Inspection Report

27 April 2023

Kingdom Healthcare Ltd

Type of service: Domiciliary Care Agency
Address: 15 Stranmillis Road, Belfast, BT9 5AF
Telephone number: 028 9033 2190

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: Kingdom Services Group Limited **Responsible Individual:** Mrs Niamh Conaty (registration pending)	**Registered Manager:** Not applicable **Date registered:** Not applicable
Person in charge at the time of inspection: Acting manager	
Brief description of the accommodation/how the service operates: Kingdom Healthcare Ltd is a domiciliary care agency which provides a range of personal care and social support services to 131 service users living in their own homes. Service users are supported by 77 staff. The service users care is commissioned by the Belfast Health and Social Care Trust (BHSCT), the Northern Health and Social Care Trust (NHSCT) and the South Eastern Health and Social Care Trust (SEHSCT). A small number of service users pay privately for their care and support. Service users have a range of needs including physical disability, dementia, learning disability, mental health and elderly care needs. The agency is also contracted by the NHSCT to provide a rapid response service when service users are discharged from hospital.	

2.0 Inspection summary

An unannounced inspection took place on 27 April 2023 between 9.30 a.m. and 3 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), Care records, Restrictive practices and Dysphagia management were also reviewed.

Areas for improvement identified related to staff training, induction and the need for policy development. The timely completion of records, auditing and availability of records also required improvement. In addition, there was a need for the agency to proactively contact service users, to ascertain their views on service provision.

There were mixed responses received from service users and relatives in relation to the care and support provided.

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 manager living in their own home.

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

4.0 What did people tell us about the service?

We spoke with a number of service users and their relatives who spoke positively in relation to the care and support provided. Comments received included:

Service users' comments:

- "I am very happy, they are very good and very jolly. You couldn't get better, they are just lovely and helpful and they would even do a wee message for you. They love coming into our home and we always make them feel welcome."

Service users' relatives'/representatives' comments:

- "They can be up and down. Things are ok recently but I would be worried about the staffing shortages. Sometimes I am asked to fill in if they are only able to send one carer (instead of two)"
- "Everything seems to be grand. (Name of service user) is happy with everything. They always show up and are nice and polite."
- "Absolutely no concerns, (Name of service user) is very fond of the girls, they go that bit further than previous agencies we have had. They are always on time and I am very impressed with them, the best so far."
- "Haven't heard any complaints."

- "I am happy, can't complain about the girls, they are a lovely bunch of girls."
- "There have been a few calls missed here and there, they generally do contact us if they know they cannot cover the call (but not always)."
- "Seems to be all fine, no complaints. Some are not as good as other but on the whole we are very happy. They are very good and would contact us if they weren't able to come."
- "No concerns. They always be there on time and we are very happy."

HSC Trust representatives' comments:

- "All okay to date, with minimal issues identified and followed up quickly by the Provider."
- "We do not have any current concerns in respect of this provider presently."
- "No concerns that I know of."

Feedback from Trust representatives also indicated that the agency had not consistently followed the correct procedure in relation to notifying the Trust where they had planned to stand down calls due to staff shortages. Whilst this matter had been satisfactorily resolved, RQIA will keep this matter under review.

No questionnaires were returned within the timescale for inclusion within the report.

A number of staff responded to the electronic survey. The respondents indicated that they were 'satisfied' that care provided was safe, effective and compassionate and that the service was well led. Written comments included:

- "Really good agency to work for."

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 12 April 2022 by a care inspector. Two areas for improvement were included on the Quality Improvement Plan (QIP). This was approved by the care inspector and was validated during this inspection.

Areas for improvement from the last inspection on 12 April 2022		
Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 22 (6)(8) **Stated:** First time	The Responsible Individual ensure that every complaint made under the complaints procedure is fully investigated; records are maintained of each complaint, including details of the investigation made, the outcome and any action taken. The Responsible Individual must also ensure that there is a record to note if the outcome of the investigation was to the satisfaction of the complainant.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 12.4 **Stated:** First time	The Responsible Individual shall ensure that all staff undertake training in relation to the Deprivation of Liberty Safeguards (DoLS) and Dysphagia as relevant to their roles and responsibilities.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

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 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 in the process of being completed. This will be viewed at future inspection.

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. Review of records confirmed that the agency had a clear process in place for identifying and reporting any actual or suspected incidences of abuse. Any concerns raised under the whistleblowing procedures 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.

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.

There was a system in place to ensure that staff undertook all elements of mandatory training. Review of records confirmed that there were good compliance levels in relation to completion of the modules that were deemed mandatory. However, there were a number of service users who had specialist needs, for example Nasogastric (NG) tubes and Percutaneous Endoscopic Gastrostomy (PEG) tubes. These required the staff attending to have specific training that would not be ordinarily included in the mandatory training provided to all care workers. The manager advised that plans were in place for this training to be provided by the District Nurse within the relevant trust. An area for improvement has been identified to ensure the training is provided and to ensure that records of training provided by external professionals are retained by the agency.

Where service users required the use of specialised equipment to assist them with moving, this was included within the agency's mandatory training programme. The manager advised that there were no service users currently requiring more than one piece of specialised equipment. Advice was given in relation to modifying the electronic recording system, so that information relating to specialised equipment, could be easily extrapolated in the future.

A review of the policy pertaining to moving and handling training and incident reporting identified that it required to explicit in relation to the types of equipment included in the practical training; directing staff on the process to follow in the event of a deterioration in a service users' ability to weight bear; and the decision making around re-commencing the use of equipment, when the service users' condition improves. An area for improvement has been identified.

The manager advised that representatives from the agency attended the Trust-led care reviews, when invited. They also undertook their own Provider Review at the same time. Whilst the agency made contact with service users and their representatives when issues arose, there was a need to formalise contact with service users on a regular basis. Making proactive contact with service users on a regular basis should lead to improvements in identifying any issues relating to service provision. An area for improvement has been identified.

All staff had been provided with training in relation to medicines management. The manager advised that the competency assessment relating to medicines administration did not include direction for staff in relation to administering liquid medicines. This was relevant, given that service users with NG and PEG tubes would require their medicine to be administered in liquid form. An area for improvement has been identified and is subsumed into the area for improvement detailed above regarding training.

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 had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The manager reported that none of the service users were subject to DoLS.

Advice was given in relation to developing a resource folder containing DoLS information which would be available for staff to reference. It was good to note that this was put in place on the day of the inspection.

5.2.2 What are the arrangements for ensuring service users get the right care at the right time?

The service users' care records generally contained details about the level of support they may require. However, a number of service users whose care commenced under the Rapid Response service did not have the Assessment of Need or care plan put in place in a timely manner. Two areas for improvement have been identified.

In addition, review of the daily notes identified that there were missing entries relating to a number of calls. This meant that we were not assured that the calls had been undertaken as planned. There was no formal auditing process in place, which would assist the agency in identifying whether or not such calls were missed or whether it was a record keeping issue. An area for improvement has been identified.

Discussion also took place regarding the return of records that are held in the 'Hub Office'. There was no formalised process in place to ensure that records were transported from the Hub Office to the registered office in a timely manner. This meant that service users' records were not available for inspection. An area for improvement has been identified to ensure that the records are returned to the main office in a timely manner; this area for improvement will also assist the agency in being able to audit the returned daily notes in a more timely manner.

There was a system in place for reporting any instances where staff are unable to gain access to a service user's home.

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

The manager advised that there were no service users who had been assessed by SALT as needing their food to be of a specific consistency. Where service users had been discharged from SALT services, a copy of the SALT assessment was available for staff to access. This meant that staff could be vigilant in identifying potential swallowing problems.

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

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 on a regular basis to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC). Advice was given in relation to the system for ensuring registrations are completed within the six-month timescale allowed my NISCC. The manager agreed that care workers would be removed from the rota if the timescale was exceeded.

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 structured, three-day induction programme which also included shadowing of a more experienced staff member. However, the shadowing shifts were not recorded on the staff rota. Review of records also confirmed that the number of shadowing shifts undertaken were not consistent. For example, in some records, staff had attended 13 calls, in which they shadowed another experienced member of staff; in another, the care worker had only shadowed for three calls. An area for improvement has been identified.

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. Whilst it was good to note that any areas for improvement identified by the RQIA were consistently reviewed as part of the monthly quality monitoring processes, the persons undertaking the visits should also focus on missed calls and calls which were stood down by the agency due to staffing shortages.

The Annual Quality Report was reviewed. Advice was given in relation to further developing the process to ensure that it reflected a wider quality improvement focus, as opposed to being solely comprised of stakeholder feedback.

No incidents had occurred 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. There was also evidence of valid public and employers' liability insurance.

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

We discussed the acting management arrangements which have been ongoing since 21 April 2023; RQIA will keep this matter under review.

6.0 Quality Improvement Plan (QIP)/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	5	2

The areas for improvement and details of the QIP were discussed with the acting manager and the applicant Responsible Individual, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007

Area for improvement 1 **Ref:** Regulation 16 (2)(a) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that staff receive training in relation to Percutaneous Endoscopic Gastrostomy (PEG) and Nasogastric (NG) tube care; staff must also have competency assessments completed in relation to the administration of medicines via these routes; and records pertaining to the training and the competency assessments must be retained by the agency, regardless of whether the training is provided by the agency or by an external provider. Ref: 5.2.1
	Response by registered person detailing the actions taken: All staff attending the specific service user with requirements for PEG and NG care have all had the appropriate training and evidence of the training, including their competency assessments are in place.This is now in place for any new staff who may be introduced to the service user.
Area for improvement 2 **Ref:** Regulation 15 (5)(a) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that a system is developed and implemented to ensure that service users and/or their representatives are proactively contacted on a regular basis, to ascertain their views on the service provided by the agency; and records of such contacts are retained. Ref: 5.2.1
	Response by registered person detailing the actions taken: We have implemented a system whereby a designated person will contact service users and/or their representatives every 3 months to obtain their feedback on the service they receive. The quality monitoring forms will be sent to the Registered Manager for any follow up action required.
Area for improvement 3 **Ref:** Regulation 15 (2) (b)(c)	The registered person shall ensure that assessments of need, service user agreements and care plans are put in place for all service users in keeping with the regulations; written notes in relation to all calls must be recorded from the first call to the service users' home.

Stated: First time **To be completed by:** Immediate from the date of the inspection	Ref: 5.2.2
	Response by registered person detailing the actions taken: Initial visits to service users are completed within 72 hours of commencement. Carers are provided with blank files containing daily record sheets which they are able to use to record notes from the very first call if the initial visit has not taken place before the POC commenced.

Area for improvement 4 **Ref:** Regulation 21 (1)(c) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall develop and implement a system to ensure that records are retrieved from the 'Office Hub' within a specified period; this relates to completed daily notes, in addition to the full care records of discontinued packages of care; records pertaining to this process should be retained. Ref: 5.2.2
	Response by registered person detailing the actions taken: Any records, files etc which are returned to the office hub are collected the next day and brought to the registered office where they are audited and filed appropriately. The files/records for POCs which have been ceased with prior notice, will be colleced by staff members at the final call. Contact is made with serivce users or their representatives for POCs which have ceased without notice to arrange collection of files.
Area for improvement 5 **Ref:** Regulation 16 (5)(b)(i) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall review the induction process to ensure that new staff shadow an appropriate number of calls with an experienced care worker; records of the 'shadowing' shifts should be recorded on the electronic system in addition to being recorded on the staff induction form. Ref: 5.2.6
	Response by registered person detailing the actions taken: Shadowing of new staff is carried out as part of the staff members induction period. New staff are required to shadow experieced staff on the runs/sits that they will be completing. If staff members move from sits to runs, they will complete further shadowing of the runs they will be completing. All shadowing will be recorded on CarePlanner, clearly
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 9.1 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the moving and handling policy and training content are reviewed and implemented, to ensure that they are explicit in relation to the types of equipment included in the practical training; direction for staff on the process to follow in the event of a deterioration in a service users' ability to weight bear; and the decision making around re-commencing the use of equipment, when the service users' condition improves.

	Ref: 5.2.1
	Response by registered person detailing the actions taken: Stedy has been ordered for each training facility so that all staff have training on this equiptment. Moving and handling policy has been reviewed and updated. The decision about re-commencing of use of equiptment will be taken by either a senior staff member, if direction has been previously given by physio (2 step approach) or the Trust physio will be contacted to attend before recommencement of use of equipment

Area for improvement 2 **Ref:** Standard 8.10 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that working practices are systematically audited to ensure that they are consistent with the agency's documented policies and procedures; this refers specifically to the auditing of daily written records returned from service users' homes; records of the auditing process must identify be retained and must evidence any follow up action taken as a result of any deficits identified. Ref: 5.2.2
	Response by registered person detailing the actions taken: Care records are to be collected monthly (by the 10th of each month, for the previous month) and returned to the registed office where they will be audited. Checks for any missed calls/late calls made and these are checked against Careplanner and the spreadsheet of late/missed calls. Audits of the records for full and complete information; ensuring staff are giving sufficient information in each log, writing is clear and legible, times and dates recorded, and that staff are signing in and out. Audit sheet is completed for each month. Any occurrences of calls not recorded/ information not up to standard are followed up on by the Registered Manager and action taken to rectify for future.

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