The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Hutchinson at Home**

Provider: **Hutchinson Homes Limited**

Date of Inspection: **11 February 2025**

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:	Hutchinson Homes Limited
Responsible Individual/Responsible Person:	Ms Naomi Carey
Registered Manager:	Ms Lisa Gifford
Service Profile – Hutchinson at Home is a domiciliary care agency which provides support to individuals living in their own home. Services are commissioned by the Northern Health and Social Care Trust (NHSCT) and include personal care, medication support and meal provision.	

2.0 Inspection summary

An unannounced inspection took place on 11 February 2025, between 9.00am and 3.25pm by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards. The inspection also sought to determine if the agency is delivering safe, effective and compassionate care and if the agency is well led.

The inspection examined the agency's governance and management arrangements, reviewing areas such as staff recruitment, professional registrations, staff induction and training and adult safeguarding. The reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS), service user involvement, restrictive practices and Dysphagia management.

Good practice was identified in relation to staff mandatory training compliance, staff induction and care plans were person centred.

Areas for improvement identified related to: recruitment and selection processes; duration of calls to service users, agency's contribution to Trust care reviews and the availability of Speech and Language Therapist (SALT) risk assessments in service users' care records.

The concerns identified in respect of the recruitment processes were similar to issues previously identified alongside other areas of concern and addressed through RQIA enforcement procedures in May 2022. Whilst the agency was subsequently assessed as compliant in these matters it was evident the improvement in relation to recruitment had not been sustained.

Following the inspection, RQIA requested an action plan to be submitted by the agency outlining the actions taken or actions they planned to take to address the matters identified.

This action plan was reviewed and provided the assurances necessary if implemented to ensure future compliance.

The last care inspection of the agency was undertaken on 18 September 2023 by a care inspector. No areas for improvement were identified.

Hutchinson at Home uses the term “clients” to describe the people to whom they provide care and support. For the purposes of the inspection report, the term ‘service user’ is used, in keeping with the relevant regulations.

3.0 The inspection

3.1 How we Inspect

RQIA’s inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the agency was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this agency. This included the previous areas for improvement identified, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning Trust.

Information was provided to service users, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included questionnaires and an electronic survey.

3.2 What people told us about the service and their quality of life

Service users and their representatives indicated that they were ‘very satisfied’ or ‘satisfied’ that care provided was safe, effective and compassionate and that the service was well led.

Staff stated they were happy working at the agency, they were supported by the management team and received training commensurate with their role and responsibilities.

3.3 Inspection findings

3.3.1 Governance and Managerial Oversight

The agency’s registration certificate was up to date and displayed appropriately along with current certificates of public and employers’ liability insurance.

RQIA had been notified appropriately of any incidents in keeping with the regulations. Records viewed and discussions with the person in charge indicated that incidents had been

managed appropriately. The agency's Statement of Purpose (SOP) required updating to include reference to submission of notifiable incidents to RQIA. This will be reviewed at the next inspection.

There were monitoring arrangements in place in compliance with Regulations and Standards. A review of the reports of the agency's quality monitoring established that there was engagement with service users, service users' relatives, staff and HSC Trust representatives. The agency was advised to consider using identifiers in relation to records/staff files viewed and to add a section to capture the checks the manager completed of staffs' NISCC registration status. The reports included details of a review of service user care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements. It was noted that the deficits in the recruitment process were not identified during these quality monitoring reports viewed during inspection.

The Annual Quality Report was reviewed and was satisfactory.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure.

There were no complaints received since the last inspection. Should complaints be received they would be reviewed as part of the agency's quality monitoring process. Information in relation to the complaints process is provided to service users and staff were aware of the complaints policy.

There was a system in place to ensure that records were retrieved from discontinued packages of care in keeping with the agency's policies and procedures.

Where staff are unable to gain access to a service users home, the service has an operational policy, procedure or protocol that clearly directs staff from the agency as to what actions they should take to manage and report such situations in a timely manner.

3.3.2 Staffing (recruitment and selection, induction and training).

Safe staffing begins at the point of recruitment and continues through to staff induction and regular staff training.

A review of the agency's staff recruitment records identified deficits in recruitment. Pre-employment checks were not fully completed; gaps in employment for two staff members were not explored; the reason for leaving previous employment for three staff members was not recorded; and two references for one staff member was a poor quality copy of the document and therefore difficult to identify who they had been submitted by; and one staff member's second reference was provided by an establishment not listed on their application form. The agency's quality assurance mechanisms were not sufficiently robust as the deficits identified during the inspection had not been identified within monthly monitoring reports. These concerns were raised with the Responsible Individual and Registered Manager of the agency following the inspection. They were advised to submit an action plan identifying the measures they would take to address these issues. This action plan when fully implemented and embedded provided RQIA with assurances once implemented and embedded into practice will ensure compliance with the legislation. Progress in relation to these matters will be assessed

as part of future inspections. An area for improvement has been identified in relation to recruitment.

Criminal record checks (AccessNI), were completed and verified before staff members commenced employment and had direct engagement with service users. Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC) there was a system in place for professional registrations to be monitored monthly by the manager.

There were no volunteers deployed within the agency.

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care, to ensure they were competent to carry out the duties of their job in line with the agency's policies and procedures. There was a structured, three-day induction programme which also included shadowing of a more experienced staff member. Written records were retained by the agency of the person's capability and competency in relation to their job role.

All registrants must maintain their registration for as long as they are in practice. This includes renewing their registration and completing Post Registration Training and Learning. Post registration training requirement was discussed at supervision with staff to ensure that all staff are compliant with the requirements.

The agency has maintained a record for each member of staff of all training, including induction and professional development activities undertaken. These records indicated that all staff were compliant with all training requirements. The was evidence of robust oversight arrangements in relation to ensuring ongoing training compliance.

Staff were provided with training appropriate to the requirements of their role.

All staff had been provided with training in relation to medicines management. The person in charge advised that no service users required their medicine to be administered with a syringe. They were aware that should this be required; a competency assessment would be undertaken before staff undertook this task.

Where service users required the use of specialised equipment to assist them with moving, this was included within the agency's mandatory training programme. A review of records confirmed that staff were compliant with their manual handling training and use of manual handling equipment in use was reflected in care records.

3.3.3 Care Records

A formal review of a service user's care plan should take place at least once per year. The person in charge confirmed that annual review meetings organised by the Trust were not consistently arranged by the Trust for all service users. The agency does not routinely contribute to the annual review of the service users care plans by providing a report to the Trust in preparation for reviews. The person in charge advised that most service users have duty Social Workers and communication can be challenging, which they have raised at Trust contract meetings. An area for improvement has been identified in relation to contributing to review of service users' carer plans.

A review of care records identified that moving and handling risk assessments were up to date. Where a service user required the use of more than one piece of specialised equipment, direction on the use of each was included in the care plan.

It was noted in the daily care records that the duration of a number of calls logged with services users were shorter than the commissioned time specified in the service users care plans. The reason for shorter calls were on occasions attributed to the service users wishes. Care staff recorded the care delivered which appeared to be in line with the service users assessed needs. This was discussed with the person in charge and whilst it appeared the service user had received their planned care there was the potential of them feeling rushed. There was also the potential of changing needs of the service user and therefore required review by the commissioning Trust. There was no evidence provided indicating this had been requested by the agency. An area for improvement has been identified.

A number of service users were assessed by SALT with recommendations provided and some required their food and fluids to be of a specific consistency. Discussions with staff and review of service users' 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. Staff implemented the specific recommendations of the SALT to ensure the care received in the setting was safe and effective. However, care records did not include a copy of the full SALT risk assessment. The person in charge was advised a copy of the SALT risk assessment should be available in both the office and service user's home file. The person in charge confirmed this had been actioned appropriately promptly following the inspection. An area for improvement has been identified.

A review of training records confirmed that staff had completed training in Dysphagia and in relation to how to respond to choking incidents.

3.4.4 Safeguarding

The agency's provision for the welfare, care and protection of service users was reviewed. The organisation's adult safeguarding policy and procedures were reflective of the Department of Health's (DoH) regional policy and clearly outlined the procedure for staff in reporting concerns. The organisation had an identified Adult Safeguarding Champion (ASC). The agency's annual Adult Safeguarding Position report was reviewed and found to be satisfactory.

Discussions with the person in charge established that they were knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting and managing adult safeguarding concerns.

Staff were required to complete adult safeguarding training during induction and every two years thereafter.

A referral made to the HSC Trust in relation to adult safeguarding was reported and managed appropriately.

The person in charge was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

3.4.5 Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act (MCA) provides a legal framework for making decisions on behalf of service users who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, service users make their own decisions and are helped to do so when needed. When service users lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The agency shared a copy of their newly developed risk register and provided assurances it would be updated at regular intervals. Staff who spoke with the inspector demonstrated their understanding that service users who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the MCA.

Staff had completed appropriate DoLS training appropriate to their job roles. The person in charge reported that none of the service users were subject to DoLS.

The agency maintained a register of restrictive practices, this required updating to reflect the addition of service users who had recently commenced a package of care with the agency.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	2	2

Areas for improvement and details of the Quality Improvement Plan were discussed with the assistant manager as part of the inspection process and with Ms Naomi Carey, Responsible Individual and Mrs Lisa Gifford, Registered Manager following the inspection. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Domiciliary Care Agency Regulations (Northern Ireland) 2007	
Area for improvement 1 **Ref:** Regulation 13(d) Schedule 3 **Stated:** First time **To be completed by:** 31 May 2025	The Registered Person shall ensure that all pre-employment checks are obtained and are satisfactory before the worker commences employment. These checks should include ensuring a full employment history is obtained with no gaps, reasons for leaving are identified and appropriate references are obtained. Ref: 3.3.2
	Response by registered person detailing the actions taken: All staff files have been thoroughly checked to ensure any gaps identified on the application form have been explained and a copy in each file. References have been thoroughly checked to ensure they are legible and appropriate – meeting standard required. The manager now includes a pre-employment checklist to ensure all aspects are completed. This will be audited on a monthly basis to ensure ongoing compliance
Area for improvement 2 **Ref:** Regulation 15 2(a) **Stated:** First time **To be completed by:** 31 May 2025	The Registered Person shall ensure that the timings and duration of calls to service users are in accordance with their care plan as commissioned by the NHSCT. Ref: 3.3.3
	Response by registered person detailing the actions taken: The registered manager audits the recording sheets on a monthly basis and updates the named worker if the commissioned times are not being utilised. The importance of utilising the full call time has been emphasised to the staff and they are encouraged to report if call time not appropriate to the clients needs.

Action required to ensure compliance with The Domiciliary Care Agency Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 6.2 **Stated:** First time **To be completed by:** 31 May 2025	The Registered Person shall ensure the agency participates in review meetings organised by the referring Trust. They should complete an annual review of the service users' care needs and/or attend Trust review meetings or contribute by submitting a written report prior to such meetings. Ref:3.3.3
	Response by registered person detailing the actions taken: The registered manager participates in reviews either in person or by sending a report of any conerns. We also update the named workers regularly if there is any changes in the needs of our clients and this will prompt a review.In addition to this the Service manager will commence annual reviews for each client to identify any issues early and a copy will be held in file
Area for improvement 2 **Ref:** Standard 3.2 **Stated:** First time **To be completed by:** 31 May 2025	The Registered Person shall ensure that the SALT risk assessment are available in the services users care records both in the registered office and in their home. Ref: 3.3.3
	Response by registered person detailing the actions taken: This was a new client on the day of inspection, communication had already been sent to the named worker to highlight that we required the SALT risk assessment. This was sent by the named worker on the day of the inspection and was in the clients folder that evening. Acopy will be held in clients file in the office

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

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