Inspection Report
22 and 27 April and 17 May 2021

Potens Domiciliary Care Agency

Type of Service: Domiciliary Care Agency
Address: 8a Creamery Road, Main Street, Derrygonnelly, BT93 7FZ
Tel No: 028 6864 1857

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 provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

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. A team of staff provide the care to seven service users living in two houses in Derrygonnelly and one service user in Derry/Londonderry, where staff members support service users 24 hours per day.

3.0 Service details

Organisation/Registered Provider: Potensial Ltd **Responsible Individual:** Mrs Nicki Stadames	**Registered Manager:** Mr Mike Barton (Acting)
Person in charge at the time of inspection: 22 April 2021 Deputy Manager 27 April 2021 Mr Mike Barton, Manager (Acting) 17 May 2021 Deputy Manager	**Date manager registered:** No application required

4.0 Inspection summary

An unannounced care inspection took place on 22 April 2021 from 10.25 to 15.50 hours and 27 April 2021 09.45 to 13.35 hours.

In addition an announced finance inspection took place on 17 May 2021 from 10:45 to 15:45 hours. Short notice of the finance inspection was provided to the manager in order to ensure that arrangements could be made to facilitate the inspection.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to continue to respond to ongoing areas of risk identified in services.

Information received by the Regulation and Quality Improvement Authority (RQIA) prior to this inspection raised concerns in relation to a number of matters relating to Potens Domiciliary Care Agency. The information received related specifically to the management of complaints and the governance and management arrangements.

It is not the remit of RQIA to investigate whistleblowing concerns made by or on behalf of individuals, as this is the responsibility of the registered providers and the commissioners of care. However, where RQIA is notified of a potential breach of regulations or minimum standards, it will review the matter and take the appropriate action as required; this may include an inspection of the agency.

Following an assessment of information held by RQIA relating to the service and in light of the concerns raised, an inspection was undertaken on 22 and 27 April 2021 to examine the agency's current compliance with The Domiciliary Care Agencies regulations and standards. Due to the potential impact on service users, a decision was made to undertake an on-site inspection adhering to social distancing guidance.

The inspection findings did substantiate a number of the concerns raised within the information shared with RQIA. This included the management of complaints and the governance and management arrangements.

In accordance with RQIA's Enforcement Policy and Procedures, RQIA wrote to the registered person to advise of the concerns. On 24 May 2021 RQIA held a serious concerns meeting, via teleconferencing facilities, with the responsible person, the regional manager and the manager

to discuss the inspection findings. Given the assurances provided in this meeting, RQIA were assured that no further action was required at this time. A Quality Improvement Plan (QIP) has been issued, to address the concerns and those actions required by the agency.

Areas of good practice were identified in relation to staff training, consultation with service users, audit arrangements, incident management, infection prevention and control measures, retaining appropriate records confirming corporate appointee for service users and undertaking finance audits of service users' monies on a quarterly basis.

Eight areas requiring improvement were identified in relation to the management of complaints, the management of care and support plans, auditing of returned daily logs, completion of daily logs including recording of communications with service users' representatives and Health and Social Care (HSC) professionals, spot checks in the conventional service and the management of staff duty rosters and staff leave. Two matters in relation to recording transactions on behalf of service users were also identified.

Those consulted with spoke positively in relation to the care and support provided.

This inspection was underpinned by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Domiciliary Care Agencies Regulations (Northern Ireland) 2007 and the Domiciliary Care Agencies Minimum Standards, 2011.

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	2	6

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mr Mike Barton, Manager and the Deputy Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection dated 22 January and 12 February 2021

No further actions were required to be taken following the most recent inspection on 22 January and 12 February 2021.

5.0 How we inspect

Prior to inspection we reviewed the information held by RQIA about this agency. This included the previous inspection report notifiable events, and any written and verbal communication received since the previous care inspection.

Following our inspection we focused on contacting the service users' representatives, staff and HSC professionals to obtain their views on the service. We spoke with one service user's representative and four staff. We also obtained the views of seven HSC professionals.

During the inspection we reviewed records relating to:

- Quality monitoring reports
- Records relating to adult safeguarding incidents
- Complaints records
- Care records
- Accident/Incident records
- Spot check records
- Staff duty rosters
- Governance and management arrangements
- The management of complaints
- Service users' financial records.

RQIA provided information to service users, staff and other stakeholders to support feedback on the quality of service delivery. This included "Tell Us" cards, service user's/relative questionnaires and a staff poster to enable the stakeholders to feedback to the RQIA. No responses were received.

We would like to thank the manager, deputy manager, HSC professionals, service users, the service user's representative and staff for their support and co-operation throughout the inspection process.

6.0 The inspection

There were no areas for improvement made as a result of the last care inspection.

6.1 Inspection findings

6.1.1 What people told us about this agency

During the inspection we spoke with the manager and the deputy manager. Service users were afforded the opportunity to meet with the care inspector however, they declined.

Prior to the inspection we provided a number of easy read questionnaires for those supported to comment on the service quality. Returned questionnaires show that those supported thought care and support was either excellent or good.

We also spoke with a service user's representative and four staff post inspection and obtained views from HSC professionals. All those spoken with indicated that that they were happy with the care and support provided by the agency. Comments are detailed below:

Comments from staff included:

- "There is good communication in the service and you also get a handover when you come on shift."

- "I got a very good induction into the service and spent several days shadowing staff to I felt comfortable in my role."
- "I have regular supervision and an annual appraisal. I have supervision planned for this Friday."
- "There is always a manager on call if you have any issues and contact details are available."
- "I feel care and support is good here."
- "I undertook lots of training such as infection prevention and control, Covid-19, fire safety and lots more."
- "Lots of PPE and hand sanitiser available and we do lots of extra cleaning that is recorded."
- "I have access to all service users' care plans and risk assessments. We write up our daily records noting any changes or things of importance regarding the service user."

Comments from service users' included:

- "I am happy with the care and support I'm receiving."
- "I feel happy that we are getting on well."

Comments from a service user's representative included:

- "XXXX is happy living in the setting and anytime I talk to XXXX they seem to be happy and content."
- "The staff are good to XXXX and help them with day to day things."
- "I think XXXX is well looked after and enjoys living in the setting."

Comments from HSC professionals included:

- "Our senior social worker has worked closely with Potens DCA regarding a client they support and we have had positive outcomes."
- "Satisfied with service delivery."
- "We have had a recent contract meeting with the agency and we had no concerns, positive views."
- "My client has stated that the supported living accommodation is their home."

6.1.2 Governance and management arrangements

On the day of the inspection it was noted that a number of incidents had taken place since the previous inspection. Review of records found that the agency had dealt with the incidents in accordance with the required regulations and their own policy and procedure.

We discussed the monitoring arrangements in compliance with Regulation 23 of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007. Quality monitoring visits had been undertaken monthly by a senior manager. A sample of reports viewed for January to March 2021 provided evidence that the monitoring process included engagement with service users, service users' representatives and staff; and the review on the conduct of the agency and development of action points.

The agency maintains and implements a policy relating to complaints. On the day of the inspection it was noted that the agency had one complaint since the last inspection. Review of the records identified that the complainant had contacted the agency on 11 February 2021 to raise his complaint with the Manager. A record of the complaint was not made until 19 February 2021 and a letter of acknowledgment had not been forwarded to the complainant until 18 February 2021. The elements of the complaint were not accurately recorded in the record of

complaint or the acknowledgment letter. This matter was brought to the attention of the manager by the complainant on 23 February 2021, via email. A response was not provided to the complainant within the 28 day timeframe nor was an extension letter to the 28 day timeframe issued. It was identified that the complaint had not been managed in accordance with Regulation 22 of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007. An area for improvement has been made in this regard.

Review of staff duty rosters identified on a small number of occasions care staff had not been rostered on duty to cover a commissioned care package. Review further identified that a robust system was not in place in relation to the management of annual leave. A period of two weeks leave for a staff member was approved by management however, management did not provide alternative cover arrangements and the care package was not delivered. An area for improvement has been made in this regard.

Review of the records of spot checks for staff working in the conventional service identified that spot checks were infrequent and had not been undertaken in accordance with the organisation's policies and procedures. An area for improvement has been made in this regard.

6.1.3 Care records

The inspector reviewed two service users' care records. It was noted that one service user's care record identified that the care and support plan was not completed in a timely manner. Review of records and discussion with the manager confirmed that a copy of the updated care and support plan had not been provided in the service user's home following review and update. An area for improvement has been made in this regard.

The inspector reviewed a number of returned daily logs. No evidence was available that returned daily logs were consistently audited. The system for auditing returned daily records was discussed with the manager and it was evident that a system needed to be formalised, to ensure that a record was maintained of the auditing process. An area for improvement has been made in this regard.

Review of a service user's daily logs evidenced that entries were not made on every visit by agency staff. On a number of occasions communications with a service user's representative and HSC professionals were not recorded. An area for improvement has been made in this regard.

Areas of good practice

Areas of good practice were identified in relation to staff training, consultation with service users, audit arrangements, incident management and infection prevention and control.

Areas for improvement

Six areas requiring improvement were identified in relation to the management of complaints, the management of care and support plans, auditing of returned daily logs, completion of daily logs including recording of communications with service users' representatives and HSC professionals, spot checks in the conventional service and the management of staff duty rosters and staff leave.

	Regulations	Standards
Total number of areas for improvement	2	4

6.1.4 Management of Service Users' Finances

Financial systems and controls in place at the agency regarding service users' monies were reviewed. These included the system for recording transactions undertaken on behalf of service users, recording the reconciliations of service users' monies, charging service users' for transport and the system for retaining service users' monies.

Discussion with staff confirmed that a corporate appointee was in place for five service users, namely an organisation authorised by the Department for Communities (DfC) to receive and manage the social security benefits on behalf of an individual. A sample of two service users' files evidenced that copies of written confirmation from DfC for the agency to act as corporate appointee were retained at the agency's head office.

Discussion with staff confirmed that no bank accounts were managed by the agency on behalf of service users; service users had bank accounts in their own names for which the agency provided support to the service users, such as escorting a service user to make a withdrawal.

A sample of three records of amounts lodged at the agency from bank withdrawals for one service user showed that receipts were retained from two of the withdrawals. The amounts on the receipts reflected the amounts recorded as lodged at the agency. The manager was advised to ensure that receipts are retained from all transactions (where possible). Where it is not possible to obtain a receipt the service users' records are annotated to reflect this.

Discussion with staff confirmed that a vehicle, owned by the agency, was available for service users to undertake journeys. The miles undertaken for the journeys were recorded and subsequently invoiced to the service users at an agreed rate per mile. A sample of transport invoices raised for one service user was reviewed; the miles invoiced to the service user reflected the information recorded within the agency's records.

A review of two service users' files showed that copies of written agreements between the service users' and the agency were retained. The agreements provided details of the terms and conditions in respect of the services provided to service users. Agreed budget plans for the service users were also retained as part of the written agreements.

A review of records and discussion with staff confirmed that individual transaction sheets were maintained for each service user. The sheets were used to record the details of transactions undertaken on behalf of service users, for example the purchase of items and the recording of monies retained at the agency on behalf of service users.

A review of records from purchases undertaken by members of staff on behalf of two service users showed that the details and the amount of the purchases were recorded. Two signatures were recorded against all of the transactions reviewed. Receipts from the purchases were retained at the time of the inspection. Good practice was observed in relation to the audit process as a number was recorded on the receipts and the corresponding number was recorded against the purchases in the service users' transaction sheets.

A review of the transaction sheets also showed that the amount of the items purchased was recorded rather than the actual amount withdrawn from service users' monies to make the purchases. The remaining monies returned from the purchases were not recorded. This was discussed with the manager and identified as an area for improvement.

A number of the recorded entries in the service users' transaction sheets had been written over with no explanation for the errors recorded. This was discussed with the manager and identified as an area for improvement.

No records were available of items held on behalf of service users for safekeeping such as bank cards; there were no details of when the items were withdrawn from and returned to the safe place. The manager presented a draft template during the inspection which was in the process of being implemented at the agency. The template addressed the areas for recording the withdrawal and return of the items. The manager contacted RQIA the day following the inspection to confirm that the template had been implemented. This procedure will be reviewed at the next RQIA inspection.

Good practice was observed as a comprehensive finance audit of service users' monies was undertaken by either the manager or deputy manager on a quarterly basis. A review of previous audit reports showed that any discrepancies found during the audits were immediately addressed by the agency, for example missing receipts from purchases.

It was noticed that housekeeping monies held separately for two service users to purchase food were not included as part of the quarterly audit. The manager explained that the procedure for purchasing groceries for the two service users had recently been reviewed and a decision was made to change the procedure in order to be in line with other service users. This will ensure that all monies held on behalf of service users will be included in the finance audits. This procedure will be reviewed at the next RQIA inspection.

Policies and procedures for the management and control of service users' finances were in place at the time of the inspection. A review of the policies evidenced that monies held on behalf of service users exceeded the maximum amount permitted under the policies. The manager advised that the policies had recently been revised to increase the maximum amount held by the agency on behalf of service users. The manager contacted RQIA following the inspection to confirm that the new policy had been implemented.

Areas of good practice

There were examples of good practice found in relation to retaining appropriate records, confirming corporate appointee for service users and undertaking finance audits of service users' monies on a quarterly basis.

Areas for improvement

Two areas for improvement were identified in relation to recording transactions on behalf of service users.

	Regulations	Standards
Total number of areas for improvement	0	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Mike Barton, manager and the deputy manager, 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 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 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. Ref: 6.1.2
	Response by registered person detailing the actions taken: a) Managers to follow policy of organisation in relation to Complaints Management. b) Concerns, Complaints, Compliments, Suggestions & Feedback policy updated and made NI Specific • If complaint about a manager – go ne next in line • Updated Policy has been distributed to PWS, Staff, Families and Professionals. • c) All Managers / Team Leads / SSW to read and sign Concerns, Compliments, Complaints, Suggestions & Feedback Policy as part of next supervisions session to ensure this has been understood. d) All complaints to be escalated to Area Manager for review to ensure process being followed. e) Lesson learning to be completed after each complaint to see what practice needs amending, what information to share and to strive to not repeat.
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 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; Ref: 6.1.3
	Response by registered person detailing the actions taken: a) All PWS Support Plans / Risk Assessments to be reviewed and updated, post any: • Change in need. • Medical advice • Incident / accident. • Care management review. b) All Support Plans should be written in first person and use language and terminology that will not cause offence to the PWS or reader c) Updated plans should be printed and shared with staff, social worker, families within 72 hours d) Updated plans to be added to PWS File at Registered Office and Home within 72 hrs e) All staff should read and sign to show they understand and are aware of any changes f) Review timeframe amended on all PWS Care Plans and RA's to 12 months Review sooner, post any: Change in need. • Medical advice • Incident / accident. • Care management review.

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011	
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. Ref: 6.1.4
	Response by registered person detailing the actions taken: Recording sheet introduced to record cash & cards taken out and returned, This is also checked during weekly and monthly finance Audits
Area for improvement 2 **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 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. Ref: 6.1.4
	Response by registered person detailing the actions taken: This has been raised with all staff and will be monitored through fiancé audits. Any issued will be highlighted and addressed individually.
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. Ref: 6.1.3
	Response by registered person detailing the actions taken: A robust system is in place to ensure timely collection and review of daily records. This is also reported on in managers monthly report and Area Manager Monthly Audit
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. Ref: 6.1.2
	Response by registered person detailing the actions taken: Spot checks for the conventional part of the service are back in line with organisational policy and procedure and are reviewed as part of managers monthly report and Area Manager Audit to ensure compliance.

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. Ref: 6.1.3
	Response by registered person detailing the actions taken: a) All PWS Support Plans / Risk Assessments to be reviewed and updated, post any: • Change in need. • Medical advice • Incident / accident. • Care management review. b) All Support Plans should be written in first person and use language and terminology that will not cause offence to the PWS or reader c) Updated plans should be printed and shared with staff, social worker, families within 72 hours d) Updated plans to be added to PWS File at Registered Office and Home within 72 hrs e) All staff should read and sign to show they understand and are aware of any changes f) Review timeframe amended on all PWS Care Plans and RA's to 12 months Review sooner, post any: • Change in need. • Medical advice • Incident / accident. • Care management review. Staff Rota would have start and end time for each staff member noted
Area for improvement 6 **Ref**: Standard 8.10 **Stated:** First time	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.

To be completed by: Immediate and ongoing from the date of inspection	This refers specifically to the management of staff duty rosters and the management of staff leave. Ref: 6.1.2
	Response by registered person detailing the actions taken: Duty Rota is maintained via CareSys electronic records system and an excel spreadsheet that has a separate tab per week. Rota is shared with each service in advance and reviewed each Monday to ensure any changes have been noted for accuracy. Annual leave is booked in accordance with policy and procedure. **a)** Rota management oversight required by NI DCA Manager to ensure commissioned hours are delivered: • Manager to create rota at least 4 weeks in advance and share with staff and families. • Copy to be kept on File and electronically. • Manager to sign printed copy b) Shortfalls in provision must be escalated to Area Manager / Social Worker and families at earliest opportunity to ensure pro-active communication and plan on resolution c) Rota to be reviewed against Weekly Exceptions Reports to ensure accuracy for invoicing purposes and escalate any issues to NI DCA Manager / Area Manager

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