Inspection Report

3 June 2021

HarmonI

Type of service: Domicillary
Address: 39 Downshire Road, Bangor, BT20 3RD
Telephone number: 028 9146 5211

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: HarmonI **Responsible Individual:** Mr Samuel Andrew Humphries	**Registered Manager:** Ms Margaret Millar – Acting Manager - registration pending **Date registered:** 31 May 2017
Person in charge at the time of inspection: Manager	
Brief description of the accommodation/how the service operates: HarmonI is a domiciliary care agency supported living type, which provides services up to 31 service users living in their own homes within the South Eastern Health and Social Care Trust (SEHSCT) area, who require care and support with mental health and learning disabilities. The services users are supported by 51 staff which includes the manager, care manager, team leader and administration staff.	

2.0 Inspection summary

An unannounced inspection took place on 3 June 2021, at 09.45 am by the care inspector.

This inspection focused on recruitment, Northern Ireland Social Care Council (NISCC) registrations, adult safeguarding, notifications, complaints, whistleblowing, Deprivation of Liberty safeguards (DoLS) including money and valuables, restrictive practice, monthly quality monitoring and Covid-19 guidance and we sought to assess progress with issues raised in the last quality improvement plan (QIP).

Good practice was identified in relation to recruitment, appropriate checks being undertaken before staff stated to provide care and support to the service users. Good practice was found in relation to system in place of disseminating Covid-19 related information to staff. There were good governance and management oversight systems in place.

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

RQIA were assured that this agency supplies support workers who are providing safe, effective and compassionate care; and that the agency is well led.

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

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

4.0 What people told us about the service

We spoke with four service users, one relative, the responsible individual, manager, care manager and two staff.

An email was received from a SEHSCT representative post inspection and feedback is listed below.

In addition we received feedback from service users/relatives which indicated that all respondents were happy generally with the service provided by the agency. However, one response from a service user indicated that they were 'undecided' that the service was well led.

As there were no contact details for the service user, we spoke to the care manager on 21 June 2021 and discussed the feedback received. We were assured by the care manager that the comment made would be discussed in the forum of a residents meeting and a record retained for review at the next inspection.

Comments received during inspection process-

Service users' comments:

- "The staff are good."
- "The staff are well trained."
- "I go to work on a Monday and Tuesday in the office."
- "The staff wear personal protection equipment (PPE)."
- "The staff look after me well."

Relative comments:

- "I am always thrilled with the service."
- "The staff are very and respectful."

HSCT representatives' comments:

- "Harmoni's communication with the Trust is good."
- "Where issues arise HarmonI investigate and additional measures are put in place to reduce chances of reoccurrence."

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 HarmonI was undertaken on 28 July 2020 by a care inspector. A QIP was issued. This was approved by the care inspector and will be validated during this inspection.

Areas for improvement from the last inspection on 28 July 2020		
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011.		**Validation of compliance**
Area for Improvement 1 **Ref**: Standard 8.12 **Stated:** Second time	The registered person shall ensure that the quality of services provided is evaluated on at least an annual basis and follow-up action taken. Key stakeholders are involved in this process. Ref: 6.1	**Met**
	Action taken as confirmed during the inspection: We confirmed that the agency had evaluated the quality of services provided on an annual basis.	
Area for improvement 2 **Ref**: Standard 9.5 **Stated:** Second time	The registered person shall ensure that policies and procedures are subject to a systematic three yearly review, and the registered person ratifies any revision to or the introduction of new policies and procedures. Ref: 6.1	**Met**
	Action taken as confirmed during the inspection: We confirmed that policies were reviewed in line with standards.	
Area for improvement 3 **Ref:** Standard 9.5 **Stated:** First time	The registered person shall ensure that policies and procedures are subject to a systematic three yearly review, and the registered person ratifies any revision to or the introduction of new policies and procedures. This relates specifically to updating the Infection Prevention and Control policy to include procedures in respect of Covid-19. Ref: 6.1	**Met**
	Action taken as confirmed during the inspection: We reviewed the Infection Prevention Policy and evidenced it had been updated to include procedures in respect to Covid-19.	

5.2 Inspection findings

5.2.1 Are there systems in place for identifying and addressing risks?

The agency's provision for the welfare, care and protection of service users was reviewed. The organisation's policy and procedures reflect information contained within the Department of Health's (DOH) regional policy 'Adult Safeguarding Prevention and Protection in Partnership' July 2015 and clearly outlines the procedure for staff in reporting concerns. The organisation has an identified Adult Safeguarding Champion (ASC). The Adult Safeguarding Position report for the agency has been formulated and was reviewed.

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

It was noted that staff are required to complete classroom based 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 has a system for retaining a record of referrals made to the SEHSCT in relation to adult safeguarding. Records viewed and discussions with the manager indicated that adult safeguarding referrals made since the last inspection had been managed in accordance with policy and procedure.

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 have undertaken DoLS training appropriate to their job roles. However, it was established during the discussion with the manager and review of documentation that DoLS' practices were not embedded into practice due to Covid-19. The manager gave assurances that the agency would contact the SEHSCT key workers and advise that DoLS' practices were required to be in place before the next inspection.

Staff demonstrated that they have an understanding that service users who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the Mental Capacity Act.

The manager 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.

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

5.2.2 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 manager told us that there were a number of care partners visiting the service users. The care partners adhere to Covid-19 guidelines set down by the Public Health Agency (PHA). The care partners do not undertake any personal care with the service users and are only permitted in certain areas of the service.

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

The discussions with the manager, 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.

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

5.2.4 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, service user surveys,

safeguarding matters, complaints, staff recruitment, training, 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 is a process for recording complaints in accordance with the agency's policy and procedures. It was noted that complaints received since the last inspection had been managed in accordance with the 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.

It was established during discussions with the manager that the agency had not been involved in any Serious Adverse Incidents (SAI's) Significant Event Analysis's (SEA's) or Early Alert's (EA's).

6.0 Conclusion

Based on the inspection findings and discussions held RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the manager/management team

7.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with the manager and care manager, as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority

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

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