The Regulation and Quality Improvement Authority

Inspection Report

11 November 2021

Slievegrane

Type of service: Domiciliary Care Agency
Address: 2A Ardglass Road, Downpatrick, BT30 6JG
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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: South Eastern HSC Trust **Responsible Individual:** Mr Seamus McGoran, acting	**Registered Manager:** Miss Abigail Gourley, registration pending **Date registered:** Application received 25 July 2021
Person in charge at the time of inspection: Miss Abigail Gourley	
Brief description of the accommodation/how the service operates: Slievegrane, is a domiciliary care agency supported living type located in Downpatrick. Agency staff provide care and support to service users living in shared accommodation and within the local community. The service users have a range of enduring mental health needs. The agency's aim is to provided care and support to service users; this includes assisting service users with personal care needs, meals, medication, housing support and assistance to access community services with the overall goal of promoting independence and maximizing the quality of life.	

2.0 Inspection summary

An announced inspection was undertaken on 11November 2021 between 10.00 am and 4.00pm by the care inspectors.

This inspection focused on staff recruitment, Northern Ireland Social Care Council (NISCC) registrations, adult safeguarding, incident reporting, complaints and whistleblowing. Other areas reviewed included Deprivation of Liberty Safeguards (DoLS) including money and valuables, restrictive practice, monthly quality monitoring and Covid-19 guidance.

Good practice was identified in relation to adult safeguarding, staff recruitment and the agency's system in place of disseminating Covid-19 related information to staff.

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.

The inspection focused on:

- contacting the service users, their relatives, HSC Trust representatives 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.

Information was provided to service users, staff and other stakeholders to request feedback on the quality of service provided and this included questionnaires. In addition, an electronic survey was provided to enable staff to feedback to the RQIA.

4.0 What people told us about the service

No questionnaires were returned prior to the issue of the report. No staff members responded to the electronic survey.

We consulted with two service users and three staff during the inspection process; comments received are detailed below.

Service user comments:

- "Very easy living here, I am very independent. You are your own person."
- "Staff get you involved in groups."
- "I don't have a lot of needs, I feel safe here. I could report if something wasn't right."
- "I do not really have concerns."
- "It's good, no complaints."
- "I have no concerns."
- "I could speak to staff, they listen to me."

Staff comments:

- "Service users managed very well over the last year, their mental health wasn't unduly impacted."
- "Management and staff work well together."
- "One hundred percent happy at work."

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 was undertaken on 22 October 2019 by a care inspector; no areas for improvement were identified. An inspection was not undertaken in the 2020-2021 inspection year due to the impact of the first surge of Covid-19.

5.2 Inspection findings

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

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

Discussions with the manager and staff 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 identified 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. It was noted that a number of referrals had been made with regard to adult safeguarding since the last inspection. Records viewed indicated that the referrals made had been managed appropriately.

The agency has provided service users with information with regard to the process for reporting any concerns. Service users who spoke to us indicated that they had no concerns regarding their safety; they described how they could speak to staff if they had any concerns and stated that staff are very responsive and supportive.

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. We noted that two incidents had occurred in regard to smoking and fire safety. We discussed with the manager the need to review this matter to ensure that a robust risk assessment is completed in conjunction with the organisation's fire safety officer and HSCT keyworkers. An area for improvement was made.

It was noted that staff have completed appropriate 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. There are arrangements are in place to ensure that service users who require high levels of supervision or monitoring and restriction have had their capacity considered and, where appropriate, assessed.

It was noted that where restrictive practices are in place, appropriate risk assessments had been completed in conjunction with the HSC Trust representatives.

It was identified that the HSCT are appointee for a small number of service users. The manager started that there is a system in place for notifying RQIA if the organisation is managing individual service users' monies in accordance with the guidance. We reviewed the finance records for one service users; we discussed with the manager the need to ensure that receipts are numbered and that a check of monies is completed at all shift handovers. An area for improvement was made.

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

5.2.2 Is there a system in place for identifying care partners who visit service users to promote their mental health and wellbeing during Covid-19 restrictions?

The manager advised us that there were no care partners visiting service users during the Covid-19 pandemic restrictions.

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' commenced employment and had direct engagement with service users. Records viewed evidenced that criminal record checks (AccessNI) had been completed for staff.

A review of the records confirmed that all staff provided are appropriately registered with NISCC. Information regarding registration details and renewal dates are monitored by the manager in conjunction with the organisation's human resources department. We discussed with the manager the benefits of including details of individual staff renewal dates and the date the checks are completed on the records retained.

The manager stated that staff are aware that they are not permitted to work if their professional registration lapses. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

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

Discussions with staff and review of service user care records reflected the multi-disciplinary input and the collaborative working undertaken to ensure service users' health and social care needs were met within the agency. There was evidence that staff made referrals to the multi-disciplinary team as appropriate. Staff were also implementing the specific recommendations of the SALT to ensure the care received was safe and effective.

It was noted that a one service user has been assessed by SALT in relation to dysphagia needs and specific recommendations made with regard to their individual needs in respect of food and fluids. It was noted that some staff had undertaken dysphagia awareness training; we discussed the need to ensure that all staff supporting the identified service user have received appropriate training. An area for improvement was identified.

5.2.5 Are there robust governance processes in place?

There were monitoring arrangements in place in compliance with Regulation 23 of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007. Reports relating to the agency's monthly monitoring were reviewed. The process included evidence of engagement with service users, service users' relatives, staff and HSC Trust representatives on the majority of the visits.

The reports included details of the review of service user care records; accident/incidents; safeguarding matters; complaints. However, it was identified that the reports were required to include more detail with regard to the matters reviewed during the visit. We discussed with the manager the need to include details of the review of NISCC and DOLS in the report. We discussed the guidance issued by RQIA with regard to quality monitoring. An area for improvement was identified.

There is a process for recording complaints in accordance with the agency's policy and procedures. It was noted that no complaints have been received since the last inspection. Complaints are reviewed as part of the agency's monthly quality monitoring process.

There was a system in place to ensure that staff received supervision and training in accordance with the agency's policies and procedures. However it was noted that the training matrix did not accurately reflect all details of training completed by staff. An area for improvement was identified.

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

The environment was observed during the inspection and there was evidence of infection Prevention and Control (IPC) measures in place such as Personal Protective Equipment (PPE) which was available for staff.

6.0 Conclusion

Based on the inspection findings five areas for improvement were identified. Four were in relation to safe and effective care and one was in relation to the service being well led.

7.0 Quality Improvement Plan/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.

	Regulations	Standards
Total number of Areas for Improvement	3	2

Areas for improvement and details of the Quality Improvement Plan were discussed with the person in charge as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007	
Area for improvement 1 **Ref:** Regulation 14.(a) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that where that agency is acting otherwise that as an employment agency, the registered person shall make suitable arrangements to ensure that the agency is conducted, and the prescribed services arranged by the agency, are provided- (a) so as to ensure the safety and wellbeing of service users. This relates specifically to fire safety risks associated with smoking. Ref: 5.2.1
	Response by registered person detailing the actions taken: An individual fire risk assesment has been completed detailing actions taken to date and ongoing actions to minimise risk. Fire risk assement was completed in partnership with HSCT key workers, service user, and risk management/goverance. Additional fire retardant furnishings have been purchased and a 2nd smoke alarm in place in bedroom. Service user also offered additional support around smoking indoors and fire risk.

Area for improvement 2 **Ref:** Regulation 14.(b) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that where that agency is acting otherwise that as an employment agency, the registered person shall make suitable arrangements to ensure that the agency is conducted, and the prescribed services arranged by the agency, are provided- (b) so as to safeguard service users against abuse or neglect. This relates specifically to the process for managing service users' monies. Ref: 5.2.1
	Response by registered person detailing the actions taken: Receipts are now numbered and correlated with the ledger sheet. Money/ Balance checks have been moved and now take place at shift change- this is minimim in the morning and at night.
Area for improvement 3 **Ref:** Regulation 23. (1) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Senior Manager will cross reference Datix and Safeguarding incidents as part of the monthly Monitoring Visits to the scheme. A 6 weekly Registered Manager's meeting has been introduced with Incidents tabled to identify patterns and trends.
Action required to ensure compliance with the Domiciliary Care Agencies Minimum Standards, 2011.	
Area for improvement 1 **Ref:** Standard 12.4 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that staff are trained for their roles and responsibilities. This relates specifically to Dysphagia training. Ref: 5.2.4
	Response by registered person detailing the actions taken: All staff have now undertaken Dysphagia training and it has been added to our mandatory training matrix.
Area for improvement 2 **Ref:** Standard 12.7	The registered person shall ensure that the staff training information is an accurate reflection of the training completed by staff.

Stated: First time **To be completed by:** Immediate and ongoing from the date of inspection	Ref: 5.2.4
	Response by registered person detailing the actions taken: A new electronic training matrix has been developed to ensure easier oversight by management, and clearer record keeping. Management to complete regular checks of the training matrix to ensure all staff are maintaining training records.

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

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