The Regulation and Quality Improvement Authority

Inspection Report

14 September 2021

Potens Domiciliary Care Agency

Type of service: Domiciliary Care Agency
Address: 8a Creamery Road, Main Street, Derrygonnelly, BT93 7FZ
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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: Potensial Ltd **Responsible Individual:** Miss Nicki Stadames	**Registered Manager:** Mr Mike Barton (Acting) **Date registered:** Not Applicable
Person in charge at the time of inspection: Deputy Manager	
Brief description of the accommodation/how the service operates: Potens Domiciliary Care Agency provides care and support to service users who have a learning difficulty. Service users are living in their own homes or with their families in County Fermanagh and Derry/Londonderry localities.	

2.0 Inspection summary

An announced care inspection was undertaken on 14 September 2021 between 10.25 a.m. and 2:10 p.m.

This inspection focused on staff registrations with the Northern Ireland Social Care Council (NISCC), adult safeguarding, notifications, complaints and whistleblowing, Deprivation of #Liberty Safeguards (DoLS), restrictive practice, dysphagia arrangements, monthly quality monitoring and Covid-19 guidance.

There were no areas for improvement identified during this inspection.

Good practice was identified in relation to staff training, staff recruitment and the monitoring of staffs' registrations with the NISCC. Good practice was also 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.

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

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the service was 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 the Quality Improvement Plan (QIP) any written and verbal communication received since the previous care inspection.

The inspection focused on:

- meeting with the service users and staff to obtain their views of the service
- reviewing a range of relevant documents, policies and procedures relating to the agency's governance and management arrangements.

Eight areas for improvement identified at the previous inspection were reviewed and assessment of compliance recorded as met.

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

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

4.0 What people told us about the service

No questionnaires or electronic feedback was received prior to the issue of the report.

The inspector spoke with three staff. Service users were afforded the opportunity to meet with the care inspector however, they declined.

Staff comments:

- "I am well supported in my role."
- "Spot checks are unannounced and this includes checking to see if we are wearing our PPE."
- "There is always a manager available and there is an on call rota in place."
- "Very good training provided and I've done all the mandatory training including IPC and Covid-19 awareness training."
- "I got a good induction and was well supported into my new role."
- "We have regular team meetings and there is good communication in the service."
- "I think service users are very well supported and care and support is person centred."

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 Potens Domiciliary Care Agency was undertaken on 22 and 27 April and 17 May 2021 inspector; eight areas for improvement were identified. 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 22 and 27 April and 17 May 2021		
Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 22 (6)(7) **Stated**: First time **To be completed by**: Immediate and ongoing from the date of inspection	The registered person shall ensure that every complaint made under the complaints procedure is fully investigated. The registered person shall, within the period of 28 days beginning on and including the date on which the complaint is made, or such shorter period as may be reasonable in the circumstances, inform the person who made the complaint of the action (if any) that is to be taken in response.	**Met**
	Action taken as confirmed during the inspection: The returned quality improvement plan and discussion with the deputy manager confirmed that this area for improvement had been addressed. A review of the complaints record evidenced that this area for improvement had been addressed. Complaints had been managed in accordance with the agency's policy and procedures.	
Area for improvement 2 **Ref**: Regulation 15 (2)(a)(b)(c)(3)(a)(b)(c) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall, after consultation with the service user, or if consultation with the service user is not practicable, after consultation with the service user's representative, prepare or ensure that a written plan ("the service user plan") is prepared which shall— (a) be consistent with any plan for the care of the service user prepared by any Health and Social Services Trust or Health and Social Services Board or other person with responsibility for	**Met**

	commissioning personal social services for service users; (b) specify the service user's needs in respect of which prescribed services are to be provided; (c) specify how those needs are to be met by the provision of prescribed services. (3) The registered person shall— (a) make the service user's plan available to: (i) the service user; (ii) any representative of a service user who was consulted on its preparation or revision; (b) keep the service user plan under review; (c) where appropriate, and after consultation with the service user, or if consultation with the service user is not practicable, after consultation with the service user's representative, revise the service user plan.	
	Action taken as confirmed during the inspection: The returned quality improvement plan and discussion with the deputy manager confirmed that this area for improvement had been addressed. A review of two care records evidenced that this area for improvement had been addressed. Care records reviewed were of a good standard.	
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 8.15 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that monies withdrawn by a member of staff to undertake transactions on behalf of service users are recorded. Any remaining monies returned from the transactions should be recorded separately.	**Met**
	Action taken as confirmed during the inspection: The returned quality improvement plan and discussion with the deputy manager confirmed that this area for improvement had been addressed. A review of financial records evidenced that this area for improvement had been addressed.	

Area for improvement 2 **Ref**: Standard 8.15 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection First time	The registered person shall ensure that any errors recorded in the service users' transaction sheets are dealt with appropriately, such as a clear line crossed through the incorrect entry with an amendment on the line below. All amendments should be initialled by the member of staff recording the entry.	**Met**
	Action taken as confirmed during the inspection: The returned quality improvement plan and discussion with the deputy manager confirmed that this area for improvement had been addressed. A review of financial records evidenced that this area for improvement had been addressed.	
Area for improvement 3 **Ref**: Standard 8.10 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that working practices are systematically audited to ensure that they are consistent with the agency's documented policies and procedures. This refers specifically to the auditing of daily log records returned from service users' homes.	**Met**
	Action taken as confirmed during the inspection: The returned quality improvement plan and discussion with the deputy manager confirmed that this area for improvement had been addressed. A review of audit records confirmed that a robust system had been implemented regarding the auditing of daily log records returned from service users' homes.	
Area for improvement 4 **Ref**: Standard 8.10 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that spot checks completed for staff working in the in the conventional part of the service, are undertaken in line with the organisation's policies and procedures.	**Met**
	Action taken as confirmed during the inspection: The returned quality improvement plan and discussion with the deputy manager confirmed that this area for improvement had been addressed. A review of spot records evidenced that this area for improvement had been addressed.	

Area for improvement 5 **Ref**: Standard 5.2 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that the record maintained in the service user's home details (where applicable): • the date and arrival and departure times of every visit by agency staff; • actions or practice as specified in the care plan; • changes in the service user's needs, usual behaviour or routine and action taken; • unusual or changed circumstances that affect the service user; • contact between the care or support worker and primary health and social care services regarding the service user; • contact with the service user's representative or main carer about matters or concerns regarding the health and well-being of the service user; • requests made for assistance over and above that agreed in the care plan; and • incidents, accidents or near misses occurring and action taken.	**Met**
	Action taken as confirmed during the inspection: The returned quality improvement plan and discussion with the deputy manager confirmed that this area for improvement had been addressed. A review of two care records evidenced that this area for improvement had been addressed.	
Area for improvement 6 **Ref**: Standard 8.10 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that working practices are systematically audited to ensure that they are consistent with the agency's documented policies and procedures. This refers specifically to the management of staff duty rosters and the management of staff leave.	**Met**
	Action taken as confirmed during the inspection: The returned quality improvement plan and discussion with the deputy manager confirmed that this area for improvement had been addressed. A review of staff duty rotas evidenced that a robust system had been implemented in regards to the management of staff duty rosters and the management of staff leave.	

5.2 Inspection findings

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

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

Discussions with the deputy manager demonstrated that they were knowledgeable in matters relating to adult safeguarding and the process for reporting adult safeguarding concerns. Staff could describe the process for reporting concerns including out of hours arrangements.
It was confirmed that staff are required to complete adult safeguarding training during their induction programme and required updates thereafter.

Staff indicated that they had a clear understanding of their responsibility in identifying and reporting any actual or suspected incidents 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 in relation to adult safeguarding matters. Records viewed and discussions with the deputy manager indicated that one referral had been made since the last inspection with regard to adult safeguarding. It was noted that the referral had been managed appropriately. Adult safeguarding matters are reviewed as part of the monthly quality monitoring process.

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.

It was noted that staff have completed relevant DoLS training appropriate to their job roles. Those spoken with demonstrated that they have an understanding that people who lack capacity
to make decisions about aspects of their care and treatment have rights as outlined in the Mental Capacity Act. The deputy manager confirmed that no restrictive practices were used in the agency.

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

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 deputy manager advised us that there were no care partners visiting service users during the Covid-19 pandemic restrictions. It was positive to note that a number of service users had regular contact with family and friends.

5.2.3 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 direct engagement with service users. Records viewed evidenced that criminal record checks (AccessNI) had been completed for staff.
A review of records confirmed all staff working in the agency were registered with NISCC. Information regarding registration details and renewal dates was monitored by the deputy manager; this system was reviewed and found to be in compliance with regulations and minimum standards. The deputy manager confirmed that all staff were aware that they were not permitted to work if their professional registration was to lapse.

Discussion with staff confirmed that they were registered with NISCC. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

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. Quality monitoring visits had been undertaken by a monitoring officer. A sample of reports viewed provided evidence that the monitoring process included engagement with service users, service users' representatives and staff, also that the conduct of the agency was examined and that action plans for improvement were developed, if necessary.

There was a process for recording complaints in accordance with the agency's policy and procedures. The deputy manager confirmed that one complaint was received since the date of the last inspection. It was noted that complaints had been managed in accordance with the agency's policy and procedures.

Discussion with staff confirmed that they knew how to receive and deal with complaints and ensure that the manager or deputy manager was made aware of any complaints.

Discussions with staff evidenced that they were knowledgeable regarding service users' individual needs. Staff also demonstrated awareness of the need for person-centred interventions which facilitate engagement with service users and promote effective communication and social engagement.

Discussions with the deputy manager and staff described positive working relationships in which issues and concerns could be freely discussed; staff reported they were confident that they would be listened to. In addition, staff confirmed that they felt supported by management.

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

It was established during discussions with the deputy manager that the agency had not been involved in any Serious Adverse Incidents (SAIs)/Significant Event Analyses (SEAs) or Early Alerts (EAs).

5.2.5 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 deputy manager and staff confirmed that no service users require assessment by the SALT in relation to dysphagia needs. The deputy manager advised that he was aware of the SALT referral process if a service user presented with eating, drinking or swallowing difficulties.

It was positive to note that all staff had attended dysphagia awareness training.

6.0 Conclusion

Based on the inspection findings and discussions held with the deputy manager and staff, RQIA was satisfied that this service was providing safe and effective care in a caring and compassionate manner; and that the service was well led by the manager.

There were no areas for improvement identified during this inspection.

The inspector would like to thank the deputy manager and staff for their support and co-operation throughout the inspection process.

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 deputy manager, as part of the inspection process and can be found in the main body of the report.

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