The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Rathview Mews Supported Living Service

Provider: Western Health and Social Care Trust

Date of Inspection: 12 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:	Western Health and Social Care Trust
Responsible Individual/Responsible Person:	Mr Neil Guckian
Registered Manager:	Ms Mary Patricia McBride
Service Profile Rathview Mews Supported Living Service, is a supported living type of domiciliary care agency located in Omagh. The agency provides personal care and social support to adults who have mental health needs. The agency has 12 individual self-contained flats, two of which have been adapted for people with a disability, shared lounge areas and gardens. Services are commissioned by the Western Health and Social Care Trust (WHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 12 December 2024 between 10.00 a.m. and 3.30 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 determined if the agency is delivering safe, effective and compassionate care and if the agency is well led.

The inspection established that safe, effective and compassionate care was delivered to service users and that the agency was well led. Areas for improvement identified related to recruitment practices and staff roster.

It was evident that staff promoted the independence and well-being of service users and that staff were knowledgeable and well trained to deliver safe and effective care.

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 and staff team for their help and support in the completion of 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 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 staff survey.

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

We spoke with the service users and staff to seek their opinions on the quality of the care and support, their experiences of living, or working within Rathview Mews Supported Living Service.

Service users said that they were happy with the care and support provided and that staff were kind and helpful. Two comments included the following statements; 'Staff always take time to listen to me and talk things through" and "I have my own front door and have great privacy".

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

A returned questionnaire indicated that the respondent was very satisfied with the care and support provided. The respondent commented "Very happy."

The information provided indicated that there were no concerns in relation to the agency.

We did not receive any responses from the staff electronic survey.

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 19 July 2023 by a care inspector. No areas for improvement were identified.

3.4 Inspection findings

3.4.1 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 staff recruitment records evidenced that Enhanced AccessNI pre-employment checks had not been satisfactorily completed before four ancillary staff had commenced employment. It was explained that this was due to the Trusts' policy and procedure in relation to the employment of Trust ancillary staff. This was discussed with the manager, who took immediate action to address the matter. An area for improvement has been identified.

A record of ancillary staff members' hours of work was not consistently maintained. An area for improvement has been identified.

Checks were made to ensure that staff were appropriately registered with the Nursing and Midwifery Council (NMC) and/or 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.

Written records were retained by the agency of the person's capability and competency in relation to their job role. Advice was given to the manager regarding the level of detail included when completing competency assessments. In particular, it was suggested that the comments section should include some detail on how competence was achieved before signing off on the identified task. The manager agreed to implement this in the future.

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

Regular staff meetings were held and minutes maintained of the meetings for staff, unable to attend, to read for information sharing.

3.4.2 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.

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. The review confirmed that an effective incident/accident reporting policy and system was in place. Staff are required to record any incidents and accidents in a centralised electronic record, which is then reviewed and audited by the manager and the WHSCT governance department. A review of a sample of accident/incident records evidenced that these were managed appropriately.

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

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.

3.4.3 The arrangements for promoting service user involvement

From reviewing service users' care records and through discussions with a service user, 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.

Service user meetings were held on a regular basis which enabled the staff to keep service users updated on any issues arising that may affect them. Some matters discussed included health and safety, shared living arrangements and the complaints procedure. The meetings also enabled the service users to discuss any activities they would like to become involved in.

3.4.4 The arrangements to ensure robust managerial oversight and governance

The Manager had been in post since 5 October 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; complaints and staff training.

There were processes in place to review the quality of the service on an annual basis.

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.

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.

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 Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	2	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Mary McBride, 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:** Immediate from the date of the inspection	The Registered Person shall ensure that Enhanced AccessNI pre employment checks are satisfactorily carried out for all staff before they commence employment. Ref: 3.4.1
	Response by registered person detailing the actions taken: Enhanced Access NI Checks are in place for all staff providing care and support to service users. Enhanced Access NI reference numbers and certificate dates are retained by HR and in the facility. Following inspection,an immediate risk management plan was put in place to ensure supervision of support services staff (carrying out domestic duties within the communal areas of the facilty), who did not have and enhanced AccessNI, this remained in place until their Enhanced Access NI checks were completed. WHSCT HR dept. provided the facility manager with a record of Enhanced Access NI reference numbers and certificate dates. A plan is now in place to ensure that staff are only employed in the facility when this information has been provided.
Area for improvement 2 **Ref:** Regulation 21 (1) (a)(c) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that a record is maintained of the staff rostered on duty on a daily basis and the time that each shift commences and concludes. This specifically relates to ancillary staff. Ref: 3.4.1
	Response by registered person detailing the actions taken: A roster is in place for all staff providing care and support to service users. A paper copy of the roster is held in the facility and records are also available on the electronic roster system. Records are held in accordance with data retention requirements. Following inspection, a system is in place to ensure an advance roster is provided by the support services manager for staff carrying out the daily domestic duties in the communal areas of the facility,a daily register is also completed detailing names and times staff enter and leave the building. These records are retianed in the facility.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews