The Regulation and Quality Improvement Authority

Inspection Report

3 February 2022

The Brook

Type of Service: Domiciliary Care Agency
Address: Brook Street, 6 Brook Green, Coleraine, BT52 1QG
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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: Northern HSC Trust **Responsible Individual:** Mrs Jennifer Welsh (Acting)	**Registered Manager:** Mrs Sylvia Campbell **Date registered:** 24 October 2018
Person in charge at the time of inspection: Mr Ernest Kelly, Senior Support Worker	
Brief description of the accommodation/how the service operates: The Brook is a supported living type domiciliary care agency which provides care and support for people living with dementia or cognitive impairment, with provision of 56 flats. In addition staff from The Brook provide support services to five bungalows which are located beside the complex. The agency is managed by the Northern Health and Social Care Trust (NHSCT) in partnership with Radius Housing Association, who acts as the landlord to the premises.	

2.0 Inspection summary

The care inspector undertook an announced inspection on 3 February 2022 between 10.00 a.m. and 1.45 p.m.

The inspection focused on the agency's governance and management arrangements as well as staff recruitment, staff' registrations with the Northern Ireland Social Care Council (NISCC), the Nursing and Midwifery Council (NMC), adult safeguarding, notifications, complaints, whistleblowing, Deprivation of Liberty Safeguarding (DoLS) including money and valuables, restrictive practices, monthly quality monitoring, Dysphagia and Covid-19 guidance.

Service users and relatives spoken with said that they were very satisfied with the standard of care and support provided.

Good practice was identified in relation to appropriate checks being undertaken before staff started to provide care and support to the service users. Good practice was found in relation to the system in place for disseminating Covid-19 related information to staff.

Areas for improvement were identified in relation to staff training. An area for improvement was also identified in relation to the quality monitoring processes, which should have identified the deficits in staff training.

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 and Quality Improvement Plan (QIP), records of Notifiable incidents, 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 the NISCC and the NMC were monitored by the agency.

During the inspection we discussed any complaints that had been received and any 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 person in charge at the conclusion of the inspection.

4.0 What people told us about the service

Due to the risks associated with the Covid-19 pandemic, we did not meet with any service users. However, we observed a number of service users in the communal areas and noted that they appeared to be relaxed and comfortable in their interactions with staff.
We spoke with a number of staff and relatives.

The following comments were received:

Staff' comments

- "Definitely no concerns,"
- "Very good here, we are all happy."
- "Everything is fine, I love my wee job."

Relatives comments:

- "I don't see a problem, everything is good."
- "I am happy. (My relative) is well cared for."

- "We are very happy, (my relative) has settled well in there."
- "I am happy."
- "Very happy with how they are getting on there."

In addition, feedback was received from service users and relatives in the questionnaires returned to RQIA. The responses received indicated that the respondents felt very satisfied that the care was safe, effective and compassionate and that the service was well led.

No responses were received via the electronic survey.

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 The Brook was undertaken on 5 March 2021 by a care inspector. A QIP was issued. This was approved by the care inspector and was validated during this inspection.

Areas for improvement from the last inspection on 5 March 2021		
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 8.1 **Stated:** Second time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure there is a defined management structure that identifies the lines of accountability, specifies roles and details responsibilities for areas of activity. This relates to missed calls to service users. The agency is required to have a system in place which records any calls that did not occur to the service user.	**Met**
	Action taken as confirmed during the inspection: A review of the audits of daily care records identified that no calls had been missed.	
Area for improvement 2 **Ref**: Standard 10.5 **Stated:** Second time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure staff are trained to create, use, manage and dispose of records in line with good practice and legislative requirements. This is in relation to all entries being recorded under the correct date and a time for starting and finishing a call are specified. It also relates to entries being completed in full and signatures being written in a legible manner	**Met**

	for every care call. **Action taken as confirmed during the inspection**: A review of the daily care records identified that the entries were recorded in keeping with best practice.	
Area for improvement 3 **Ref**: Standard 8.11 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the monthly monitoring reports include stakeholder views. This includes those of staff, service users, relatives and HSC trust' representatives. **Action taken as confirmed during the inspection**: A review of the available monthly quality monitoring reports identified that stakeholder feedback had been included.	**Met**

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 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).

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

It was noted that incidents had been managed in accordance with the agency's policy and procedures.

A system was in place to provide staff with training appropriate to the requirements of their role. This included adult safeguarding training. A review of the staff training records identified a number of staff that were overdue their update training and a number who had yet to complete training in this regard. Training dates for relief staff indicated that their adult safeguarding training was also out of date. An area for improvement has been identified in this regard.

The person in charge 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. Examination of service users care records confirmed that

DoLS practices were embedded into practice with the appropriate recent documentation available for review.

A review of the staff training records identified that a number of staff had yet to undertake training in relation to DoLS. An area for improvement has been identified in this regard.

The person in charged advised that there were no restrictive practices used in The Brook.

A review of the monthly quality monitoring reports identified that the agency manages individual monies belonging to a number of service users. The monthly quality monitoring reports identified that a system is being further developed to ensure there is oversight of the monies held, to ensure that RQIA is informed, should the monies accrue and exceed twenty thousand pounds.

None of the service users were currently taking part in any research projects.

Advice was given in relation to accessing the Department of Health Codes of Practice, as a resource for the staff.

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

The person in charge advised us that whilst visitors were encouraged to visit service users in communal areas, due to the coronavirus (COVID-19) pandemic, relatives had been asked to refrain from visiting service users in their individual flats. The person in charge was familiar with the Care Partner approach and advised that no relatives had expressed an interest in this regard.

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

New standards for thickening food and fluids were introduced in August 2018. This was called the International Dysphagia Diet Standardisation Initiative (IDDSI). Discussion with the person in charge confirmed training in dysphagia was available on the online e-learning platform. A review of the training records identified that a number of staff had yet to undertake the training.

Whilst there were no service users identified as having swallowing difficulties or requiring their food to be of a specific consistency, the Dysphagia is aimed at raising staff awareness in relation to swallowing difficulties and how they should respond in the event of a choking incident. An area for improvement has been identified in this regard.

5.2.4 Are there 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 support workers

are supplied to work with the service users. Records viewed evidenced that the required checks had been completed for staff.

A review of the records confirmed that all support workers are appropriately registered with NISCC and the 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.

5.2.5 Are there robust governance processes in place?

The quality monitoring processes were reviewed to ensure that they were undertaken in line with Regulation 23 of the Domiciliary Care Agencies Regulations (Northern Ireland) 2005. Whilst there was evidence that staff training had been reviewed as part of the quality monitoring process, it was concerning that the person designated with the responsibility of undertaking the visits, had not identified the staff training deficits, referred to in above sections. An area for improvement has been made in this regard.

It was established during discussions with the person in charge that the agency had not been involved in any Serious Adverse Incidents (SAIs)/Significant Event Analyses (SEAs) or Early Alerts (EAs). Safeguarding incident records were reviewed and it was noted that they had been reported and managed appropriately.

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

6.0 Conclusion

Based on the inspection findings, improvements were identified in relation to staff training and the quality monitoring processes. Despite this, the people we consulted with as part of the inspection process, told us that the service was providing safe, effective and compassionate care. Details can be found in the Quality Improvement Plan included.

7.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	2	2

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

Quality Improvement Plan

Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007	
Area for improvement 1 **Ref:** Regulation 16 (2)(a) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that each staff member undertakes their mandatory training; this relates to, but is not limited to, adult safeguarding training; and there must be management oversight of the staff training matrix. Ref: 5.2.1
	Response by registered person detailing the actions taken: An updated matrix on an Excel spreadsheet has been created to include the date the training is booked, date attended, reasons for non-attendance and a filter option has also been added. Training will also be colour-coded to highlight outstanding areas. This ensures that all training for each staff member can be monitored at a glance. Clear evidence for non-attendance can be seen and addressed. A copy of the matrix will be examined on a monthly basis by management, reviewed and an electronic signature attached to provide evidence of mangerial oversight. The matrix will also be available on the staff shared drive for access during supervision.
Area for improvement 2 **Ref:** Regulation 23 (1) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the person designated with responsibility for undertaking the monthly quality monitoring visits, reviews staff compliance with all mandatory training requirements. Ref: 5.2.5
	Response by registered person detailing the actions taken: The training matrix will be viewed by the person designated to complete monthly monitoring and any areas of concern identified and addressed at the next monitoring visit.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011	
Area for improvement 1 **Ref:** Standard 12.4 **Stated:** First time	The registered person shall ensure that all staff undertake training in relation to the Deprivation of Liberty Safeguards (DoLS), as relevant to their roles and responsibilities. Ref: 5.2.1

To be completed by: Immediate from the date of the inspection	**Response by registered person detailing the actions taken:** An updated matrix has been created to include the date the training is booked, date attended, reasons for non-attendance and a filter option has been added. This matrix includes training in relation to Deprivation of Liberty Safeguards. At the monthly review by management any anomlies will be highlighted and raised with the staff member.This will ensure that all staff are compliant with training in this area.

Area for improvement 2 **Ref:** Standard 12.4 **Stated:** First time	The registered person shall ensure that all staff undertake training in relation to Dysphagia and Responding to Choking Incidents, as relevant to their roles and responsibilities. Ref: 5.2.3
To be completed by: Immediate from the date of the inspection	**Response by registered person detailing the actions taken:** The updated training matrix will include training in relation to Dysphagia and Responding to Choking. This will be monitored on a montlhy basis by management and any issues noted will be highlighted and raised with the staff member.

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

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