The Regulation and Quality Improvement Authority

Inspection Report

30 December 2022

Magherafelt Community Services

Type of Service: Domiciliary Care Agency
Address: Thompson House, Mid-Ulster Hospital Site, 59 Hospital Road, Magherafelt, BT45 5EX

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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:** Ms Jennifer Welsh	**Registered Manager:** Mrs Claire Appolonia O'Hare **Date registered:** 18 August 2009
Person in charge at the time of inspection: Mrs Claire Appolonia O'Hare	
Brief description of the accommodation/how the service operates: Magherafelt Community Services is a Northern Health and Social Care Trust (NHSCT) domiciliary care agency. The staff team of 118 provides care and social support to 206 service users in the Magherafelt locality.	

2.0 Inspection summary

An unannounced inspection took place on 30 December 2022 between 9.30 a.m. and 2.15 p.m. The inspection was conducted by a care inspector.

The inspection examined the agency's governance and management arrangements, reviewing areas such as staff recruitment, professional registrations, staff induction and training and adult safeguarding. The reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS), Service user involvement, Restrictive practices and Dysphagia management.

Areas for improvement identified related to the care plans, the monthly quality monitoring reports and the moving and handling training policy.

Service users spoken with spoke in positive terms about the care provided.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

In preparation for this inspection, a range of information about the service was reviewed. This included any previous areas for improvement identified, registration information, and any other written or verbal information received from service users, relatives, staff or the Commissioning Trust.

As a public-sector body, RQIA has a duty to respect, protect and fulfil the rights that people have under the Human Rights Act 1998 when carrying out our functions. In our inspections of domiciliary care agencies, we are committed to ensuring that the rights of people who receive services are protected. This means we will seek assurances from providers that they take all reasonable steps to promote people's rights. Users of domiciliary care services have the right to expect their dignity and privacy to be respected and to have their independence and autonomy promoted. They should also experience the individual choices and freedoms associated with any manager living in their own home.

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

4.0 What did people tell us about the service?

As part of the inspection process we spoke with a number of service users' relatives and staff who spoke positively in relation to the care and support provided. Comments included:

Service users' Relatives' comments:

- "We are very happy. Sometimes they do not stay the whole (allocated) time, they shouldn't be rushing."
- "They do what they have to do and they are very polite, no complaints here."
- "No issues at all, they are all 100 percent."
- "The girls are very good, I have no complaints at all."
- "I have very good staff, I am happy with them. You could set the clock by them."

Staff' comments:

- "I love it here, it is so much better than anywhere else I worked."
- "The managers are very supportive, I have no concerns."

No responses were received by electronic survey or questionnaire.

5.0 The inspection

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

The last care inspection of the agency was undertaken on 31 January 2022 by a care inspector. No areas for improvement were identified.

5.2 Inspection findings

5.2.1 What are the systems in place for identifying and addressing risks?

The agency's provision for the welfare, care and protection of service users was reviewed. The organisation's adult safeguarding procedures were reflective of the Department of Health's (DoH) regional policy and clearly outlined the procedure for staff in reporting concerns.

Discussions with the manager established that they were knowledgeable in matters relating to adult safeguarding and the process for reporting and managing adult safeguarding concerns.

Staff had completed adult safeguarding training.

No concerns had been raised to the manager under the whistleblowing policy.

There was a system in place to retain records of any referrals made to the Adult Protection Gateway Service (APGS) in relation to adult safeguarding incidents. The manager advised that there had been no referrals made since the last inspection.

The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

Staff were provided with training appropriate to the requirements of their role.

Where service users required the use of specialised equipment to assist them with moving, training was provided.

There was a system in place to ensure that staff received supervision and appraisals in keeping with the agency's policies and procedures.

A review of care records identified that care plans were not consistently up to date. For instance, the care plans should have included the use of specialised equipment such as walking aids and stand aids. There was also a need to archive out of date moving and handling plans, when the service user's needs had changed. In situations where service users require the use of more than one piece of moving and handling equipment, the care plan should clearly outline for staff, when they should use each piece of equipment. The records reviewed identified that this information was included in the moving and handling risk assessment, however, this was not included in the care plan. An area for improvement has been identified.

Further discussion with the manager identified that the policy on moving and handling required to be updated to include direction for staff on when not to use specialist equipment. This relates specifically to staff having a clear procedure to follow in the event of a deterioration in a service user's ability to weight bear. This information is also required to be included in the moving and handling training. An area for improvement has been identified.

All staff had been provided with training in relation to medicines management. The manager advised that no service users required their medicine to be administered with a syringe. The manager was aware that should this be required, a competency assessment would be undertaken before staff undertook this task.

The Mental Capacity Act (MCA) provides a legal framework for making decisions on behalf of service users who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, service users make their own decisions and are helped to do so when needed. When service users lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The manager reported that none of the service users were subject to DoLS. DoLS information was distributed to staff as part of their training.

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

The service users' care plans contained details about the level of support they may require. However, as discussed above, the care plans were not consistently up to date or reflective of specialist risk assessments.

Review of the daily notes made by the carers identified deficits in relation to the level of detail required to be documented. For instance, the notes did not consistently include meal preparation or when topical creams were applied. There was also no section on the form for staff to record the type of specialised equipment they used. The manager advised that a new proforma for daily records had been developed to address these matters. This will be followed up at future inspection.

The review of records identified that calls were generally delivered in keeping with the care plan.

There was a system in place for reporting any instances where staff are unable to gain access to a service user's home. Communications had been issued to staff which clearly directs them as to what actions they should take to manage and report such situations both within and out of office hours.

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

A number of service users were assessed by SALT with recommendations provided and some required their food and fluids to be of a specific consistency. A review of training records confirmed that staff had completed training in Dysphagia; this also included training on how staff should respond to any choking incidents.

As discussed in section 5.2.1, the care plans were not consistently up to date. This meant that the care plans were not reflective of specialist risk assessments undertaken by the SALT. The manager advised that the up to date risk assessments were also retained in the service users' own homes. However, the care plan did not include any reference to the SALT risk assessment. This has been incorporated into the area for improvement referenced in section 5.2.1.

5.2.4 What systems are in place for staff recruitment and are they robust?

A review of the agency's staff recruitment records confirmed that criminal record checks (AccessNI), were completed before staff members commenced employment and had direct engagement with service users. Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC); there was a system in place for professional registrations to be monitored by the manager.

There were no volunteers working in the agency.

5.2.5 What are the arrangements for staff induction and are they in accordance with NISCC Induction Standards for social care staff?

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care, to ensure they were competent to carry out the duties of their job in line with the agency's policies and procedures.

The agency has maintained a record for each member of staff of all training, including induction and professional development activities undertaken.

5.2.6 What are the arrangements to ensure robust managerial oversight and governance?

There were monitoring arrangements in place to ensure compliance with the Regulations and Standards. The reports included details of service user reviews; accident/incidents; missed and late calls; and safeguarding matters. It was noted that there was engagement with service users, service users' relatives, staff and HSC Trust representatives. However, advice was given to the manager regarding the need for there to be more feedback from service users and relatives included within the monthly quality monitoring report, to ensure that the sample spoken with was representative of the number of service users. Advice was also given regarding the need for the person designated the responsibility of undertaking the visits, to review the training matrix, as opposed to reviewing a small number of records. This would enable better oversight of compliance. However, review of the reports of the agency's quality monitoring established that these had not been consistently undertaken on a monthly basis. An area for improvement has been identified.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Where complaints were received since the last inspection, these were appropriately managed and were reviewed as part of the agency's quality monitoring process.

The manager advised that no complaints had been made to the Northern Ireland Public Services Ombudsman (NIPSO) about the agency.

There was a system in place to ensure that records were retrieved from discontinued packages of care in keeping with the agency's policies and procedures.

The Annual Quality Report was reviewed. Advice was given in relation to the need to include feedback from staff and HSCT professionals.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAIs) or Significant Event Audits (SEAs) procedures. It was good to note that where learning was identified from SAIs that had occurred in other services, the agency reviewed the systems in place, to ensure that measures were put in place to reduce the risk of occurrence within the Magherafelt Community Services.

There was a system in place to ensure that records were retrieved from discontinued packages of care in keeping with the agency's policies and procedures.

The agency's registration certificate was up to date and displayed appropriately.

6.0 Quality Improvement Plan (QIP)/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	2	1

The areas for improvement and details of the QIP were discussed with the manager, 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 23 (1) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that quality monitoring visits are undertaken on a monthly basis. Ref: 5.2.6
	Response by registered person detailing the actions taken: The registered person will ensure that quality monitoring visits care completed on monthly basis. A system will be put into place to ensure that, in the absence of the area manager, quality monitoring visits are still completed.
Area for improvement 2 **Ref:** Regulation 15 (2) (a)(b)(c) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that care plans are up to date and reflective of any risk assessments; this relates particularly to instances where service users use more than one piece of specialist moving and handling equipment; and in relation to any service user who requires a modified diet. Ref: 5.2.1 and 5.2.3
	Response by registered person detailing the actions taken: Care plans are completed and updated by professional staff within our community teams. The registered manager will continue to escalate care plans that require review and updating and will also ensure that a specific care plan is received in relation to service users who require a modified diet. Management will link with relevant professional staff to highlight the required level of care plan detail. With regards to detail on specialist moving and handling equipment, this information is not included on the care plan but within the individual risk assessment. In the event that more than one piece of specialist moving and handling equipment is required, this will be detailed clearly within the risk assessment.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 9.1 **Stated:** First time	The registered person shall ensure that the moving and handling policy and training content are reviewed to ensure that they are explicit in relation to when staff should not use any specialist moving and handling equipment. Ref: 5.2.1

To be completed by: 17 June 2023	
	Response by registered person detailing the actions taken: Management will review and update the existing moving and handling policy to reflect the required detail in relation to specific types of equipment staff are trained in and the process for staff to follow in the event of a deteriorating patient.

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

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