Unannounced Care Inspection
11 June 2018 and Follow up Inspection 19 July 2018 Report

Enable Care Services (UK) Limited

Type of Service: Domiciliary Care Agency
Address: 54 Moore Street, Aughnacloy, BT69 6AY
Tel No: 02885557745
Inspector: Marie McCann
User Consultation Officer: Clair McConnell

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Enable Care Services (UK) Limited is a domiciliary care agency which provides a range of personal and social care services, meal provision and sitting services to people living in their own homes. Service users have a range of diagnosis's including dementia, mental health, learning disability and physical disability.

3.0 Service details

Organisation/Registered Provider: Enable Care Services (UK) Limited **Responsible Individual(s):** Mrs Christine Margaret McGirr	**Registered Manager:** Mrs. Edel Mary Beatty- application received - "registration pending".
Person in charge at the time of inspection on 11 June 2018 and 19 July 2018: Mrs Edel Beatty	**Date manager registered:** As above

4.0 Inspection summary

An unannounced inspection took place on 11 June 2018 from 09.00 to 16.45. The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the agency was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to adult safeguarding, risk management, effective communication between service users, agency staff and other key stakeholders, and management of complaints and incidents and maintaining good working relationships.

Areas requiring improvement were identified in relation to recruitment information held by the agency, staff training, service user care records and monthly quality monitoring reports.

A further follow up inspection took place on 19 July 2018 from 09:10 to 14:00. The inspection was undertaken following information received by RQIA, with a specific focus on staff recruitment and induction training.

An area requiring improvement was identified during this inspection in relation to staff induction.

Both inspections were underpinned by the Domiciliary Care Agencies Regulations (Northern Ireland) 2007 and the Domiciliary Care Agencies Minimum Standards, 2011.

Comments made by service users are included within the report.

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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	3	3

Details of the Quality Improvement Plan (QIP) identified on 11 June 2018 and 19 July 2018 were discussed with Edel Beatty, manager and a director of the agency, as part of the inspection process. The timescales for completion commenced from the dates of each respective inspection.

Enforcement action did not result from the findings of the inspections.

4.2 Action/enforcement taken following the most recent care inspection dated 13 September 2017

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 13 September 2017.

5.0 How we inspect

Prior to the inspections a range of information relevant to the service was reviewed. This included the following records:

- unannounced care inspection report dated 13 September 2017
- incident notifications which evidenced that three incidents had been notified to RQIA since the last care inspection on 13 September 2017
- written and verbal communications received since the last care inspection on 13 September 2017

As part of the inspection process the User Consultation Officer (UCO) spoke with three service users and four relatives, by telephone, on 7 and 8 June 2018 to obtain their views of the service. The service users and relatives spoken with informed the UCO that they received assistance with the following:

- management of medication
- personal care
- meals
- sitting service

During the inspection on the 11 June 2018 the inspector met with the manager, a member of the management team and, a director, the agency's service user monitoring officer and one staff member.

During this inspection the manager was asked to display a poster prominently within the agency's registered premises which invited staff to give their feedback to RQIA via electronic means regarding the quality of service provision. The manager reported that in addition to displaying the poster, a copy of the poster would be forwarded to all staff. No staff questionnaires were returned.

During the inspection on the 19 July 2018 the inspector met with the manager and a director.

The following records were examined across both inspections:

- Three service users' individual care records
- Eight staff individual personnel records
- A sample of induction records
- A sample of minutes of office staff meetings from 21 January 2018 to 29 May 2018
- A sample of minutes of care staff meetings from March 2018, April 2018 and May 2018
- A sample of incidents/complaints for April 2018 and May 2018
- A range of staff rotas
- Recruitment Policy
- Induction, Supervisions, Appraisals and Training Policy
- Complaints Policy
- Adult Safeguarding Policy
- Incidents Policy
- Whistleblowing Policy
- Staff handbook
- Service User Guide/ Service User Agreement
- Statement of Purpose May 2017

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met and not met.

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

The inspector would like to thank the manager, staff and service users for their support and co-operation during the inspection process.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 13 September 2017

The most recent inspection of the agency was an unannounced care inspection.

The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 13 September 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Minimum Standard 8.12. **Stated:** Second time	The registered manager is recommended to expand their annual quality review process to include staff and service commissioners' views.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and review of reports during the inspection confirmed that the monthly quality monitoring reports included evidence of staff and service commissioner engagement.	
Area for improvement 2 **Ref**: Standard 12.1 **Stated:** First time	Newly appointed staff are required to complete structured orientation and induction, having regard to the Northern Ireland Social Care Council (NISCC) Induction Standards for new workers in social care, to ensure they are competent to carry out the duties of their job in line with the agency's policies and procedure.	**Not met**
	Action taken as confirmed during the inspection: The agency provided evidence that they had a structured induction process including provision of a dedicated trainer employed by the agency with regard to NISCC induction standards for new workers in social care. However, discussions with the manager and a director confirmed that one staff member had not received an induction and there was not sufficient evidence to confirm that a number of staff had received their full induction. This area for improvement has not been met and has been stated for a second time.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to service users from the care, treatment and support that is intended to help them.

The UCO was advised by all of the service users and relatives spoken to that they had no concerns regarding the safety of care being provided by the agency. New carer workers had been introduced to the service users by a regular member of staff; this was considered to be important both in terms of service users' security and that the staff had knowledge of the assessed needs of service users.

No issues regarding care staff training was raised with the UCO by the service users or their relatives; examples of training provided to staff included: moving and handling, use of equipment and management of medication.

All of the service users and relatives spoken to confirmed that they could approach the care staff and office staff if they had any concerns. Examples of some of the comments made by service users or their relatives are listed below:

- "No complaints whatsoever."
- "Would be lost without them."
- "If it wasn't for the carers we wouldn't be able to stay in our home."

The inspector reviewed the agency's systems in place to avoid and prevent harm to service users; it included the review of staffing arrangements in place within the agency. Feedback from service users and relatives who spoke with the UCO; discussions with staff and review of agency rotas confirmed that the agency had appropriate staffing levels in various roles to meet the assessed needs of their service users.

The agency's recruitment policy outlines the process for ensuring that staff pre-employment checks are satisfactorily completed prior to commencement of employment. The inspector reviewed eight staff personnel records, which highlighted a lack of information as required by Regulation 13, Schedule 3, of the Domiciliary Care Agencies Regulations (Northern Ireland) 2007.

These related specifically to the requirement to obtain two written references, one from an applicant's current or most recent employer. The inspector referred the manager to recent communication issued by RQIA to providers on 22 March 2018 which provided guidance on the management of pre-employment references. The inspector advised that the agency also needs to improve their system to verify references received. Assurances were provided by the manager that reference requests are made directly from the agency to the referee. The inspector requested that evidence of this communication and verification of references needs to be maintained within recruitment records. This will be reviewed at future inspections.

The inspector identified variations in the recruitment records maintained; several records had a recruitment checklist which recorded a date of an initial interview with applicants prior to a formal interview being undertaken at a later date. There was no other record maintained of this initial interview. The manager advised that at the initial interview/meeting the applicant would be provided with information regarding the role and on occasions Access NI paperwork. The inspector advised that the agency's recruitment processes and records are reviewed to ensure, that an agreed process was in place for all applicants and that they were more robust, evidencing clearly the stages of recruitment and a record of an initial interview if undertaken.

In addition, the inspector identified that there was no written evidence to confirm that gaps in the employment history of applicants had been explored. It was also noted that one application form was not fully completed. The inspector advised the manager that the agency should review and update their interview process to ensure that these weaknesses are adequately addressed with immediate effect. An area for improvement has been made in regard to these deficits identified.

Furthermore, the inspector recommended that the agency update the eligibility questions which form part of their interview process in order to highlight whether applicants have been involved in disciplinary proceedings in previous employment.

A review of the agency's induction records and discussion with the manager and a director established that one staff member did not receive an induction and deficits were identified with respect to the induction records maintained for a number of other staff records viewed. The agency induction records require the trainer and staff member to sign the record to confirm specific training completed and competency achieved. The induction records maintained for two staff of the sample viewed were not signed by the staff member and were not as comprehensive as the induction records of other staff. In addition although the agency provided a range of dates on which two staff undertook shadowing of experienced staff prior to the commencement of their role, the inspector was unable to verify this during inspection.

The manager and a director acknowledged the deficits in the induction records for a number of staff. They provided assurances that there is an induction programme in place which meets the requirement for a minimum of three days induction. This was evidenced in the remainder of induction records viewed, which included evidence of training in a range of mandatory areas and shadowing agency staff. These records evidenced that the induction training provided a range of practical, interactive and written assessment methods. However the inspector stressed the need for consistency with recording. An area for improvement has been stated for a second time in this regard.

It was positive to note that the agency had a process in place in which they maintained weekly contact for a period of four weeks with newly appointed staff to confirm if they had any issues to raise. These included the need for further training, understanding of the whistleblowing policy, use of equipment, medication management, reporting change in service user's health, and understanding adult safeguarding issues. However it was identified during inspection that this process was not undertaken with all staff. The inspector also noted that on two occasions staff identified an issue which required follow up, the manager was unable to evidence during the inspection if these issues had been addressed. The inspector highlighted if a need is identified for additional support by staff, it is incumbent on the agency to ensure that this is addressed and actions taken are recorded. The inspector noted that staff signatures where not always recorded on the record of these contacts, the manager advised that this was due to some contacts being undertaken by telephone. The inspector recommended that this should be

reflected on the documentation and staff signature obtained at a later date, to reflect staff agreement with areas discussed and actions taken.

Assurances were further provided to the inspector that the agency has an in house training officer who provides mandatory training updates for care staff, in line with the legislation, minimum standards and good practice guidance. One staff member spoken with on the 11 June 2018 commented that "training is very thorough and the trainer is knowledgeable." The manager stated that the senior training officer maintains a record of all training completed and updates required for staff; this assists the agency in identifying training needs are being met. This information was not available during the inspection. An area for improvement was made in this regard.

The inspector discussed with the manager the benefits of developing a staff training matrix to assist them in providing evidence that all staff training updates have been completed as required and that updated training needs are being planned for.

The manager advised how they assisted new employees to register with NISCC. Assurances were provided that the agency has a process in place for monitoring the registration status of staff and for ensuring that staff will not be supplied for work if they are not appropriately registered. A staff member spoken with on the 11 June was able to describe the registration process with NISCC and the ongoing duties that are expected of all NISCC registrants.

The inspector reviewed the agency's provision for the welfare, care and protection of service users. It was identified that the agency has updated its policy and procedures to reflect information contained within the Department of Health's (DOH) regional policy 'Adult Safeguarding Prevention to Protection in Partnership' July 2015 and its associated Operational Procedures September 2016. The policy outlines the procedure for staff in relation to reporting concerns. Discussion with the agency's Adult Safeguarding Champion (ASC) and manager demonstrated that they had the appropriate knowledge as to how to address matters if and when they arose, to ensure the safety and wellbeing of service users and support appropriate protection planning and investigation.

The agency's whistleblowing policy and procedure was reviewed and found to be satisfactory. The staff member spoken with on the 11 June 2018 confidently described how to escalate any concerns regarding the wellbeing of a service user or the practice of a colleague. The staff member described that open communication with the office staff promoted a timely and effective response and that staff could access support out of hours.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to adult safeguarding.

Areas for improvement

Three areas for improvement were made in regards to recruitment information held by the agency, staff induction and staff training.

	Regulations	Standards
Total number of areas for improvement	2	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The UCO was informed by the service users and relatives spoken with that they had no concerns regarding the carers' timekeeping or that care had been rushed. The service users and relatives spoken to also advised that they had not experienced any missed calls from the agency. Service users were introduced to new carer workers by a regular carer.

No issues regarding communication between the service users, relatives and staff from the agency were raised with the UCO. The majority of the service users and relatives spoken to where able to confirm that home visits or phone calls have taken place to obtain their views on the service or that they had received a questionnaire.

Examples of some of the comments made by service users or their relatives are listed below:

- "I raised an issue with the manager. It was handled well."
- "… can depend on them. They never miss us."
- "Very happy with the service."

Review of service users' records evidenced that these included referral information received from the appropriate referring professionals and information regarding service users and/or their representatives. The referral information detailed the services being commissioned and included relevant assessments and risk assessments, as necessary.

The agency provides recording sheets in each service user's home file on which care staff record details of their visits. These records are reported to be collected routinely every four weeks from service users' homes. Two staff were noted to have specific roles for auditing the daily observation record sheets. The inspector reviewed three such completed records during the inspection and found good standards of recording. Audits were noted to be undertaken with respect to the appropriateness of records and actual call times measured against allocated times. The manager advised that ongoing discrepancies would then be discussed in consultation with the South Health and Social Care Trust (SHSCT) keyworker.

The inspector noted that there were arrangements in place within the agency to monitor, audit and review the effectiveness and quality of care delivered to service users.

Staff spoken with on the day of inspection confirmed that ongoing quality monitoring of services received by service users and staff practice, was completed to ensure effective service delivery. The service user quality monitoring officer described that three monthly monitoring visits were undertaken with service users. Service users were asked for feedback with respect to record keeping, quality of care, tasks carried out in line with the care plan, behaviour of staff with respect to ensuring that service users were treated with dignity and respect and that confidentiality was maintained. A sample of these records signed by service users was viewed and feedback noted to be positive. In addition, monthly monitoring calls were completed by the responsible person to service users and/or their relatives. A sample of records for May 2018 were reviewed and feedback was noted to be positive. The inspector recommended that the template for recording monthly monitoring telephone contacts should be updated to ensure the time of the call was recorded and were applicable, the name of the relative who was spoken with on behalf of the service user. The quality monitoring arrangements completed by the

agency on an ongoing basis evidenced that service users and/or their representatives' views were obtained and where appropriate, influenced changes made to the service provided.

Discussions with a director of the agency and review of the organisational structure confirmed that the agency had two staff monitoring officers who undertake review of rotas and staff spot checks, typically every three months or more, if required. The manager stated that on occasions, these spot checks were reported to have resulted in additional training being provided to care staff. The staff member spoken with on 11 June 2018 confirmed that such monitoring arrangements were taking place.

The staff member spoken with on the 11 June 2018 confirmed that they were provided with details of the care planned for each new service user and were kept informed of any changes to existing service users' care plans. However, review of a sample of records identified that agency care plans were not signed by service users and/or their relatives. It was agreed that the agency care plan template should be amended to ensure that such a signature is obtained in order to promote a collaborative approach with all service users. One record viewed, identified that an updated referral from the SHCST, which highlighted a change to a service user's assessed needs and care provision was not reflected in the agency's care plan. The manager agreed to ensure this record was updated. In addition, the inspector recommended that all care plan and risk assessment records should accurately reflect the full date on which the documents were completed rather than just the month. An area for improvement was made in regards to these shortfalls.

It was positive to note that the agency records evidenced the date of an annual review of service users' risk assessments. However, the document needs to be improved to reflect the name and role of the person who reviewed the risk assessment.

It was further noted that service users' records did not include minutes of annual care reviews which had been carried out by SHSCT representatives with service users. The manager and a director advised that while the agency staff were invited to and attended SHSCT reviews, they did not make a record of the review or receive minutes of the review. It was agreed with the manager that the agency request a copy of SHSCT reviews as appropriate and ensure they maintain a record of the review meeting, including any agreed outcomes and actions required. An area for improvement was made in this regard.

The inspector noted that service user information was retained within a number of locations/files. The inspector recommended that all individual service user information was streamlined into one file to include: the referral information, care plan, risk assessments, quality monitoring, and communications with SHSCT staff.

Examination of documentation and discussion with staff indicated that the agency promotes good working relationships with a range of appropriate professionals, when relevant.

Service users are provided with contact details of agency office staff and the on call service on commencement of the service. It was evident that the agency then maintained a range of methods to communicate with and record the comments of service users; through monthly monitoring telephone calls, regular monitoring visits and annual satisfaction surveys.

The manager advised that staff meetings are held six weekly with office staff and that team meetings with care staff are held in three different geographical areas, typically every three months. On the day of inspection, team meeting records were only available for recent

meetings as the manager advised that previous minutes had been archived. A review of records reflected information sharing and feedback from care staff. The inspector recommended that the system for recording and sharing the minutes of staff meetings should be reviewed to ensure that the minutes also reflect agreed outcomes, actions required by whom and applicable timescales, In addition, the minutes of team meetings should be shared with all staff including those not in attendance.

The staff member who spoke with the inspector on 11 June 2018 indicated that office and management staff were supportive and communication was good.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication between service users and agency staff and other key stakeholders.

Areas for improvement

Two areas for improvement were identified in relation to service users' care plans/ risk assessments and records of annual reviews.

	Regulations	Standards
Total number of areas for improvement	0	2

6.6 Is care compassionate?

Service users are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

All of the service users and relatives spoken to by the UCO felt that care was compassionate. They advised that carers treat them with dignity and respect, and that care had not been provided in a rushed manner. Service users also confirmed, as appropriate, that they are given their choice in regards to meals and personal care.

Views of service users and relatives have been sought through home visits, phone calls and questionnaires to ensure satisfaction with the care that has been provided by the agency. Examples of some of the comments made by service users or their relatives are listed below:

- "I was very anxious at the start but the carer put me at ease."
- "Very fond of them."
- "Lovely girls."

Discussions with staff during inspections provided confirmation that values such as choice, dignity and respect were embedded into the culture of the organisation. The importance of service user confidentiality was a focus within the staff induction training and in addition information relating to confidentiality was contained in the agency's staff handbook. Information received by RQIA post inspection raised concerns regarding a potential breach of confidentiality. This was subsequently discussed with a director of the agency who provided assurances that the agency had reviewed their processes to reduce risk of potential breach of confidentiality.

There were a range of systems in place to promote effective engagement with service users in conjunction with the SHSCT community keyworker; they included the agency's monthly quality monitoring process; compliments and complaints process; and monitoring visits.

During the inspection the inspector noted examples of how service user choice was being upheld by agency staff. The Service User Guide details the agency's Charter of Rights for service users which states that the agency "will not allow service users to be subjected to discrimination for any reason and expects that all service uses will be treated equally and fairly…"

It was positive to note a letter had been received by the agency from the Western Health and Social Care Trust (WHSCT) Contracts Department thanking the agency for the "excellent service" they had provided.

Areas of good practice

There were examples of good practice identified in relation to the agency's processes for engaging with service users and effective communication.

Areas for improvement

No areas for improvement were identified in this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

All of the service users and relatives spoken with confirmed that they are aware of whom they should contact if they have any concerns regarding the service. No concerns regarding the management of the agency were raised during the interviews.

During the inspections the RQIA registration certificate was up to date and displayed appropriately.

Discussion with the manager and staff evidenced that there was a clear organisational structure within the agency and a copy of the organisational structure was provided to the inspector. Staff could describe their roles and responsibilities and where clear regarding their reporting responsibilities in line with the agency procedures. However, review of the Statement of Purpose highlighted that it did not include the organisational structure of the agency. The inspector advised that the Statement of Purpose should be updated to include this information.

The process for registration of the current manager with RQIA was also discussed. The manager stated that it was her intention to withdraw her current application with RQIA as another member of the agency's management team intended to apply for this position. The need to keep RQIA informed of all such changes in keeping with regulatory requirements was highlighted.

The agency was noted to have a range policies and procedures in paper format which were contained within the agency's office. A sample of policies and procedures viewed were noted to have been reviewed and updated in accordance with timescales outlined within the relevant minimum standards. The manager confirmed that staff are made aware of the agency's policies and procedures and the process for accessing them during their induction and these are also referred to in the staff handbook. The staff member spoken with on 11 June 2018 confirmed that they were aware of how to access policies and procedures as needed in the office.

Discussion with the manager and a director regarding the introduction of the General Data Protection Regulation (GDPR) identified that the agency is in the process of reviewing their systems to ensure ongoing compliance. The inspector recommended that the agency review guidance provided on the RQIA website and also maintain liaison with SHSCT regarding their GDPR responsibilities, as appropriate.

The agency's procedures for auditing and reviewing information with the aim of promoting safety and improving the quality of life for service users were reviewed. Records viewed and discussions with the staff indicated that the agency's governance arrangements promote the identification and management of risk; these include: provision of required policies, monthly audit of complaints, accidents/incidents, and safeguarding referrals by the registered person.

A review of the reports for three monthly monitoring visits and monthly monitoring telephone calls evidenced that service user or relative feedback confirmed that they were aware of whom they should contact if they had any concerns regarding the service.

The agency's complaints policy outlines the process for managing complaints. Discussions with the manager and the staff member spoken to on the 11 June 2018 indicated that they had a clear understanding of the actions required in the event of a complaint being received. It was noted that staff receive information in relation to managing complaints during their induction process.

Discussions with staff and review of the agency's complaints records confirmed that the agency had received a number of complaints since the previous inspection. A review of a sample of these complaints identified that the majority of these complaints were dealt with in conjunction with the SHSCT contracts department. The management team also described actions taken in response to incidents and complaints in order to identify trends and enhance service provision. A quality improvement form has been introduced by the agency to improve auditing arrangements of incidents and accidents.

Discussion with the manager confirmed that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

The staff member spoken with on 11 June 2018 indicated that they felt supported by the management team. They described a recent situation in which staff had requested additional training with respect to stoma care and this was provided the following day.

The staff member described quality monitoring, supervision, annual appraisal and training processes as supportive and informative in the context of providing quality care to service users. A review of the records for three staff evidenced that individual supervision was provided on a three monthly basis and that annual appraisals had been undertaken.

Monthly quality monitoring visit reports for the period September 2017 to April 2018 were available on the day of inspection. The report for May 2018 was provided to RQIA following inspection. A review of a number of these reports identified that they lacked sufficient detail in relation to the agency's consultation with service users, relatives, SHSCT representatives, and staff. The inspector discussed the rationale for ensuring that the number of service users and relatives' contacted is recorded, including the need for a process which makes comments traceable using an appropriate system of identification. In addition, the inspector advised that the review of incidents/complaints should be detailed in three geographical areas as per service delivery, for the purpose of monitoring any trends and facilitating action if needed. Incidents which result in a complaint or contracts compliance with SHSCT should be cross referenced within the report. The May 2018 report did not reflect a record of an accident involving a service user fall which the inspector noted in the agency's records. An area for improvement was made in regards to these shortfalls.

The inspector discussed arrangements in place that relate to the equality of opportunity for service users and the importance of the staff being aware of equality legislation whilst recognising and responding to the diverse needs of service users. The manager confirmed that the agency had not received any complaints with respect to equality issues from service users and/or their representatives.

The inspector noted that the agency collects equality information in relation to service users, during the referral process. The manager advised that the agency does not seek any further equality information from the service users other than that provided by the commissioning HSCT. The data provided by the SHSCT is used effectively and with individual service user involvement when a person centred care plan is developed.

Some of the areas of equality awareness identified during the inspection include:

- effective communication
- service user involvement
- adult Safeguarding
- advocacy
- equity of care and support
- individualised person centred care
- individualised risk assessment
- disability awareness

Areas of good practice

There were examples of good practice found throughout the inspection in relation to management of complaints and incidents and maintaining good working relationships.

Areas for improvement

An area for improvement was identified in regards to the information detailed in monthly quality monitoring reports.

	Regulations	Standards
Total number of areas for improvement	1	0

7.0 Quality improvement plan

Areas for improvement identified during the inspections are detailed in the QIP. Details of the QIP were discussed with the manager and a director, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP 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 the agency. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 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/or the Domiciliary Care Agencies Minimum Standards, 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007	
Area for improvement 1 **Ref**: Regulation 13 (d) Schedule 3 **Stated**: First time **To be completed by**: With immediate effect	The registered person shall ensure that no domiciliary care worker is supplied by the agency unless— (d) full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 3. Ref:6.4
	Response by registered person detailing the actions taken: Enable Care Services have now introduced an easy read ticklist page for induction training and the recruitment process. One copy remains in the staff member's training file and another in staff recruitment file. No domiciliary care worker commences employment until this full recruitment tick list is complete and cleared by the registered manager.
Area for improvement 2 **Ref**: Regulation 21(1)(c) Schedule 4 **Stated**: First time **To be completed by**: With immediate effect	The registered person shall ensure that the records specified in Schedule 4 are maintained, and that they are— (c) at all times available for inspection at the agency premises by any person authorised by the Regulation and Improvement Authority. This relates specifically to the information formulated and retained by the senior training officer in relation to staff training. Ref:6.4
	Response by registered person detailing the actions taken: All training records will be backed up on a pen drive which will be retained in the office for further inspections. A back up copy of the training records are updated on a weekly basis and will be available.
Area for improvement 3 **Ref:** Regulation 23 (1)(2)(3)(4)(5) **Stated**: First time **To be completed by**: With immediate effect	**(**1) The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided. (2) At the request of the Regulation and Improvement Authority, the registered person shall supply to it a report, based upon the system referred to in paragraph (1), which describes the extent to which, in the reasonable opinion of the registered person, the agency—(a) arranges the provision of good quality services for service users; (b) takes the views of service users and their representatives into account in deciding— (i) what services to offer to them, and (ii) the manner in which such services are to be provided; and (c) has responded to recommendations made or requirements imposed by the Regulation and Improvement Authority in relation to

	the agency over the period specified in the request. (3) The report referred to in paragraph (2) shall be supplied to the Regulation and Improvement Authority within one month of the receipt by the agency of the request referred to in that paragraph, and in the form and manner required by the Regulation and Improvement Authority. (4) The report shall also contain details of the measures that the registered person considers it necessary to take in order to improve the quality and delivery of the services which the agency arranges to be provided. (5) The system referred to in paragraph (1) shall provide for consultation with service users and their representatives. Ref: 6.7
	Response by registered person detailing the actions taken: All incidents and findings will be recorded within our monthly reviews to establish patterns or trends that may be highlighted and possibly developing. This will help sustain good practice and governance as part of our overall monitoring that will enable a complete picture of our overall status.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011	
Area for improvement 1 **Ref**: Standard 12.1 **Stated**: Second time **To be completed by**: With immediate effect	Newly appointed staff are required to complete structured orientation and induction, having regard to the Northern Ireland Social Care Council (NISCC) Induction Standards for new workers in social care, to ensure they are competent to carry out the duties of their job in line with the agency's policies and procedure. Ref: 6.4
	Response by registered person detailing the actions taken: All newly appointed staff with Enable Care Services are completing induction training in line with NISCC standards and part of their recruitment process. All evidence will be shown in their training file and staff recruitment file.
Area for improvement 2 **Ref**: Standard 10.4 **Stated**: First time **To be completed by**: With immediate effect	The registered person shall ensure that information held on record is accurate, up to date and necessary. This includes, but is not limited to: • all required signatures within records of induction. • all required signatures are recorded on service users' care plans, (where the service user is unable or chooses not to sign this is recorded), • full date is recorded on care plans and risk assessments evidencing when they were completed, reviewed and by whom, • ensuring care plans are amended to reflect changes in commissioned services and the assessed needs of service users.

	Ref: 6.5
	Response by registered person detailing the actions taken: All induction training paperwork will be signed by all staff and an attendance sheet is signed on the day of training as evidence of attendance. Any updates or changes to service users careplan or risk assessment will be updated, signed and updated by person completing the same said change. A signature of the service user will be received on the careplan (if able). If the service user (or NOK) is unable to sign or chooses not to sign, this will be recorded.
Area for improvement 3 **Ref**: Standard 6.1 **Stated**: First time **To be completed by**: With immediate effect	The agency participates in review meetings organised by the referring HSC Trust responsible for the service user's care plan. This relates to the minutes of all such reviews being sought from relevant HSCT bodies and retained by the agency. Ref: 6.5
	Response by registered person detailing the actions taken: Any review meetings that are held with regards service users, we take minutes when appropriate for our part of the care package involved. Social Workers also would forward to us their minutes for our attention and agreement.

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

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