration status, and that the record retained is accurate and up to date.

Ref: 6.1</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
It was identified that a process has been implemented to ensure that all staff NISCC registrations are monitored monthly; this</td></tr>
</table>

	includes staff accessed from another domiciliary care agency. A record of checks completed is retained.	

5.2 Inspection findings

5.2.1 Are there 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 policy and procedures reflect information contained within the Department of Health's (DOH) regional policy 'Adult Safeguarding Prevention and Protection in Partnership' July 2015 and clearly outlines the procedure for staff in reporting concerns. The organisation has an identified Adult Safeguarding Champion (ASC). The Adult Safeguarding Position Report for the agency for 2020-2021 was viewed and noted to be completed in a detailed and comprehensive manner.

Discussions with the person in charge demonstrated that they were knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting adult safeguarding concerns. Staff could describe the process for reporting concerns including out of hours arrangements.

It was identified that staff are required to complete adult safeguarding training during their induction programme and required updates thereafter.

Staff indicated that they had a clear understanding of their responsibility in identifying and reporting any actual or suspected incidents of abuse. They could 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 has a system for retaining a record of referrals made in relation to adult safeguarding matters. It was noted that a number of referrals had been made with regard to adult safeguarding since the last inspection. Records reviewed and discussions with the person in charge indicated that referrals made had been managed appropriately. Adult safeguarding matters are reviewed as part of the monthly quality monitoring process and by the ASC.

The agency has provided service users and relatives with information with regard to the process for reporting any concerns. Those who spoke to us stated that they had no concerns regarding their safety; they described how they could speak to staff if they had any concerns in relation to safety or the care being provided. Service users stated that staff were supportive and listened to them.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. It was noted that incidents had been managed in accordance with the agency's policy and procedures and are reviewed as part of the monthly monitoring process.

Information reviewed during and following the inspection indicated that staff have completed appropriate DoLS training appropriate to their job roles. Those spoken with demonstrated that they have an understanding that people who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the Mental Capacity Act. There are arrangements in place to ensure that service users, who require high levels of supervision or monitoring and restriction have had their capacity considered and, where appropriate, assessed.

It was noted that where DoLS or restrictive practices are in place, appropriate risk assessments had been completed in conjunction with the HSC Trust representatives.

The person in charge stated that the agency is not managing individual service users' monies.

There was a clear system in place in relation to the dissemination of information relating to Covid-19 and Infection Prevention and Control (IPC) practices.

5.2.2 Is there a system in place for identifying care partners who visit service users to promote their mental health and wellbeing during Covid-19 restrictions?

The person in charge advised us that there were no care partners visiting service users during the Covid-19 pandemic restrictions. It was positive to note that a number of service users had regular contact with family.

5.2.3 Are their robust systems in place for staff recruitment?

The review of the agency's staff recruitment records and discussion with the person in charge confirmed that staff recruitment was managed in accordance with the regulations and minimum standards, before staff members' commenced employment and had direct engagement with service users. Records viewed evidenced that criminal record checks (AccessNI) had been completed for staff prior to commencement of employment.

A review of the records confirmed that all staff provided are appropriately registered with NISCC. Information regarding registration details and renewal dates are monitored by the manager in conjunction with the organisation's human resources department.

The person in charge confirmed that all staff are aware that they are not permitted to work if their professional registration lapses. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

5.2.4 Is there a system in place for identifying service users Dysphagia needs in partnership with the Speech and Language Therapist (SALT)?

It was noted that a small number of service users have been assessed by SALT in relation to dysphagia needs. Discussions with the person in charge and staff, and review of service user 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 by service users was safe and effective.

Staff spoken with demonstrated a good knowledge of service users' wishes, preferences and assessed needs with regards to eating and drinking. It was identified that staff had not completed dysphagia awareness training. An area for improvement was identified.

5.2.5 Are there robust governance processes in place?

There were monitoring arrangements in place in compliance with Regulation 23 of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007. Reports relating to the agency's monthly monitoring were reviewed. The process included evidence of engagement with service users, service users' relatives, staff and HSC Trust representatives on the majority of the visits.

The reports included details of the review of service user care records; accident/incidents; safeguarding matters; complaints; staff recruitment and training, NISCC registration and staffing arrangements and the environment. In addition, there was evidence of audits having been completed with regards to medication and finance. However it was identified that reports developed were required to include more detail of the matters reviewed and needs to reflect that matters identified on the action plan have been addressed. An area for improvement has been identified.

There is a process for recording complaints in accordance with the agency's policy and procedures. It was noted that complaints received since the last inspection had been managed in accordance with the procedures. Complaints are reviewed as part of the agency's monthly quality monitoring process.

There was a system in place to ensure that staff received supervision and training in accordance with the agency's policies and procedures.

It was established during discussions with the person in charge that the agency had not been involved in any Serious Adverse Incidents (SAIs) Significant Event Analyses (SEAs) or Early Alerts (EAs) since the last inspection.

Staff described the measures in place with regards to IPC such as Personal Protective Equipment (PPE), regular cleaning of touch points, encouraging social distancing and good hand hygiene. Staff were observed to be using PPE appropriately and stated that there are no difficulties in accessing sufficient supplies are needed. There was a supply of hand sanitiser throughout shared areas of the building.

6.0 Conclusion

As a result of this inspection two areas for improvement were identified in respect of the agency's Quality Monitoring reports and staff training with regard to Dysphagia. Details can be found in the Quality Improvement Plan included.

7.0 Quality Improvement Plan/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, 2021

	Regulations	Standards
Total number of Areas for Improvement	1	1

Areas for improvement and details of the Quality Improvement Plan were discussed with the person in charge, 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

Area for improvement 1 **Ref:** Regulation 23. (2)(a)(b)(i)(ii)(c)(3)(4) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall (2) At the request of the Regulation and Improvement Authority, the registered person shall supply to it a report, based upon the system referred to in paragraph (1), which describes the extent to which, in the reasonable opinion of the registered person, the agency— (a) arranges the provision of good quality services for service users; (b) takes the views of service users and their representatives into account in deciding— (i) what services to offer to them, and (ii) the manner in which such services are to be provided; and (c) has responded to recommendations made or requirements imposed by the Regulation and Improvement Authority in relation to the agency over the period specified in the request. (3) The report referred to in paragraph (2) shall be supplied to the Regulation and Improvement Authority within one month of the receipt by the agency of the request referred to in that paragraph, and in the form and manner required by the Regulation and Improvement Authority. (4) The report shall also contain details of the measures that the registered person considers it necessary to take in order to improve the quality and delivery of the services which the agency arranges to be provided. A copy of the monthly monitoring report should be forwarded to RQIA by the 10th of the month until further notice. Ref: 5.2.5
	Response by registered person detailing the actions taken: As noted in the inspection monitoring arrangements are in place in compliance with Regulation 23 of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007. Reports relating to the agency's monthly monitoring will continue to be available for review and will be emailed to RQIA as requested. Evidence of engagement with service users, service users' relatives, staff and HSC Trust representatives on the majority of the visits will continue however greater detail on progress against identifed actions will be included. Greater detail of the matters reviewed and matters identified on the action plan which have been addressed will be also be included in more detail.

	The reports will continue to provide details of the review of service user care records; accident/incidents; safeguarding matters; complaints; staff recruitment and training, NISCC registration and staffing arrangements and the environment. As noted at inspection evidence of audits having been completed with regards to medication and finance and these will continue to be available upon request.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2021	
Area for improvement 1 **Ref:** Standard 12 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that staff are trained for their roles and responsibilities. This relates specifically to Dysphagia training. Ref: 5.2.4
	Response by registered person detailing the actions taken: Course "Dysphagia - elearning for healthcare (e-lfh.org.uk) " was registered for for the scheme by scheme manager and Staff have been registered to completed the following course: "Dysphagia Essentials" . All staff have been registered including block booked agency staff members. To date the following number of PC staff members have completed (not including staff members on LT sick or Maternity) : 12 / 18 core staff team- the remainder of the staff team have been directed to complete by end of February 2022 and this will be monitored and Quality assured by manager.

Please ensure this document is completed in full and returned via Web Portal

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