The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Moneydarragh Flexicare**

Provider: **Moneydarragh Flexicare Ltd**

Date of Inspection: **5 December 2024**

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:	Moneydarragh Flexicare Ltd
Responsible Individual/Responsible Person:	Mrs Karen Cunningham
Registered Manager:	Mrs Karen Cunningham
Service Profile Moneydarragh Flexicare is a domiciliary care agency located in the village of Ballymartin. Under the direction of the owner/manager Karen Cunningham, 53 staff provide care services to 98 service users in their own homes in the Annalong and Kilkeel areas of County Down. The services provided range from personal care, practical support to sitting services. Their services are commissioned by the Southern Health and Social Care Trust (SHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 5 December 2024, from 9.15 a.m. to 4.00 p.m. 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 and dysphagia management were also examined.

Two areas for improvement were identified, relating to the recruitment and selection process and the agency's contribution to annual care plan reviews.

Good practice was identified in relation to engagement with service users.

Moneydarragh Flexicare 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 any previous areas for improvement, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning trust.

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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 for staff.

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

Staff and service users spoken to as part of the inspection indicated that there were no concerns in relation to the agency. Staff and service users spoke very positively in regard to the care delivery in the agency. Staff indicated they enjoyed working at the agency and were supported by the manager. Service users confirmed they were treated with dignity and respect by all staff.

No responses were received to the electronic staff survey or the service users' questionnaires.

3.3 What has this service done to meet any areas for improvement identified at or since the last inspection?

The last care inspection of the agency was undertaken on 27 February 2024 by a care Inspector. A Quality Improvement Plan (QIP) was issued. This was approved by the care Inspector and was validated during this inspection.

Areas for improvement from the last inspection on 27 February 2024		
Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (d) Schedule 3 **Stated:** Second time	The registered person shall ensure that full and satisfactory information is available in relation to the candidate in respect of the matters specified in Schedule 3. This relates to full employment histories being obtained for every applicant and employment references are verified prior to the commencement of employment. Ref: 5.2.4	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed references were verified prior to the commencement of employment, and full employment histories were evident.	
Area for Improvement 2 **Ref:** Regulation 13 (b) **Stated:** First time	The registered person shall ensure that no domiciliary care worker is supplied by the agency unless they have the experience and skills necessary, this relates specifically to the interview scoring system being unclear. Ref: 5.2.4	**Met**
	Action taken as confirmed during the inspection: A review of two newly recruited staff records evidenced the interview process had been strengthened by the use of a clear scoring system for the interviews.	
Area for improvement 3 **Ref:** Regulation 23 (1) **Stated:** First time	The registered person shall ensure that they shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided. This relates specifically to the accuracy of action plans and feedback from staff and professionals. Ref: 5.2.6	**Met**

	Action taken as confirmed during the inspection: A review of the four most recent monthly monitoring reports evidenced that they each contained feedback from relevant stakeholders and actions recorded were applicable.	
Area for improvement 4 **Ref:** Regulation 22 (1) **Stated:** First time	The registered person shall establish a procedure for considering complaints made to the registered person by a service user or a service user's representative. This relates specifically to the lack of evidence that these were appropriately recorded and managed. Ref: 5.2.6	**Met**
	Action taken as confirmed during the inspection: The agency had not received any complaints since the last inspection. The complaints log was viewed. Completion of this document would ensure all relevant information would be captured including actions and outcome.	
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 8.12 **Stated:** Second time	The registered person shall ensure that the quality of services provided is evaluated on at least an annual basis and follow-up action taken. Key stakeholders are involved in this process. The report should be in a format which is suitable for the service users to understand. Ref: 5.2.6	**Met**
	Action taken as confirmed during the inspection: Inspector confirmed the annual quality report format was suitable for service users to understand. It included information relating to staff training information, incidents/accidents and stakeholder views.	

3.4 Inspection findings

3.4.1 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.

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 reports included details of a review of service user care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

The Annual Quality Report was reviewed and was satisfactory.

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

Review of the complaints policy identified that whilst it outlined the process of how to complain, it was not specific to the agency as it referred to roles and personnel who were not part of the organisational structure. This policy required updating to ensure it is service specific and clearly identifies the individuals responsible for managing complaints alongside their responsibilities. The agency updated the policy and submitted it to RQIA and it was assessed as satisfactory.

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. In some circumstances, complaints can be made directly to the commissioning body about agencies. The complaints process was discussed with staff and advice was given in relation to recording information which may not have previously been considered as a complaint.

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.

3.4.2 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 for two new staff members confirmed that all pre-employment checks, including 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 by the manager. During discussions with administrative staff, it was evident

that AccessNI checks had not been completed for office based staff. The manager was informed that all staff required these checks to be completed before commencing work with the agency. The manager promptly actioned the request to have AccessNI checks completed for administrative/office based staff currently employed by the agency. An area for improvement has been identified.

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. It was noted that the induction records did not include evidence that staff were informed of what to do if they were unable to gain access to a service users' home. The manager confirmed this was discussed with staff, they were advised to ensure this was reflected in the induction records. This will be reviewed at the next inspection.

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 a small number of staff were not compliant with all training requirements. The manager has since confirmed that all outstanding training has been completed. The oversight arrangements in relation to training compliance requires strengthening to ensure ongoing 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 manager advised that no service users required their medicine to be administered with a syringe. The manager was 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 a number of staff were not compliant with their manual handling training. Confirmation was received following the inspection providing assurances that this training has now be completed.

3.4.3 Care Records

A formal review of a service user's care plan should take place at least once per year. The manager confirmed that annual review meetings organised by the Trust were not consistently arranged for all service users. There were no records provided to evidence that the agency contributes to the annual review of the service users care plans either by either attending meetings or submitting a report in advance. Review reports should refer to any matters

regarding the current care plan; general changes in the service users' situation; and details of important events including incidents or accidents occurring during the review period. An area for improvement has been identified.

A review of care records identified that moving and handling risk assessments and care plans 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. Daily records completed by staff noted the type of equipment used on each occasion.

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

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. Care records included SALT dietary requirements.

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 manager 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.

The agency had not had any referrals made to the HSC Trust in relation to adult safeguarding therefore there were no records to review.

The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any concerns.

The manager 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. 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 manager reported that none of the service users were subject to DoLS.

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	1	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Karen Cunningham, Responsible Individual and Registered Manager, 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 13(d) **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 3. This relates to ensuring criminal record checks (AccessNI) are completed for all staff including administrative staff. Ref: 3.4.2
	Response by registered person detailing the actions taken: The three staff members involved in Administration work (including the director) Access NI checks sent 06.12.24 - three clear checks received and available to view. Any future positions within Admin will include an Access NI check being completed as part of recruitment process and prior to employment commencing.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021.	
Area for improvement 1 **Ref:** Standard 6.2 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure the agency participates in review meetings organised by the referring Trust. Staff should either attend review meetings or contribute by submitting a written report prior to the meeting. Ref: 3.4.3
	Response by registered person detailing the actions taken: A new protocol will be implemented whereby the Supervisor will be visiting each SU home and completing a form which will be created through requesting a copy of the Trust's form they use for their annual review; and making it more applicable to us. This will include a review of risk assessments, careplan, changes in POC, Service User Agreement reviewed if any changes in POC. This information will be forwarded to Trust.

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

The Regulation and Quality Improvement Authority

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