PRIMARY INSPECTION

Name of Establishment:	**Bryson Charitable Group**
Establishment ID No:	**10779/10781/10782**
Date of Inspection:	**1, 3 and 15 December 2014**
Inspector's Name:	**Amanda Jackson**
Inspection No:	**IN017358 / IN017361 / IN017362**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

General Information

Name of agency:	Bryson Charitable Group
Address:	Bryson Lagan Sports Rivers Edge 13-15 Ravenhill Road Belfast BT6 8DN
Telephone Number:	02890 452136
E mail Address:	Dom-care@brysongroup.org
Registered Organisation / Registered Provider:	Bryson Charitable Group/Ms Josephine Marley
Registered Manager:	Ms Joy Coates (registering manager)
Person in Charge of the agency at the time of inspection:	Ms Joy Coates (registering manager)
Number of service users:	190
Date and type of previous inspection:	Annual announced inspections for legacy services 16 July 2013 (10779 – Shankill Centre long term service) 26 July 2013 (10781/10782 – ND & Ards Home from Hospital Service)
Date and time of inspection:	Annual Unannounced Inspection 1 December 2014 09.15 to 16.30 hours and 3 December 2014 09.00 to 12.30 hours and 15 December 2014 14.30 to 15.30 hours (HR recruitment file reviews)
Name of inspector:	Amanda Jackson

Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect domiciliary care agencies. A minimum of one inspection per year is required.

This is a report of a primary unannounced inspection to assess the quality of services being provided. The report details the extent to which the regulations and standards measured during the inspection were met.

Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to service users was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of domiciliary care, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Domiciliary Care Agencies Regulations (Northern Ireland) 2007
- The Department of Health, Social Services and Public Safety's (DHSSPS) Domiciliary Care Agencies Minimum Standards (2008)

Other published standards which guide best practice may also be referenced during the inspection process.

Methods/Process

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the Minimum Standards.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

Specific methods/processes used in this inspection include the following:

- Analysis of pre-inspection information
- Discussion with the registered manager
- Examination of records
- Consultation with stakeholders
- File audit
- Evaluation and feedback

Any other information received by RQIA about this registered provider and its service delivery has also been considered by the inspector in preparing for this inspection.

Consultation Process

During the course of the inspection, the inspector spoke to the following:

Service users	1
Staff	6
Relatives	5
Other Professionals	1

Questionnaires were provided, prior to the inspection, to staff to find out their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	**Number issued**	**Number returned**
Staff	72	0

Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to establish the level of compliance achieved with respect to the following three quality themes.

- **Theme 1**
  Standard 8 – Management and control of operations
  Management systems and arrangements are in place that support and promote the delivery of quality care services.

- **Theme 2**
  Regulation 21 (1) - Records management

- **Theme 3**
  Regulation –13 Recruitment

The registered provider and the inspector have rated the service's compliance level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report.
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report.
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report.
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report.
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report.
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

Profile of Service

Bryson Care Services domiciliary care agency (Belfast and North Down and Ards) is based on the Ravenhill Road, Belfast and provides long-term domiciliary services mainly for adults over the age of 65 years with a small percentage of service users with mental ill health, physical disability, learning disability and palliative care. Services are provided to approximately 190 service users by a staff team of approximately 70 care workers and includes personal care, meal provision, household duties (attending laundry, washing dishes and general tidy up) medication and staff communication to district nursing on the matter of pressure ulcer dressings. Services are funded by the Belfast and South Eastern Health and Social Care Trusts.

No requirements or recommendations were made during the agency's previous inspections on 16 July 2013 (10779 – Shankill Centre long term service) and 26 July 2013 (10781/10782 – ND & Ards Home from Hospital Service.

Summary of Inspection

Detail of inspection process

The annual unannounced inspection for Bryson Care Services was carried out on 1 December 2014 09.15 to 16.30 hours, 3 December 2014 09.00 to 12.30 hours and 15 December 2014 14.30 to 15.30 hours (HR recruitment file reviews). The agency has under gone considerable restructuring since the previous inspection with the loss of all previous managers across all services and loss of a considerable number of care staff also across all services. As a result the agency has struggled to maintain compliance with regulations and minimum standards which was reflected across a large number of matters reviewed during inspection. In light of the matters requiring attention and to ensure compliance is achieved a follow up inspection is planned for three months from the date of this inspection.

Visits to service users were carried out by the UCO following the inspection on 04 December 2014, and a summary report is contained within this report. Findings following these home visits were discussed with the Assistant director, the home from hospital co-ordinator and the operational and compliance manager during the second Bryson (home from hospital) inspection on 15 December 2015.

The inspector had the opportunity to meet with six staff members on the 15 December 2014 during the home from hospital inspection to discuss their views regarding the service and their feedback is included within the body of this report. Staff feedback detailed appropriate line management support and competence despite recent challenges during the restructuring phase of the organisation. Discussion with the staff group during inspection supported that they have an appropriate knowledge in the area of recording. Staff also described recruitment processes in line with the agency policy and procedure.

Eight requirements and one recommendation have been made in respect of the outcomes of this inspection.

<u>Staff survey comments</u>

72 staff surveys were issued and 0 received which is a disappointing response.

Home Visits summary

As part of the inspection process RQIA's User Consultation Officer (UCO) spoke with one service user and five relatives on 4 December 2014 to obtain their views of the service being provided by Bryson Charitable Group. The service users interviewed have been using the agency for a period of time ranging from approximately nine months to nine years, receive at least two calls per day and are receiving assistance with the following:

- Management of medication
- Personal care
- Meals

There were mixed results regarding care being provided by a small, consistent team; it was felt that better consistency would improve the relationship between the service user, family and carers. It was good to note that service users or their representatives are usually introduced to new members of staff by a regular carer. The majority of the people interviewed confirmed that there were no concerns regarding the timekeeping of the agency's staff or the length of calls.

The UCO was advised that all of the people interviewed had no concerns regarding the quality of care being provided by the staff from Bryson Charitable Group and they were aware of whom they should contact if issues arise. One relative advised that a complaint had been made to the agency regarding consistent carers and the matter was yet to be addressed; this was discussed with the compliance manager. Examples of some of the comments made by service users or their relatives are listed below:

- "I think it would be better if there was better consistency of carer; my XXX has complex needs."
- "They're a great bunch. I am extremely happy with them."
- "No complaints; couldn't do without them."

There were mixed results regarding management visits to ensure satisfaction with the service or observation of staff practice. The matter was discussed with the compliance manager who is to provide assurance that this is being carried out.

Documentation is one of the themes being inspected during the 2014 / 15 inspection year; as part of the home visits the UCO reviewed the documentation kept in the home of four service users. During the home visits, the UCO noted that three service users experience restraint in the form of bed rails and lap bands; the use of such was documented in their care plans or risk assessments.

Review of the risk assessments and care plans advised that the service users are not receiving any financial assistance, for example shopping, from the agency; this was supported by those people interviewed by the UCO. One service user receives assistance with medication by the carers from Bryson Charitable Group; however the medication log was not being completed consistently.

All visits by carers are to be recorded on log sheets which are held in the service user's home. On review of the log sheets, the UCO noted two issues namely signing of records and a number of calls not being recorded. It was also noted that the risk assessment in one file had not been completed. The above issues were discussed with the compliance manager and are to be addressed accordingly.

Summary

Theme one - Management and control of operations

Management systems and arrangements are in place that support and promote the delivery of quality care services.

The agency has achieved a level of **moving towards compliance** in relation to this theme.

The agency's 'Statement of Purpose', Service user guide and policy on Management, control and monitoring service quality standards require view to ensure they contain details of the organisational structure, the qualifications and experience of senior staff and include the roles and responsibilities of each grade of senior staff.

Discussions with the assistant director and registering manager Joy Coates during inspection and review of records for the manager and management staff supported a process in place for some but not all areas of mandatory training consistent with the RQIA mandatory training guidelines 2012. Additional areas of training and associated competency assessments have been requested for review.

A staff competency process has been developed by the agency and is operational during 2013/14 for some but not all staff and with exception to those areas referenced in the previous paragraph.

Review of appropriate appraisal processes for all management staff were confirmed during inspection however supervision processes were not in place for all management staff and have been requested for implementation.

Monthly monitoring processes are currently in place and operational. The report template was recommended for update during inspection to include an area for staff competence matters as appropriate.

Records regarding two medication incidents were reviewed and found to have been appropriately reported within RQIA timeframes however all records were not available for review and this has been required moving forward.

Six requirements and one recommendation have been made in relation to this theme and relate to registered manager and management staff training and competence in accordance with RQIA mandatory training guidelines (Regulation 11(1), 11(3) and 13(b), and the revision of the staff supervision and appraisal policy and implementation of supervision for management staff in line with Standard 9, Appendix 1 and Standards 13.2, 13.3 and 13.5. Requirements have also been made regarding the agency's Statement of purpose, Service user guide and various policy reviews together with review of the annual quality review process.

Theme 2 - Records management

The agency has achieved a level of **moving towards compliance** in relation to this theme.

The agency has a policy and procedure in place on 'Record Keeping' which was found to be satisfactory and in line with standard 5 and contain guidance for staff on this subject.

A range of templates reviewed during inspection supported appropriate processes in place for service user recording in the areas of general care and medication. Review of service user home files during inspection supported gaps in compliance in these areas and this has been reflected in the QIP attached to the report.

The agency has a policy and procedure in place on use of restraint as part of their 'Moving and Handling' policy, which was reviewed as satisfactory.

The agency currently provides care to a number of service users that require some form of restraint. Care plans and risk assessments in relation to this area were found to be appropriately detailed.

The agency has a policy and procedure on 'Handling Service Users Monies' which was reviewed as compliant.

Review of the staff handbook required updating regarding a number of policy areas and this has been detailed within the QIP.

Four requirements have been made in relation to this theme (two of which overlap with theme one requirements) and relates to staff training compliant with the RQIA mandatory training guidelines 2012, staff supervision in accordance with Regulation 16(4) and Standard 13.3, review of the staff handbook in accordance with Regulation 17 and appropriate maintenance of service user records in compliance with Regulation 21 and Schedule 4 and Standards 5.2 and 5.6.

Theme 3 – Recruitment

The agency has achieved a level of **compliant** in relation to this theme.

Review of the agency policy, procedure and recruitment records confirmed compliance with Regulation 13 and schedule 3 and Standards 8.21 and 11.2.

The Inspector and UCO would like to express their appreciation to service users, relatives and staff for the help and cooperation afforded during the course of the inspection.

Follow-Up on Previous Issues

There were no previous requirements or recommendations

<table>
<tr><th colspan="2">THEME 1
Standard 8 – Management and control of operations
Management systems and arrangements are in place that support and promote the delivery of quality care services.</th></tr>
<tr><td>Criteria Assessed 1: Registered Manager training and skills

Regulation 10 (3) The registered manager shall undertake from time to time such training as is appropriate to ensure that he has the experience and skills necessary for managing the agency.

Regulation 11 (1) The registered manager shall, having regard to the size of the agency, the statement of purpose and the number and needs of the service users, carry on or (as the case may be) manage the agency with sufficient care, competence and skill.

Standard 8.17 The registered manager undertakes training to ensure they are up to date in all areas relevant to the management and provision of services, and records of such training are maintained as necessary for inspection (Standard 12.6). Ref: RQIA’s Guidance on Mandatory Training for Providers of Care in Regulated Services, September 2012</td><td></td></tr>
<tr><td>Provider's Self-Assessment:</td><td></td></tr>
<tr><td>Bryson Care has a policy for the managment and control of operations and this outlines the governance arrangements in place to manage all services effectively. The statement of purpose provides details relating to the management structure within the services as well as the qualifications and experience of all levels of management. The current Registered Manager was appointed in May 2014 following a restructuring of Older People's Services and had the necessary professional qualifications and domiciliary care experience to carry out the role. The organisation has a learning and development policy and a corporate training plan in place which are reviewed on an annual basis and includes specific areas of management training for all levels of managers.

Personalised work objectives were agreed with the Registered Manager to cover the probationary period and this included the completion of relevant training. Training issues form an integral part of supervision with a designated senior member of staff and the annual and 6 month performance review process also incorporates training needs and a personal development plan. Any specific gaps in learning are identified during this process and the appropriate training is sourced by a representative from the Learning &</td><td>Compliant</td></tr>
</table>

Development Department.	
Inspection Findings:	
The statement of purpose which sits within the service user guide/handbook for the legacy home from hospital service within the North Down and Ards (ND&Ards) locality area was found to be out of date given the recent management structure changes which have taken place within Bryson domiciliary care services across the Belfast and North down areas and with the two service areas of long-term domiciliary care services and Home from hospital services. A complete review of the statement of purpose and service user guide for the new restructured services is required in line with Regulation 5 and 6 of the Domiciliary Care Agencies Regulations 2007. Review of a revised version (on the home from hospital inspection day 15 December 2014) for overall services dated December 2014 was found to be substantially compliant but still requires further review as the document still references the Newtownards home from hospital service and does not include the home form hospital co-ordinator in the management structure. The document is also required to clearly reference lines of responsibility and accountability which were not clearly evidenced in this version. The policy on Management, control and monitoring service quality standards dated September 2014 was reviewed as substantially compliant with exception to the new management structure within the agency and specific details around staff quality monitoring. This structure should include the registered person, registered manager(s), together with co-ordinators and all other staff including management and care staff. Training records for the registering manager Joy Coates were found to be in place regarding a number of mandatory training areas in compliance with RQIA mandatory training guidelines (September 2012) with exception to Food Hygiene. The manager has not completed training in the areas of supervision and appraisal and this has been recommended. All areas of training reviewed did not include a competency assessment element and this again has been recommended for review. The registering manager Joy Coates is not currently enrolled on any additional training and this was recommended for consideration in the future (once service provision has begun to settle following the major restructuring) in terms of keeping abreast of changes within the domiciliary care sector. It was discussed and reviewed during inspection that the registering manager is currently registered with NISCC from November 2013 subject to satisfactory completion of the AYE (Assessed year in employment). This is	Moving towards compliant

currently being undertaking with NISCC alongside Bryson as part of a group social work support perspective looking at management and professional social work issue. Review of registration for Joy Coates on the NISCC website during inspection confirmed ongoing registration is current and active.	

Criteria Assessed 2: Registered Manager's competence Standard 8.10 Working practices are systematically audited to ensure they are consistent with the agency's documented policies and procedures and action is taken when necessary. Standard 7.13 Medication errors and incidents are reported, in accordance with procedures, to the appropriate authorities. Standard 12.9 The effect of training on practice and procedures is evaluated as part of quality improvement. Standard 13.5 Staff have recorded appraisal with their line manager to review their performance against their job description and agree personal development plans in accordance with the procedures.	
Provider's Self-Assessment:	
The Assistant Director Adult Services has responsibility for carrying out monthly monitoring visits to services and identifying areas for improvement and action. The Registerted Manager addresses any poor practice and raises issues at team meetings and indivisual / group supervisions. The Assistant Director also completes an Annual Quality Report which encompasses feedback from service users, staff and stakeholders and the Registered Manager has responsibility for progressing any actions to improve service delivery. **An area for action from November 2014 has been the introduction of the Operational Compliance Manager who will have responsibility for auditing compliance in relation to all policies and procedures and mentoring the Registered Manager.** **All medication errors and incidents must be reported to the Registered Manager who has responsibility for completion of the relevent documentation.** **The Registered Manager / Quality Assurance Officer have responsibility for carrying out spot checks / monitoring visits to service user homes to include direct observations with staff. The outcomes of these are shared with staff in supervision / team meetings and an action plan for improvement if necessary is agreed. Supervision can be in the form of individual / group supervision and performance reviews take place very 6 months. A personal development plan for all levels of staff is completed and copies of all**	Substantially compliant

supervision and reviews are maintained on the staff files for auditing purposes.	
Inspection Findings:	
The agency Supervision and Performance review policy dated July 2013 referenced the practices for care staff but did not clearly reference the differences in management staff supervision and appraisal and this has been recommended for review. Supervision for the registering manager has taken place regularly over recent months due to the transitional changes taking place within Bryson care. These group supervision sessions were held between the registered person and relevant senior staff including Joy Coates and were reviewed for a range of months in 2014 (June to September). An individual supervision record for November 2014 was also reviewed with Joanne Neill (Operations and compliance manager) and appeared appropriate. Appraisal for the registering manager has taken place in October 2014 following Joy's six month probationary period in post and this again was reviewed during inspection and identified progress to date and areas for development over the coming months. The inspector reviewed the agency log of two incidents reported through to RQIA over the past year (two medication incidents. Review of these incidents confirmed appropriate recording and reporting to RQIA regarding the matters within appropriate timeframes however all associated records were not retained with the incident for inspector review (i.e.staff update training records and competence assessments/ spot checks to ensure the matter has been appropriately resolved and this was discussed for all matters ongoing. Monthly monitoring reports completed by the assistant director for October, September and June 2014 were reviewed during inspection and found to be detailed as compliant. These reports clearly referenced the matters requiring attention following the service restructuring as detailed within this inspection report. Revision of the report template was recommended during inspection to include a staff competency area for use as appropriate. The agency had completed their annual quality review for the year 2013-14 which was reviewed during inspection. This document does not currently include an evaluation of staff training completed to date and proposed future training requirements and this was recommended during inspection.	Moving towards compliant

Criteria Assessed 3: Management staff training and skills (co-ordinators, senior carers etc) Regulation 13 (b) The registered person shall ensure that no domiciliary care worker is supplied by the agency unless he has the experience and skills necessary for the work he is to perform. Standard 7.9 When necessary, training in specific techniques (the administration of medication eg eye/ear drops or the application of prescribed creams/lotions) is provided for named care workers by a qualified healthcare professional. Standard 12.4 The training needs of individual staff for their roles and responsibilities are identified and arrangements are in place to meet them. Standard 13.1 Managers and supervisory staff are trained in supervision and performance appraisal.	
Provider's Self-Assessment:	
All appointments to Manager, Quality Officer, Senior Care Worker and Care Worker roles are approved by the Recruiting Manager as per Recruitment & Selection Policy. **All Care Workers must complete a formal induction and meet the requirments of the organistation's policy on probation. Staff must also complete activities contained in a checklist based on the NISCC Induction Standards and this must be signed off by a manager to deem the person competent to carry out his/her role (see Induction Policy). All staff must complete 3 days of formal training prior to working unsupervised with service users and have completed all mandatory training. Documents to evidence this is kept in the employee's file with supervision and training records. Direct observations of practice are caried out by an experienced member of staff / manager / quality officer however, this is an area that requires improvement following the restructuring of services.** **Managers have responsibility for carrying out formal supervision and performance reviews and training has been provided at a corporate level in the organisation for all levels of managers**	Substantially compliant

Inspection Findings:	
The agency holds a Learning and Development policy and procedure dated October 2014 which details the overarching training approach for Bryson charitable group (this includes many different aspect of Bryson as a whole charitable group). The policy although referencing the responsibilities of senior managers and assistant directors to review and plan their own individual staff training needs each year, the policy does not make specific reference to the mandatory training requirements for the domiciliary aspect of Bryson care in line with RQIA mandatory training guidelines 2012 and this was discussed during inspection for development. Training records and associated competency assessments reviewed for the co-ordinator and senior care worker were found to be in place regarding a number of areas of mandatory training in compliance with RQIA mandatory training guidelines (September 2012) but not all areas were complete. Supervision and appraisal training has not taken place for the senior care worker to date as she is not currently undertaking this role. This training had been completed for the co-ordinator and this is to be commended. It was discussed and reviewed during inspection that both management staff are not currently registered with NISCC although the inspector did review implementation of the process for the co-ordinator on the NISCC website during inspection. Registration is recommended for all management staff as good practice.	Moving towards compliance

Criteria Assessed 4: Management staff competence (co-ordinators, senior carers etc) Standard 8.10 Working practices are systematically audited to ensure they are consistent with the agency's documented policies and procedures and action is taken when necessary. Standard 7.13 Medication errors and incidents are reported, in accordance with procedures, to the appropriate authorities. Standard 12.9 The effect of training on practice and procedures is evaluated as part of quality improvement. Standard 13.5 Staff have recorded appraisal with their line manager to review their performance against their job description and agree personal development plans in accordance with the procedures.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
The Assistant Director Adult Services has responsibility for carrying out monthly monitoring visits to services and identifying areas for improvement and action. The Registerted Manager addresses any poor practice and raises issues at team meetings and indivisual / group supervisions. The Assistant Director also completes an Annual Quality Report which encompasses feedback from service users, staff and stakeholders and the Registered Manager has responsibility for progressing any actions to improve service delivery. **An area for action from November 2014 has been the introduction of the Operational Compliance Manager who will have responsibility for auditing compliance in relation to all policies and procedures and mentoring managers/officers.** **All medication errors and incidents must be reported to the Registered Manager who has responsibility for the completion of the relevent documentation.** **The Registered Manager / Quality Assurance Officer have responsibility for carrying out spot checks / monitoring visits to service user homes to include direct observations with staff. The outcomes of these are shared with staff in supervision / team meetings and an action plan for improvement if necessary is agreed. Supervision can be in the form of individual / group supervision and performance reviews take place every six months. A personal development plan for all levels of staff is completed and copies of all**	Substantially compliant

supervision and reviews are maintained on the staff files for auditing purposes.	
Inspection Findings:	
Appraisal for the two management staff (co-ordinator and senior care worker) were reviewed during inspection however supervision was not present during 2014 for the senior care worker and this was required for review. The current monthly monitoring reports do not provide comment on management staff matters and competence should they arise and this was discussed during inspection with the assistant director and registering manager Joy Coates for future consideration (as required) as discussed previously under criteria two of this theme.	Moving towards compliant

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Substantially compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Moving towards compliance

THEME 2 Regulation 21 (1) - Records management	
Criteria Assessed 1: General records Regulation 21(1) The registered person shall ensure that the records specified in Schedule 4(11) are maintained, and that they are— (a) kept up to date, in good order and in a secure manner; and (c) at all times available for inspection at the agency premises by any person authorized by the Regulation and Improvement Authority. (2) The registered person shall ensure that, in addition to the records referred to in paragraph (1), a copy of the service user plan and a detailed record of the prescribed services provided to the service user are kept at the service user's home and that they are kept up to date, in good order and in a secure manner. Standard 5.2 The record maintained in the service user's home details (where applicable): • the date and arrival and departure times of every visit by agency staff; • actions or practice as specified in the care plan; • changes in the service user's needs, usual behaviour or routine and action taken; • unusual or changed circumstances that affect the service user; • contact between the care or support worker and primary health and social care services regarding the service user; • contact with the service user's representative or main carer about matters or concerns regarding the health and well-being of the service user; • requests made for assistance over and above that agreed in the care plan; and • incidents, accidents or near misses occurring and action taken. Standard 5.6 All records are legible, accurate, up to date and signed and dated by the person making the entry.	**COMPLIANCE LEVEL**

Provider's Self-Assessment:	
Bryson Care has a Records Management & Recording Standard in place and the Staff Handbook includes information on best practices in relation to record keeping. Staff supervision files contain documents relating to performance reviews, training and direct observations of practice. Any records referring to allegations of abuse or physical restraint are maintained in the employee's personal file at Head Office. **Each service user has a personal file provided at the commencement of the service. This include a copy of the agreed care / support plan, service agreement, medication service level agreement and financial records sheets as appropriate. Any identified risks are reported to the manager for appropriate action in line with the Risk Assessment Standard. Any concerns / risks relating to restraint are also documented and reported to the manager.** **Information maintained at the service user home also incorporates a daily report sheet which must be completed by care workers at each visit, identifying arrival and departure times together with accurate details of the support delivered and tasks completed. Any concerns about the user must be reported without delay to a manager for action.** **Following a recent review of practices in this area an action plan is currently being implemented to improve recording and record keeping.**	Moving towards compliance
Inspection Findings:	
The agency policy on Recording Standards dated September 2013 was found to be detailed regarding general staff recording and the policy on Staff handovers standard (i.e. reporting) dated April 2012 were found to be compliant. The Handling service user's money and valuables standard policy dated June 2011 (which is overdue for review) was compliant and the Restraint policy which is referred to in the agency's Moving and Handling policy dated April 2013 was found to be compliant. Review of the staff handbook detailed the recording standard policy but did not reference the reporting policy i.e. Staff handovers standard, restraint or managing service users monies and these have been recommended for inclusion.	Moving towards compliance

Templates were reviewed during inspection for: • Daily evaluation recording • Medication administration is detailed on the daily evaluation recording together with a separate medication administration record. The inspector confirmed during discussion with Joy Coates (registering manager) and during staff discussions at inspection that staff are not recording the number of tablets during calls however a full list of medication is detailed on the service users medication blister pack within the home. • The agency do not hold a money agreement within the service user agreement as they do not currently undertake shopping • Staff spot check template includes a section on adherence to the agency recording policy. • Staff supervision template references recording and reporting All templates were reviewed as appropriate for their purpose. Review of three staff files during inspection did not confirm staff adherence to records management as staff spot checks/supervision for 2014 have not taken place due to the agency restructuring. This was confirmed within the monthly monitoring report reviewed during inspection (as detailed within theme one of this report). Staff training records for medication, recording and reporting, restraint and managing service users monies were reviewed for three staff members during inspection and confirmed as moving towards compliance with a number of mandatory training areas complete but with a number of gaps in training reviewed. Competency assessments were also reviewed as incomplete for a number of areas. Joy Coates (registering manager) discussed records management as a topic for discussion during staff meetings/group supervision. Review of five recent staff meeting minute records dated 21 May, 18 June, 31 July, 29 October and 26 November 2014 and one recent staff email (which are sent out with staff weekly rota's) dated 28 October 2014 evidenced this topic. Review of four service user files following the inspection by the UCO confirmed an issue around appropriate recording in the general notes (i.e. a number of calls not recorded on files reviewed and staff not always recording their full signature) and medication had not been consistently recorded. The inspector discussed staff detailing the number of tablets given which is not current practice and has been recommended going forward as best practice. Registering manager and staff spoken with during inspection confirmed a full list of service user medication is held in the service user's blister pack. Review of service user records during the UCO visits did highlight restraint in place for three service users.	

Discussion with Joy Coates (registering manager) during inspection confirmed that restraint is in place for a number of service users in respect of bedrails and lapbands and this information was confirmed to be detailed within care plans or risk assessments.	

Criteria Assessed 3: Service user money records Regulation 15 (6) The registered person shall ensure that where the agency arranges the provision of prescribed services to a service user, the arrangements shall— (d) specify the procedure to be followed where a domiciliary care worker acts as agent for, or receives money from, a service user. Standard 8.14 Records are kept of the amounts paid by or in respect of each service user for all agreed services as specified in the service user's agreement (Standard 4).	
Provider's Self-Assessment:	
Bryson Care has a Managing Service Users' Money and Valuables Standard in place which identifies the procedure to follow with reference to handling money. Care Workers receive training in this area during induction and will only handle monies if it is part of an agreed care/support plan. Accurate and detailed records must be maintained of all expenditure made on behalf of the service user as per Expenditure Record Sheet and must be in ink not pencil. Receipts must be kept to correspond with each entry. **Under no circumstances should any member of staff have access to a service user's PIN number in order to collect benefits/pensions or general cash.** **Staff are not permitted to lend service users money or borrow money from them. Staff are also not allowed to accept gifts to include momey from service users.** **The records are checked during monitoring visits and any discrepancies are investigated by the Registered Manager**	Compliant
Inspection Findings:	
Discussions during inspection with Joy Coates (registering manager) confirmed the agency do not currently have any service users with financial assistance.	Not applicable

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Moving towards compliance

THEME 3 Regulation 13 - Recruitment	
Criteria Assessed 1: Regulation 13 The registered person shall ensure that no domiciliary care worker is supplied by the agency unless— (a) he is of integrity and good character; (b) he has the experience and skills necessary for the work that he is to perform; (c) he is physically and mentally fit for the purposes of the work which he is to perform; and (d) full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 3. Standard 8.21 The registered person has arrangements in place to ensure that: • all necessary pre-employment checks are carried out; • criminal history disclosure information in respect of the preferred candidate, at the appropriate disclosure level is sought from Access NI; and • all appropriate referrals necessary are made in order to safeguard children and vulnerable adults . Standard 11.2 Before making an offer of employment: • the applicant's identity is confirmed; • two satisfactory written references, linked to the requirements of the job are obtained, one of which is from the applicant's present or most recent employer; • any gaps in an employment record are explored and explanations recorded; • criminal history disclosure information, at the enhanced disclosure level, is sought from Access NI for the preferred candidate; (Note: Agencies that intend to employ applicants from overseas will need to have suitable complementary arrangements in place in this regard); • professional and vocational qualifications are confirmed; • registration status with relevant regulatory bodies is confirmed; • a pre-employment health assessment is obtained • where appropriate, a valid driving licence and insurance cover for business use of car is confirmed; and • current status of work permit/employment visa is confirmed.	**COMPLIANCE LEVEL**

Provider's Self-Assessment:	
Bryson Charitable Group has a robust Recruitment & Selection Policy in place which is currently under review. The service has clearly defined job descriptions and person specifications for domiciliary care workers which are reviewed prior to any new recruitment process taking place. Care workers are shortlisted on specific criteria highlighted in the job description and this includes paid / unpaid experience in a caring role. At the interview stage any gaps in employment are explored and documented. There is also a mandatory question at interview with reference to working with vulnerable adults and qualifications are checked. The identified recruiting manager has responsibility for the completion of a new starter folder which includes a comprehensive pre-employment checklist for workers based on the requirements outlined in Schedule 3 of the Domiciliary Care Agencies Regulations (NI) 2007. Enchanced Access NI checks are always sought and in the event of convictions being reported then it is the responsibility of the recruiting manager to convene a meeting with the applicant to explore the issues further, prior to making a final decision about confirmation of employment. Care workers cannot commence employment until all relevant checks, references and information is received and verified.	Compliant
Inspection Findings:	
Review of the staff recruitment policy dated February 2012 confirmed general compliance with regulation 13 and schedule 3. Review of two 2014 staff recruitment files during inspection confirmed compliance with Regulation 13, Schedule one and standard. Staff contracts signed at employment commencement and job descriptions issued during the recruitment process and detailed within the induction sign off process were also confirmed during inspection	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

Additional Areas Examined

Complaints

The agency completed documentation prior to the inspection in relation to complaints received between 1 January 2013 and 31 December 2013. This form was reviewed and found to be satisfactory. The inspector reviewed three of the 2014 complaints during inspection due to the late date in the 2014 calendar year and confirmed all records to be compliant.

Due to changes in management structure complaints prior to October 2014 could not be provided for review during inspection. The area of complaints management and review has recently been passed to the Quality assurance officer. Discussion and review of processes during inspection assured the inspector that procedures are now in place to ensure full and accurate records are maintained of all complaints and incidents.

Whistleblowing

The inspector discussed with the Assistant Director and reviewed both agency and BHSCT reports in regard to a whistleblowing matters raised in May 2014 regarding reduced call times to service users not in line with the commissioned care package. Investigation conclusions from both Bryson and the trust evidenced shortcomings in providing the appropriate commissioned care in respect of the length of call times as opposed to quality of care provided. The agency have put in place measures to monitor commissioned call times to avoid such concerns reoccurring in the future and have implemented additional processes to monitor staff recording in service users homes and return of all records to the agency in appropriate timeframes. The BHSCT continue to monitor the agency on a monthly basis and this was confirmed during inspector discussions following the inspection with the BHSCT quality team. The trust quality team will continue to provide feedback to RQIA following these monthly agency visits. RQIA will review the agencies compliance with the Domiciliary Care Agencies Regulations and Minimum Standards through the normal regulatory process.

Restructuring of services

The inspector discussed with the Assistant Director matters regarding the continued restructuring taking place within Bryson Care. The assistant director confirmed that cancellation of service 10782 (previously North Down and Ards Home from hospital) service will proceed as this service has now been amalgamated with the Belfast long term service (10779). The assistant director agreed to inform RQIA registration team over the coming weeks regarding this matter. The assistant director also confirmed that services 10778 and 10780 have now been amalgamated into one service (10778 – Belfast home from hospital service) and notification of cancellation of 10780 will be forwarded to RQIA registration over the coming weeks. Certificates for both cancelled services will be returned to RQIA upon request from the registration team.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with The Assistant Director and Joy Coates (registering manager) as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Enquiries relating to this report should be addressed to:

Amanda Jackson
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Quality Improvement Plan

Unannounced Primary Inspection

Bryson Charitable Group

1, 3 and 15 December 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Liz Leathem Assistant Director and Joy Coates registering manager during the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

<u>Statutory Requirements</u> **This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Domiciliary Care Agencies Regulations (NI) 2007**					
No.	**Regulation Reference**	**Requirements**	**Number Of Times Stated**	**Details Of Action Taken By Registered Person(S)**	**Timescale**
1	Regulation 5 and Schedule 1 and Regulation 6	The registering manager is required to review the Statement of purpose and Service user guide to ensure compliance with Regulation 5 and Schedule 1 and Regulation 6. As discussed within theme one, criteria one of the report.	Once	The Statement of Purpose and Service User Guide have been updated to include interim arrangements until the Registered Manager and Service Manager posts are filled	To be completed three months from the date of inspection
2	Regulation 23(1)	The registering manager is required to review the policy on Management, control and monitoring service quality standards to ensure compliance with Regulation 23(1). As discussed within theme one, criteria one of the report.	Once	The policy has been reviewed to include a revised interim management structure and details of staff quality monitoring	To be completed three months from the date of inspection
3	Regulation 11(3)	The registering manager is required to ensure training is compliant with Regulation 11(3), Minimum standards 12.3 and 12.4 and in line with RQIA mandatory training guidelines 2012. As discussed within theme one, criteria one of the report.	Once	The Registering Manager has left the organisation and any future Registered Managers will complete all mandatory training and competency assessments.	To be completed three months from the date of inspection

4	Regulation 16(4)	The registering manager is required to review and revise the agency policy on Supervision and Performance review and ensure appropriate application across all staff groups. (Minimum standard 13) As discussed within theme one, criteria two and four of the report and within theme two criteria one.	Once	The policy had been reviewed to include the requirement for management staff supervision and performance review.	To be completed three months from the date of inspection
5	Regulation 21(3) and Schedule 4(9)	The registering manager is required to review and revise the agency procedures for maintaining incident records. As discussed within theme one, criteria two of the report and within the additional areas examined section at the end of the report.	Once	The Registered Manager and Quality Assurance Officer now maintain all associated records in the one file in relation to incidents to include spot checks / staff training records and competency assessments as appropriate.	To be completed with immediate effect and ongoing

6	Regulation 16(2)(a)	The registering manager is required to review and revise the agency Learning and Development policy and procedure and ensure appropriate implementation of mandatory training across all staff groups to include supervision and appraisal training for management staff as appropriate. Competency assessments are also required for all mandatory areas. (Minimum standard 12) As discussed within theme one, criteria three and theme two, criteria one of the report.	Once	The policy has been reviewed to reference all mandatory training in line with RQIA guidelines and the need to complete competency assessments for all levels of staff.	To be completed three months from the date of inspection
7	Regulation 17	The registering manager is required to review and revise the staff handbook in compliance with Regulation 17. As discussed within theme two, criteria one of the report.	Once	The handbook has been reviewed to include the staff handover standard, restraint and managing service users' monies.	To be completed three months from the date of inspection
8	Regulation 21 and Schedule 4	The registering manager is required to ensure staff recording in service users homes is compliant with Regulation 21 and Schedule 4. (Minimum standard 5) As discussed within theme two, criteria one of the report.	Once	Staff now record their full signature and the number of tablets administered as per blister packs in service user homes. Staff also must record all calls to servivce user homes with exact times of arrival and departure.	To be completed with immediate effect and ongoing

Recommendations **These recommendations are based on The Domiciliary Care Agencies Minimum Standards (2011), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.**					
No.	**Minimum Standard Reference**	**Recommendations**	**Number Of Times Stated**	**Details Of Action Taken By Registered Person(S)**	**Timescale**
1	Standard 8.11	The registering manager is recommended to ensure future annual quality review processes include reference to staff training. As discussed within theme one, criteria two of the report.	Once	The template for the Annual Quality Review has been amended to include reference to staff training. The Annual Quality Report is completed as per Bryson's financial year and therefore will not be completed until May 2015	To be completed three months from the date of inspection

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	Mr Joe McGrann
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Ms Jo Marley

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	A.Jackson	20/01/15
Further information requested from provider			