Inspection Report

16 October 2024

Kingdom Healthcare Ltd

Type of service: Domiciliary Care Agency
Address: 74 William Street, Lurgan, BT66 6JB
Telephone number: 028 3829 4927

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: Kingdom Healthcare Ltd **Responsible Individual:** Mrs Niamh Conaty (registration pending)	**Registered Manager:** Ms Patricia Butler **Date registered:** Registration pending
Person in charge at the time of inspection: Ms Patricia Butler	
Brief description of the accommodation/how the service operates: Kingdom Healthcare Ltd is a domiciliary care agency which provides personal care, practical and social support to 122 service users living in their own homes. The service users care is commissioned by the Southern Health and Social Care Trust (SHSCT). Service users are supported by 51 staff.	

2.0 Inspection summary

An unannounced inspection took place on 16 October 2024 between 9.30 a.m. and 2.10 p.m. The inspection was conducted by a care inspector.

The inspection was focused to assess progress with the areas for improvement identified at the last care inspection and actions agreed following the serious concerns meeting held on 25 January 2024.

Service users expressed no concerns about the standard of the care provided or the responsiveness of the agency.

The outcome of the inspection evidenced that the improvements made as result of the enforcement action have been significantly progressed. An area for improvement relating to the quality monitoring process was partially met and has been stated for the second time. Another area for improvement pertaining to feedback from service users has been stated for the third and final time. No new areas for improvement were identified.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were 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.

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

As a public-sector body, RQIA has a duty to respect, protect and fulfil the rights that people have under the Human Rights Act 1998 when carrying out our functions. In our inspections of domiciliary care agencies, we are committed to ensuring that the rights of people who receive services are protected. This means we will seek assurances from providers that they take all reasonable steps to promote people's rights. Users of domiciliary care services have the right to expect their dignity and privacy to be respected and to have their independence and autonomy promoted. They should also experience the individual choices and freedoms associated with any person living in their own home.

A range of documents were examined to determine the effective systems were in place to manage the agency.

A poster was provided for staff detailing how they could complete an electronic questionnaire.

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.

4.0 What did people tell us about the service?

As part of the inspection process we sought feedback directly from a number of service users. The information provided indicated that there were no concerns in relation to the agency.

Relatives spoken with provided the following comments:

- "I am quite happy, no concerns at all."
- "I can't say anything bad about the girls, no complaints. They look after (name of service user) and are polite."
- "Sometimes, everything does not go to plan, but cancellations are few and far between. When this happens it is unavoidable and they do let us know. (One of the office staff) is amazing, on the ball and meticulous."
- "Everything is fine."
- "We are delighted, they are brilliant, just great girls. My (relative) loves to see them coming and (they) never wanted carers in the house in the first place."

Questionnaire responses were noted to be positive; no written responses were received.

There were no responses received to the electronic survey.

5.0 The inspection

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

Areas for improvement from the last inspection on 9 January 2024		
Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 14 (a)(b) **Stated:** First time	The registered person shall develop and implement a robust auditing system to ensure service users receive their care calls in a timely manner; missed and short calls identified through the auditing process, must be investigated and records retained of any action taken, including that the matters have been reported to the SHSCT; omitted departure times identified through the auditing process must be investigated and records retained of any action taken; and the system for communication with service users and/or their' representatives must be reviewed, to ensure that any matters impacting on service delivery are communicated effectively.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 **Ref:** Regulation 21(a) **Stated:** First time	The registered person shall review the on-call instant messaging service (WhatsApp) used by staff to ensure that it is secure and that the content does not contain any information pertaining to any service user that is identifiable or information that should be recorded within the service users' care records; evidence of auditing the messaging service must be retained for inspection.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

Area for improvement 3 **Ref:** Regulation 16(1) (a) **Stated:** First time	The registered person shall review the staffing contingency plan to ensure that there are sufficient staffing arrangements in place to meet the needs of the service users.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 4 **Ref:** Regulation 23 (1)(2)(3)(4)(5) **Stated:** First time	The registered person shall ensure that quality monitoring reports are robustly and comprehensively completed in keeping with Regulation; the reports must contain a time bound action plan; and must evidence meaningful and timely review by the manager and the Responsible Individual.	**Partially met**
	Action taken as confirmed during the inspection: Whilst there was evidence that the reports had been completed on a monthly basis, these were not shared with the manager in a timely manner; this area for improvement has been stated for the second time.	
Area for improvement 5 **Ref:** Regulation 22(8) **Stated:** First time	The registered person shall ensure that a robust system is developed and implemented so as to ensure that every complaint is recorded in keeping with the agency's policy and procedures; the manager should regularly and meaningfully analyse all complaints to identify patterns/trends in order to drive any necessary improvements.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 6 **Ref:** Regulation 21(1)(c) **Stated:** First time	The registered person shall ensure that the alphabetical list of service users is maintained and up to date at all times.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 11.2 **Stated:** Second time	Staff are recruited and employed in accordance with the statutory employment legislation. The manager shall ensure any gaps in an employment record are explored and explanations recorded and two satisfactory references, linked to the requirement of the job are obtained.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 **Ref:** Standard 8.11 **Stated:** Second time	The registered person shall ensure that the monthly quality monitoring visits focus on contacting service users who are in receipt of a sitting service, to ascertain their views on the care and support provided; the number of service users contacted must be representative of the size of the agency; and their feedback must bet be clearly identified within the reports.	**Not met**
	Action taken as confirmed during the inspection: Whilst there was some evidence that service users in receipt of a sitting service had been contacted, this was not consistently recorded within the monthly quality monitoring reports. Additionally, feedback was received from two service users; this is not representative of the size of the agency. This area for improvement was not met and has been stated for the third and final time.	
Area for improvement 3 **Ref:** Standard 12.4 **Stated:** First time	The registered person shall ensure that all staff are trained, by whatever means, as to their responsibilities in terms of accurate recordkeeping; and in relation to reporting requirements to the SHSCT.	**Met**

	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 What are 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 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 retained records of any referrals made to the HSC Trust in relation to adult safeguarding. These had been reviewed as part of the monthly quality monitoring process.

RQIA had been notified appropriately of any incidents that had been reported to the Police Service of Northern Ireland (PSNI) in keeping with the regulations. Incidents had been managed appropriately.

Staff were provided with training appropriate to the requirements of their role. Where service users required the use of specialised equipment to assist them with moving, this was included within the agency's mandatory training programme.

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 had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles.

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

5.2.2 What are the systems in place for ensuring service users get the right care at the right time?

Review of records identified that there had been significant improvements in the delivery of care since the last care inspection. There was no evidence of staffing shortages and a contingency plan was in place to ensure appropriate cover would be put in place, if required.
Calls had been consistently provided in keeping with the commissioned time. Daily notes were returned to the registered office on a regular basis.
There was a robust auditing system in place to ensure that any missing entries or omissions in recording departure times in the daily records were investigated in a timely manner.

Any calls that were identified as being significantly shorter than the time which was agreed by the commissioning Health and Social Care Trust were reported accordingly. Care workers who provided a sitting service also completed regular notes on the Care Planner system; this ensured that hourly updates were recorded on the live system. This is good practice.

There was evidence of regular contact with service users' and their representatives. Care plans were kept under review. The agency undertook regular reviews with service users and invited trust representatives to attend these meetings.

The use of the on-call instant messaging service, (WhatsApp) previously used by staff was no longer in use. There was evidence that staff reported any matters appropriately on the Care Planner system and reported to the SHSCT as appropriate.

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 staff had completed training in Dysphagia and in relation to how to respond to choking incidents. The care plans consistently recorded the service users' specific diet in keeping with the SALT care plan.

5.2.3 What systems are in place for staff recruitment and are they robust?

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.

5.2.4 What are the arrangements for staff induction and are they in accordance with NISCC Induction Standards for social care staff?

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, 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

5.2.5 What are the arrangements to ensure robust managerial oversight and governance?

Review of records identified that there had been significant improvements made in the governance arrangements and managerial oversight of the agency since the last care inspection.
In addition to there being sufficient staffing levels in place, there was also a cohesive management structure in place, which allowed the manager to attend to their governance and managerial responsibilities.

There was also a system in place for reporting any concerns to the responsible person on a daily basis.

Review of the monthly quality monitoring reports identified that there had been significant improvements made in relation to the quality of oversight by the responsible person. However, the reports were not shared with the manager in a timely manner. This meant that they would not have been aware of any actions requiring attention. An area for improvement has been stated for the second time in this regard.

Additionally, the numbers of service users consulted with were not representative of the size of the agency. An area for improvement in this regard has been stated for the third and final time.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Where complaints were received since the last inspection, these were appropriately managed and were reviewed as part of the agency's quality monitoring process.

The alphabetical list of service users and staff provided to the inspector was noted to be up to date.

The Annual Quality Report was reviewed. Advice was given regarding the need to further develop this report, to ensure that it includes a wider range of quality improvement initiatives, rather than focusing solely on stakeholder feedback and subsequent recommendations. This advice was welcomed by the manager who agreed to address these matters within the next annual quality process. The manager was made aware that the report should be summarised and shared with service users and their representatives on an annual basis. This will be followed up at future inspection.

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 records were retrieved from discontinued packages of care in keeping with the agency's policies and procedures. The manager agreed to inform the trust where it is not possible to retrieve the records.

It was evident that there was a procedure in place for staff to follow in the event that staff were unable to gain entry to a service users home. This was included within the induction

programme. Advice was given in relation to having all staff sign this protocol. The manager also agreed to include this within the staff supervision template going forward.

Discussion took place regarding the administration of anticoagulant medicine (blood thinners). Whilst there were no service users currently prescribed this medicine, the manager agreed to develop a policy and procedure in relation to this medicine, given that all staff should be aware of the side effects of same.
The manager welcomed this advice and agreed to develop a list of any service users currently prescribed anticoagulant medicine, should there be any that are being administered by family members.

6.0 Quality Improvement Plan (QIP)/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 (revised) 2021

	Regulations	Standards
Total number of Areas for Improvement	1*	1*

* the total number of areas for improvement includes one that has been stated for the second time; and one that has been stated for the third and final time.

The areas for improvement and details of the QIP were discussed with Patricia Butler, 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 23 (1)(2)(3)(4)(5) **Stated:** Second time **To be completed by:** Immediate from the date of inspection.	The registered person shall ensure that quality monitoring reports are robustly and comprehensively completed in keeping with Regulation; the reports must contain a time bound action plan; and must evidence meaningful and timely review by the manager and the Responsible Individual. Regulation 23 (1)(2)(3)(4)(5) Ref: 5.2.5
	Response by registered person detailing the actions taken: In light of the RI (Responsible Individual) being absent in Kingdom Healthcare, the Registered Manager from the South Eastern Trust area will complete the Monthly Quality Monitoring Reports with immediate effect until an RI is in place.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 8.11 **Stated:** Third time **To be completed by:** Immediate from the date of inspection.	The registered person shall ensure that the monthly quality monitoring visits focus on contacting service users who are in receipt of a sitting service, to ascertain their views on the care and support provided; the number of service users contacted must be representative of the size of the agency; and their feedback must bet be clearly identified within the reports. Ref: 5.2.5
	Response by registered person detailing the actions taken: Monthly monitoring reports are now focused on service users who are in receipt of both day and night sits and feedback will be clearly identified on the reports, this will now be in place across the agency.

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

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