The Regulation and Quality Improvement Authority

Inspection Report

31 March 2022

Clogher Valley Care Ltd

Type of Service: Domiciliary Care Agency
Address: T5 Dungannon Enterprise Centre, 2 Coalisland Road, Dungannon, BT71 6JT

Tel No: 028 8554 8378

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: Clogher Valley Care Ltd **Responsible Individual:** Miss Evelyn Jennifer Frizelle	**Registered Manager:** Miss Evelyn Jennifer Frizelle **Date registered:** 6 January 2009
Person in charge at the time of inspection: Miss Evelyn Jennifer Frizelle	
Brief description of the accommodation/how the service operates: Clogher Valley Care Ltd is a domiciliary care service based at the Dungannon Enterprise Centre. The service provides care and support to 135 individuals living in their own homes who have their services commissioned by the Southern Health and Social Care (HSC) Trust. Services provided include personal care, medication support and meal provision. The Agency also supports a bespoke package of care to one identified service user. Service users are supported by 74 care workers.	

2.0 Inspection summary

An unannounced inspection took place on 31 March 2022, from 9.15 a.m. to 1.30 p.m. by the care inspector.

This inspection focused on recruitment, Northern Ireland Social Care Council (NISCC) registrations, adult safeguarding, notifications, complaints, whistleblowing, Deprivation of Liberty safeguards (DoL's) including money and valuables, restrictive practices and monthly quality monitoring.

Good practice was identified in relation to recruitment and appropriate checks being undertaken before staff were supplied to service user's homes. There was good oversight of restrictive practices. It was good to note that each staff member received a booklet with information on Dysphagia and modified diets. This is commended.

Areas for improvement were identified in relation to incidents which are notifiable to RQIA, electronic daily notes, staff training in respect of a specific service user, NISCC registrations; and auditing of record keeping standards.

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 guidance, and to address any deficits identified during our inspections.

Prior to inspection we reviewed the information held by RQIA about this agency. This included the previous inspection report and QIP; and written and verbal communication received since the last care inspection.

The inspection focused on reviewing relevant documents relating to the agency's governance and management arrangements. This included checking how support workers' registrations with NISCC were monitored by the agency.

During the inspection, we discussed any complaints that had been received and incidents that had occurred, with the manager and we reviewed the quality monitoring processes to ensure that these areas were routinely monitored as part of the monthly checks in accordance with Regulation 23.

Information was provided to staff, service users and their relatives, to request feedback on the quality of service provided. This included an electronic survey to enable them to provide feedback to the RQIA.

The findings of the inspection were provided to the manager at the conclusion of the inspection.

4.0 What people told us about the service

We spoke with a number of service users and relatives. The following comments were received:

Service users' comments:

- "I am happy, they are respectful indeed."
- "They would be grand."
- "I let her tear away, (carer name) is an awful good girl."
- "I am more than happy, they are all very good."

Relatives' comments:

- "We are very happy with them. They are brilliant and we are very grateful to have them."

A review of compliments records identified the following comment:

- "It was one service above all others involved in my mother's care who stood out, that was Clogher Valley Care, an oasis, in a desert of miscommunication and lack of action. (They) never disappointed and my mother looked forward to the visits, as I did, and they became part of our family."

HSCT' representative comments:

- "All staff are more than helpful and they are very professional. The service user feedback is very positive."
- "Jennifer is very good at raising and escalating concerns with the Trust and responding appropriately."

A number of questionnaires were returned, indicating that the respondents felt very satisfied that the care was safe, effective and compassionate and that the service was well led. Written comments included:

- "Good company."
- "Very pleasant staff and office staff, really helpful and prompt."

A small number of staff responded to the electronic questionnaire. All responses indicated that they felt very satisfied in relation to all aspects of working for Clogher Valley Care. No written comments were received.

5.0 The inspection

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

The last inspection to Clogher Valley was undertaken on 20 August 2020 by a care inspector; one area for improvement was identified and was validated during this inspection.

Areas for improvement from the last inspection 20 August 2020		
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 6.1 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that policies and procedures are subject to a systematic three yearly review, and the registered person ratifies any revision to or the introduction of new policies and procedures. This relates specifically to updating the Infection Prevention and Control policy to include procedures in respect of Covid-19.	**Met**

	Action taken as confirmed during the inspection: Review of the Infection Prevention and Control policy evidenced that this had been updated.	

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 annual safeguarding position report had been completed.

Staff had been provided with training in relation to adult and children's safeguarding. Discussions with the manager demonstrated that they were knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting adult safeguarding concerns. Review of incidents identified that they had been referred appropriately. However, discussion with the manager identified one incident which had not been reported to RQIA in keeping with the Domiciliary Care Agencies regulations, 2007. An area for improvement has been identified.

Training was available for staff, appropriate to the requirements of their role. This included DoLS training. Evidence of training was retained in each staff member's individual personnel record. This meant that we were unable to establish if all the staff had completed the required training. This was discussed with the manager who agreed to retain records of training dates centrally on a training matrix. This was submitted to RQIA by email on 7 April 2022. We were satisfied that all staff had completed training in relation to DoLS.

The manager demonstrated that they have an 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. The manager and senior staff had undertaken a higher level of DoLS training.

Risk assessments were in place for service users who required the use of bedrails. It was good to note that there was a system in place to ensure that risk assessments were requested from the HSCT.

The manager confirmed the agency does not manage individual monies belonging to the service users.

5.2.2 Are service users receiving the right care at the right time?

There was a system in place to record and report any missed calls. However, a review of the returned daily notes identified poor record keeping standards in relation to legibility, use of blue pen, errors not amended clearly and staff signing using only using their full names. Given that all staff had completed training in relation to record keeping, an area for improvement has been identified to ensure that audits of the daily care records identify instances of poor record keeping and action taken to address this.

Review of care records also identified a service user who was in receipt of a bespoke package of care. Due to difficulties the staff had in retaining daily notes within the service user's home, an alternate electronic arrangement was agreed with the HSCT. Review of the system identified that it was not consistently maintained. This meant that there were a significant number of days, where records of the care delivered were not available. Additionally the system in place was not in compliance with General Data Protection Regulations (GDPR). The manager agreed to review the current system in place. An area for improvement has been identified.

The manager advised that the HSCT had provided a bespoke training programme to enable staff to provide care and support to a service user who had specific needs. An electronic version of the service user's Positive Behaviour Support (PBS) Plan was also available to staff to read. In discussion with the manager, we were not assured that all staff providing care and support to this service user had all undertaken the specialist training or if they had read the PBS plan. There was also no evidence that staff had received training in relation to the ethos of supported living. The manager was advised to incorporate these into the training matrix as discussed previously in section 5.2.1. An area for improvement has been identified.

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

The manager identified a number of service users who required assistance with eating and drinking due to having swallowing difficulties; some of whom required their food and drinks to be of a specific consistency.

Review of the records identified that the SALT risk assessments were in place. The manager advised that a copy of the risk assessments were held in each service user's home record, as appropriate.

New standards for thickening food and fluids were introduced in August 2018. This was called the International Dysphagia Diet Standardisation Initiative (IDDSI). Evidence of Dysphagia training was retained in each staff member's individual personnel record. This meant that we were unable to establish if all the staff had completed the required training. This was discussed with the manager who agreed to retain records of training dates centrally on a training matrix. This was submitted to RQIA by email on 7 April 2022. We were satisfied that all staff had completed training in relation to Dyspagia.

It was good to note that each staff member received a booklet with information on Dysphagia and modified diets. This is good practice and is commended.

5.2.4 Are there robust systems in place for staff recruitment?

Review of recruitment records confirmed that the required pre-employment checks had been undertaken before staff members commenced employment and had direct engagement with service users.

A review of the records confirmed that the majority of staff are appropriately registered with NISCC. However, there was one staff member identified who had failed to renew their registration with NISCC and had been removed from the NISCC register. Whilst there was evidence that registration details and renewal dates were monitored by office staff, the system in place was not sufficiently robust. An area for improvement has been identified.

The manager told us that the agency does not use volunteers or voluntary workers.

5.2.5 Are there robust governance processes in place?

Discussion with the manager identified one service user who was in receipt of 24 hour care. Given that this package of care sits outside the normal provision of conventional domiciliary care, the agency's Statement of Purpose was required to be updated. This was discussed with the manager, who submitted the updated Statement of Purpose to RQIA by email on 25 April 2022.

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 engagement with service users, service user's relatives, staff and NHSCT representatives.

The reports included details of the review of service user care records, missed or late calls, accident/incidents, safeguarding matters, complaints, staff recruitment, training, and staffing arrangements. Advice was given in relation to carrying forward any open safeguarding incidents, to enhance management oversight of these matters.

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 policy and procedures and are reviewed as part of the agency's monthly quality monitoring process.

The manager advised that no staff had raised any concerns under the whistleblowing policy and procedures.

The manager was aware of which incidents required to be notified to RQIA. It was noted that incidents had been managed in accordance with the agency's policy and procedures. It was established during discussions with the manager that the agency had not been involved in any Serious Adverse Incidents (SAI's) Significant Event Analysis's (SEA's) or Early Alert's (EA's).

6.0 Conclusion

Based on the inspection findings five areas for improvement were identified. Two related to effective care; and three indicated that improvements were required in the leadership of the agency. Despite this, consultation with service users and relatives evidenced a number of positive comments in relation to the care and support provided. It is reassuring that the comments received indicated that the care was safe and compassionate.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	4	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Jennifer Frizelle, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with the Domiciliary Care Agencies Regulations (Northern Ireland) 2007</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 15 (12)(b)(i)(ii)

Stated: First time

To be completed by:
DD Month Year</td><td>The registered person shall ensure that RQIA is notified of any incident reported to the police, not later than 24 hours after the registered person has either reported the matter to the police; or is informed that the matter has been reported to the police.

Ref: 5.2.1</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Any incidents required to be notified to RQIA have been completed.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Regulation 21 (2)(a)

Stated: First time

To be completed by:
Immediate from the date of the inspection</td><td>The registered person shall review the current system of electronic submission of daily notes and implement a system that is in keeping with GDPR regulations and the domiciliary care agencies regulations and minimum standards.

Ref: 5.2.2</td></tr>
<tr><td>Response by registered person detailing the actions taken:
We have 1 bespoke service user who's daily report sheets were being emailed in to us due to not being able to have a file in the home.
At present we have a folder in the medication safe in the service</td></tr>
</table>

	users home that staff are completing daily and we are monitoring same. We are also looking at options for a staff only area on our website, where staff would log in and can electronically upload reports which would be in keeping with GDPR regulations.
Area for improvement 3 **Ref:** Regulation 16 (2)(a) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall review the training needs of staff, who attend a bespoke package of care, to ensure that all staff who attend, or could potentially attend the service user, have been trained in relation to Learning Disability Awareness, the ethos of Supported Living; and that they have read the service user's Positive Behaviour Support Plan. Ref: 5.2.2
	Response by registered person detailing the actions taken: Included on our training matrix are the dates of when staff, who provide care to one bespoke service user, have read the Positive Behaviour Support Plan, have been provided with training on the ethos of Supported Living, have completed our online Autism Awarenesss training and Learning Disability awareness.
Area for improvement 4 **Ref:** Regulation 13 (d) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall further develop the recruitment process to ensure that staffs' registrations with NISCC are checked; specifically staff names that are not on the agency's NISCC portal. Ref: 5.2.4
	Response by registered person detailing the actions taken: NISCC is checked weekly to ensure that all staff remain on the register. One staff member who had been removed whilst on extended leave, was re-registered on the 01 April following several requests to NISCC for assistance with log on details.
Action required to ensure compliance with the Domiciliary Care Agencies Minimum Standards, Revised 2021	

Area for improvement 1 **Ref:** Standard 8.10 **Stated:** First time	The registered person shall develop a system for auditing the returned daily notes; records must be retained of the action taken in respect of any poor record keeping standards identified. Ref: 5.2.2
To be completed by: Immediate from the date of the inspection	**Response by registered person detailing the actions taken:** Staff reminded of the 10 points of good record keeping. signing full name, using 24hr clock, using black pen etc. System put in place for report sheets to be collected every 2 weeks, checked and details retained of staff who have displayed poor record keeping and the action taken.

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

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7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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