

Inspection Report

Name of Service: Hillview Lodge T/A Glen Caring Services Ltd -
Ballymoney

Provider: Hillview Lodge Limited

Date of Inspection: 25 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:	Hillview Lodge T/A Glen Caring Services Ltd - Ballymoney
Responsible Individual/Responsible Person:	Mrs Linda Florence Beckett
Registered Manager:	Mrs Leah Ormsby
Service Profile Hillview Lodge T/A Glen Caring Services Ltd, located in Ballymoney is a domiciliary care agency which provides personal care, practical and social support to individuals living in their own homes in the County Antrim area of Northern Ireland. The Northern Health and Social Care Trust commission these services.	

2.0 Inspection summary

An unannounced inspection took place on 25 February 2025 between 10.35 am and 4.05 pm. This was conducted by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards and to assess progress with the area for improvement identified during the last care inspection on 13 October 2023. The inspection also sought to determine if the agency is delivering safe, effective and compassionate care and if the agency is well led.

As a result of this inspection, the area for improvement previously identified was assessed as having been addressed by the provider.

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 were also reviewed.

Areas for improvement identified during this inspection related to record keeping and the management of medicines policy and procedure.

Service users spoke positively about their experience of the care and support they received from staff. Refer to Section 3.2 for more details.

We would like to thank the manager, service users, relatives, the representative from the commissioning Trust and staff team for their support and co-operation during the inspection.

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 service 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 Quality Improvement Plan (QIP) issued, 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 for staff.

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

We spoke to a range of service users, relatives, a representative from the commissioning Trust and staff to seek their views of the agency.

Service users said that they were happy with the care and support provided and that staff were kind and supportive. Two comments included the following statements; 'I am well looked after' and 'The carers go out of their way to see can they do anything else to help me'.

Relatives were keen to express praise and gratitude for the care provided and the kindness and support received from staff.

Staff spoke positively in regard to care delivery, training and managerial support.

The information provided indicated that those who engaged with us had no concerns in relation to the agency.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the skill of staff meets the needs of service users.

A review of the agency's staff recruitment records 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. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

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 robust, structured, induction programme which also included shadowing of a more experienced staff member.

This agency has maintained a record for each member of staff of all training, including induction and professional development activities undertaken.

3.3.2 The 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 reflected information contained within the Department of Health's (DoH) regional policy 'Adult Safeguarding Prevention and Protection in Partnership' July 2015 and clearly outlined the procedure for staff in reporting concerns. The organisation had an identified Adult Safeguarding Champion (ASC). The safeguarding champion was known to the staff team. The agency's annual Adult Safeguarding Position Report was reviewed and found to be satisfactory.

Staff were required to complete adult safeguarding training during induction and every two years thereafter. Staff who spoke with the inspector had a clear understanding of their responsibility in identifying and reporting any actual or suspected incidences of abuse and the process for reporting concerns. They could also 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's governance arrangements for the management of accidents/incidents were reviewed. Review of accidents/incidents records identified that a number of these records were not dated and/or signed. It was further noted that the name of the representative from the commissioning Trust that the agency was communicating with was not always recorded. An area for improvement has been identified.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Staff were provided with Moving and Handling training appropriate to the requirements of their role. Where service users required the use of specialist equipment to assist them with moving, this was included within the agency's mandatory training programme. A review of care records identified that moving and handling risk assessments and care plans were up to date.

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

There was a management of medicines policy and procedure in place. However, it lacked detail regarding the management of medication errors. An area for improvement has been identified.

A number of service users had been assessed by the Speech and Language Therapist (SALT) with recommendations provided. Staff demonstrated a good knowledge of service users' wishes, preferences and assessed needs. These were recorded within care plans along with associated SALT dietary requirements. Staff were familiar with how food and fluids should be modified.

A review of training records confirmed that staff had completed training in dysphagia and in relation to responding to choking incidents.

3.3.3 The arrangements for promoting service user involvement

From reviewing service users' care records and through discussions with service users and relatives, it was positive to note that service users had an input into devising their own plan of care. Care and support plans are kept under regular review and services users and /or their relatives participate, where appropriate, in the review of the care provided on an annual basis, or when changes occur.

There was also evidence of regular contact with service users and their representatives.

3.3.4 The arrangements to ensure robust managerial oversight and governance

The manager had been registered since 25 February 2022. Staff commented positively about the manager and described them as supportive, approachable and always available to provide guidance.

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 and staff. The reports included details of a review of service user care records; accident/incidents; safeguarding matters; missed and late calls and staff recruitment and training.

The Annual Quality Report was reviewed and was satisfactory.

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

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

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure.

Where complaints have been received since the last inspection, these were appropriately managed and were reviewed as part of the agency's quality monitoring process. Discussion with staff confirmed that they knew how to receive and respond to complaints sensitively and were aware of their responsibility to report all complaints to the manager or the person in charge.

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.

Review of records and consultation with staff identified that there was a system in place for reporting any instance where staff were unable to gain access to a service user's home.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Domiciliary Care Agencies Minimum Standards (updated August 2011).

	Regulations	Standards
Total number of Areas for Improvement	0	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Leah Ormsby, 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 Minimum Standards (updated August 2011)	
Area for improvement 1 Ref: Standard 9.1 Stated: First time To be completed by: 31 March 2025	The Registered Person shall ensure that the management of medicines policy and procedure details the actions to be taken in the event of a medication error. Ref: 3.3.2 Response by Registered Person detailing the actions taken: The medication policy and procedure has been updated to include more detail on the actions to be taken in the event of a medication error.
Area for improvement 2 Ref: Standard 5.6 Stated: First time To be completed by: Immediate and ongoing from the date of inspection	The Registered Person shall ensure all records are legible, accurate, up to date and signed and dated by the person making the entry. Ref: 3.3.2 Response by Registered Person detailing the actions taken: The registered manager has spoken to all area coordinators to ensure all records are legible, accurate and up to date, signed and dated by the person making the entry. Training on record keeping has been scheduled for 18/04/2024.

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