Inspection Report

17 August 2021

PCG Castle Lane Court

Type of service: Domiciliary Care Agency
Address: 45 Castle Lane, Lurgan, BT67 9BD
Telephone number: 028 3834 8937

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

1.0 Service information

Organisation/Registered Provider: Praxis Care Group **Responsible Individual:** Mr Greer Wilson	**Registered Manager:** Ms Chloe Mulholland **Date registered:** 6 September 2018
Person in charge at the time of inspection: Person in charge	
Brief description of the accommodation/how the service operates: This is a domiciliary care agency supported living type which provides personal care and housing support to 19 service users living at two locations with learning disabilities, mental health and complex needs within the Southern Health and Social Care Trust (SHSCT) area. Service users are supported by 46 staff.	

2.0 Inspection summary

An unannounced inspection took place on 17 August 2021, between 09.10 am and 13.30 pm by the care inspector. This inspection focused on recruitment, Northern Ireland Social Care Council (NISCC), adult safeguarding, notifications, complaints, whistleblowing, Deprivation of Liberty Safeguarding (DoLS) including money and valuables, restrictive practice, monthly quality monitoring and Covid-19 guidance.

Good practice was identified in relation to recruitment and appropriate checks being undertaken before staff were supplied to service user's homes, NISCC registrations, adult safeguarding, referrals and availability of the adult safeguarding position report, notifications, complaints, DoLS including money and valuables, restrictive practice and monthly quality monitoring. Good practice was also found in relation to system in place of disseminating Covid-19 related information to staff.

Based on the inspection findings, three areas for improvement were identified. These related to manager absence notification, mandatory training and supervision. Details can be found in the Quality Improvement Plan included.

The findings of this report will provide the agency with the necessary information to assist them to fulfil their responsibilities, enhance practice and service users' experience.

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.

Prior to inspection we reviewed the information held by RQIA about this agency. This included the previous inspection report, notifications, concerns and any written or verbal communication received since the previous care inspection.

The inspection focused on:

- contacting the service users, their relatives, HSCT representatives and staff to find out their views on the service.

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

Information was provided to service users, relatives, staff and other stakeholders to request feedback on the quality of service provided. This included questionnaires for service users/relatives. An electronic survey was provided to enable staff to feedback to the RQIA.

4.0 What people told us about the service

We spoke with four service users, one relative and three staff. No questionnaires or electronic feedback were received.

Comments received during inspection process-

Service users' comments:

- "It's alright living here."
- "Most of the staff are good."
- "I like my own flat."
- "If I had any complaints I would tell staff."
- "I share my home with another service user."

Relatives comments:

- "I think the service is very good."
- "(Agency) Very good place for somebody like XXXX."

Staff comments:

- "I got an induction checklist."
- "We done our DoLS training."
- "We did Covid-19 e-learning training."

- "Our team in here is brilliant."
- "We have a lot of contact with management."
- "We report any concerns."

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 PCG Castle Lane Court was undertaken on 19 October 2020 by a care inspector; no areas for improvement were identified.

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 had an identified Adult Safeguarding Champion (ASC). The Adult Safeguarding Position report for the agency had been formulated and was reviewed.

Discussions with the person in charge and staff demonstrated that they were knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting adult safeguarding concerns.

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

Staff indicated that they had a clear understanding of their responsibility in identifying and reporting any actual or suspected incidences of abuse. They could describe their role in relation to reporting poor practice and their understanding of the agency's policy and procedure with regard to whistleblowing.

The agency had a system for retaining a record of referrals made to the SHSCT in relation to adult safeguarding. Records viewed and discussions with the person in charge indicated that a number of adult safeguarding referrals had been made since the last inspection and that the referrals had been managed appropriately.

Service users who spoke to us stated that they had no concerns regarding their safety; they described how they could speak to staff if they had any concerns in relation to safety or the care being provided.

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

Staff had undertaken DoL's training appropriate to their job roles.

Examination of service users care records confirmed that DoLS practices were not fully embedded into practice on the day of the inspection. We established that the processes had been discussed the SHSCT representative. This will be reviewed at the next inspection.

Staff demonstrated that they had 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.

Where a service user is experiencing a restrictive practice, examination of these care records contained details of assessments completed and agreed outcomes developed in conjunction with the appropriate SHSCT representative.

The person in charge told us that the agency does not manage individual service users' monies.

There was a good system in place in relation to the dissemination of information relating to Covid-19 and infection prevention and control practices.

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

The discussions with the person in charge, staff and review of service user care records reflected the multi-disciplinary input and the collaborative working undertaken to ensure service users' health and social care needs were met within the domiciliary care agency. There was evidence that agency staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate. Staff were also implementing the specific recommendations of SALT to ensure the care received in the service user's home was safe and effective.

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

The person in charge advised us that there were no care partners visiting service users during the Covid-19 pandemic restrictions.

5.2.4 Are their robust systems in place for staff recruitment?

The review of the agency's staff recruitment records confirmed that recruitment was managed in accordance with the regulations and minimum standards, before staff members commence employment and had direct engagement with service users. Records viewed evidenced that criminal record checks (Access NI) had been completed for staff.

A review of the records confirmed that all staff provided are appropriately registered with NISCC and NMC. Information regarding registration details and renewal dates are monitored by the manager; this system was reviewed and found to be in compliance with Regulations and Standards. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

The person in charge told us that the agency does not use volunteers or voluntary workers.

5.2.5 Are there robust governance processes in place?

There were monitoring arrangements in place in compliance with Regulation 23 of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007. Reports relating to the agency's monthly monitoring were reviewed. The process included engagement with service users, service user's relatives, staff and SHSCT representatives. The reports included details of the review of service user care records; accident/incidents; safeguarding matters; complaints; staff recruitment and staffing arrangements. It was noted that an action plan was generated to address any identified areas for improvement and these were followed up on subsequent months, to ensure that identified areas had been actioned.

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

Staff described their role in relation to reporting poor practice and their understanding of the agency's policy and procedure on whistleblowing.

Review of training records confirmed that staff had not undertaken mandatory training appropriate to their job roles. This was identified as an area for improvement.

Review of supervision records confirmed that supervision meetings were not completed in accordance with policy and procedure. This was identified as an area for improvement.

It was established during discussions with the person in charge 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).

It was established that the agency had not informed RQIA of the absence of the manager. This was identified as an area for improvement.

6.0 Conclusion

Based on the inspection finding three areas for improvement were identified. Two were in relation to safe and effective care and one was in relation to the service being well led. Details can be found in the Quality Improvement Plan.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007 and the Domiciliary Care Agencies Minimum Standards, 2011.

	Regulations	Standards
Total number of Areas for Improvement	1	2

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with the person in charge, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland), 2007	
Area for improvement 1 **Ref:** Regulation 27 (1) (b) **Stated:** First time **To be completed by:** Immediate and ongoing	Where- (b) the registered manager, proposes to be absent from the agency for a continuous period of 28 days or more, the registered provider shall give notice in writing to the Regulation and Improvement Authority of the proposed absence. Ref: 5.2.5
	Response by registered person detailing the actions taken: RQIA have been informed of managers absence and as off the 31.8.21, Leona Lavery has been reigistered as 'acting manager' of the agency.This outcome has been actioned and met.
Action required to ensure compliance with the Domiciliary Care Agencies Minimum Standards, 2011	
Area for improvement 1 **Ref:** Standard 12.3 **Stated:** First time **To be completed by:** Immediate and ongoing	Mandatory training requirements are met. Ref: 5.2.5
	Response by registered person detailing the actions taken: The scheme training matrix has been updated and completion off mandatory training is on track.The matrix is being reviewed weekly by team leaders with staff who have still to complete mandatory training being identified, and time being set-aside for completion.This action is on-going currently. Team leaders are aware and will ensure that they address the issue off mandatory training in supervisons with staff.
Area for improvement 2 **Ref:** Standard 13.3 **Stated:** First time **To be completed by:** Immediate and ongoing	Staff have recorded formal supervision meetings in accordance with the procedures. Ref: 5.2.5
	Response by registered person detailing the actions taken: The supervision tracker has been updated to reflect recent supervisions, the percentage has increased to 67.65% with a number of staff self isolating and two off on sick leave.All staff will continue to receive formal supervision in accordance with Praxis policy.

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

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