Inspection Report

24 April 2023

Mallusk Supported Living Service

Type of service: Domiciliary Care Agency
Address: 3 St Andrews Bungalows, 11 Hydepark Road, Newtownabbey, Co.Antrim, BT36 4PY
Telephone number: 028 9083 9294

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: Inspire Wellbeing **Responsible Individual:** Ms Kery Anthony	**Registered Manager:** Maxine McQuillan **Date registered:**
Person in charge at the time of inspection:	
Brief description of the accommodation/how the service operates: Mallusk Supported Living Services is a domiciliary care agency operated by Inspire Wellbeing Limited. It is a purpose built building comprising of eight self-contained flats. The agency office is situated in the main building. The agency provides service for service users with a learning disability and/or autism. The scheme provides opportunities to service users based on their assessed needs. At the time of the inspection there were four individuals in receipt of care and support. The service users care and support is commissioned by the Belfast Health and Social Care Trust (BHSCT), the Northern Health and Social Care Trust (NHSCT) and the South Eastern Health and Social Care Trust (SEHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 24 April 2023 between 9.00 a.m. and 1.45 p.m. The inspection was conducted by a care inspector.

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), restrictive practices, Dysphagia management and Covid-19 guidance was also reviewed.

Good practice was identified in relation to the care records which were noted to be person-centred.

Areas for improvement related to staff training, NISCC registrations and the auditing processes. An area for improvement relating to the monthly quality monitoring arrangements has been stated for the second time.

Mallusk Supported Living Service uses the term 'people we support' 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 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.

In preparation for this inspection, a range of information about the service was reviewed. This included any previous areas for improvement identified, registration information, and any other written or verbal information received from service users, relatives, staff or the Commissioning Trust.

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.

Having reviewed the model "We Matter" Adult Learning Disability Model for NI 2020, the Vision states, 'We want individuals with a learning disability to be respected and empowered to lead a full and healthy life in their community'.

RQIA shares this vision and want to review the support individuals are offered to make choices and decisions in their life that enable them to develop and to live a safe, active and valued life. RQIA will review how service users who have a learning disability are respected and empowered to lead a full and healthy life in the community and are supported to make choices and decisions that enables them to develop and live safe, active and valued lives.

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?

During the inspection we spoke with a number of service users and staff members.

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

Comments received included:

Service users' comments:

- "I am happy here."

Staff comments:

- "I have no concerns."
- "I love it here."

Returned questionnaires indicated that the respondents were generally satisfied with the care and support provided. Written comments included:

- "All good."

No responses were 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 21 November 2022		
Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 23(2)(a)(4) **Stated:** First time	The registered person shall ensure that the monthly quality monitoring reports reviews all records to ensure the provision of good quality services for service users. This is to include a review of the DoLS arrangements in place for service users and a review of the staffs' registrations with NISCC. The reports should also detail measures that they consider necessary to take in order to improve the quality and delivery of the services which the agency arranges to be provided. These actions are to be reviewed at every monitoring visit to drive improvement.	**Partially met**
	Action taken as confirmed during the inspection: Whilst improvements had been made in relation to the monthly quality monitoring process, the reports did not demonstrate robust oversight of the staffs' NISCC registrations. This area for improvement has been stated for the second time.	

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 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 annual safeguarding position report, dated March 2022 was viewed.

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 manager advised that no concerns had been raised under the whistleblowing procedures.

The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. We were satisfied that these had been managed appropriately.

Service users indicated they had no concerns regarding their safety.

RQIA had been notified appropriately of any in keeping with the regulations. Incidents had been managed appropriately.

There was a training programme in place which included all areas of mandatory training. However, compliance rates were unsatisfactory, as recorded in the monthly quality monitoring reports. Records reviewed on the day of the inspection were also not updated following recently completed training. This meant we could not be assured as to whether or not the training had been completed. An area for improvement has been identified.

The manager reported that none of the service users currently required the use of specialised equipment. They were aware of how to source such training should it be required in the future.

The manager advised that no service users required their medicine to be administered with a syringe. There were instances where liquid medicines may be measured using a syringe due to the small amount required. Written advice was provided to the manager which would enhance the medicines competency assessment relating to medicines management.

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.

There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had had their capacity considered and, where appropriate, assessed. Where a service user was experiencing a deprivation of liberty, the care records contained the appropriate documentation.

Given that the training records were not up to date, we were not assured that all staff had undertaken training in relation to Deprivation of Liberty Safeguards (DoLS). This has been incorporated into the area for improvement detailed above.

There was a system in place for notifying RQIA if the agency was managing individual service users' monies in accordance with the guidance.

5.2.2 What are the arrangements for promoting service user involvement?

From reviewing care records, it was evident that service users care plans were person centred. Records contained details about their likes and dislikes and the level of support they may require. Staff used a document called 'Day in the Life' to outline service users' likes and dislikes. It was also good to note that the records identified the service users' strengths and objectives that were suited to their needs.

Service users' consent was sought in relation to whether or not they wanted:

- Their photograph to be used in various organisational documents.
- Relevant professionals, including RQIA, to access their care records
- Staff to hold a key to their flats
- Information pertaining to them to be stored in line with General Data Protection Regulations (GDPR)

Care records were noted to be person-centred and it was evident that the key workers were aware of the service users' individual needs. A number of documents were available in easy read format, such as:

- Hospital Passport
- Transport Agreement

It was important that service users with learning disabilities are supported to maintain their relationships with family, friends and partners during the Covid-19 pandemic. Where individuals with learning disabilities continued to experience anxiety about the pandemic, the agency was aware of the resources available to support service users.

5.2.3 What are the systems in place for identifying service users' Dysphagia needs in partnership with the Speech and Language Therapist (SALT)?

Whilst none of the service users had swallowing difficulties, the manager was aware of the referral process should a SALT assessment be required in the future.

Given that the training records were not up to date, we were not assured that all staff had undertaken training in relation to swallow awareness or how to respond to any choking incidents. This has been incorporated into the area for improvement detailed above.

5.2.4 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.

There were no volunteers working in the agency.

5.2.5 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.

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

There was a system in place to ensure that all staff were registered with NISCC or the NMC as appropriate. Review of the records relating to staffs' registrations identified that this was not up to date. In addition, records pertaining to staff supplied from recruitment agencies, did not include evidence of their NISCC or NMC status. An area for improvement has been identified.

Discussion with the manager identified that there were systems in place to audit the quality of care provision. Whilst this included an audit of incidents to identify any trends or patterns, the service users' behaviour records were not included in the auditing process. An area for improvement has been identified relating specifically to the practice of staff' withdrawal from service users' accommodation, where their presence may be contributing to a service user's behaviour. Included in this area for improvement is the need for such incidents to be recorded separately from the daily notes.

This will enable the auditing process to be more effective.

There were monitoring arrangements in place in compliance with Regulations and Standards. Whilst some improvements were noted in the quality of the monthly quality monitoring reports since the date of the last inspection, the reports did not evidence sufficient oversight of the staffs' NISCC registrations. In addition, the reports reflected poor compliance with the mandatory training requirements. Therefore, the monitoring arrangements were ineffective in driving the necessary improvements. This area for improvement has been stated for the second time.

The Annual Quality Report for 2022/2023 was in the process of being completed. This will be reviewed at future inspection.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAIs) or Significant Event Audits (SEAs) procedures.

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 were received since the last inspection, these were appropriately managed and were reviewed as part of the agency's quality monitoring process.

The agency is in the process of installing Closed Circuit Television (CCTV) in specific areas within service users' accommodation. The manager was aware of the need for a policy relating to the use of overt CCTV to be developed, in advance of the commencing using this. This also needs to be included in the Statement of Purpose, which the manager agreed to address.

The manager agreed to submit an application to RQIA for registration as manager. When submitted, RQIA will consider the application.

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	3*	1

* the total number of areas for improvement includes one that has been stated for a second time.

The areas for improvement and details of the QIP were discussed with the 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(2)(a)(4) **Stated:** Second time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the monthly quality monitoring reports reviews all records to ensure the provision of good quality services for service users. This is to include a review of the DoLS arrangements in place for service users and a review of the staffs' registrations with NISCC. The reports should also detail measures that they consider necessary to take in order to improve the quality and delivery of the services which the agency arranges to be provided. These actions are to be reviewed at every monitoring visit to drive improvement. Ref: 5.1, 5.2.1 and 5.2.6
	Response by registered person detailing the actions taken: The registered person has provided additional guidance to those responsible for the completion of quality monitoring surrounding the range of areas to be covered during monitoring and the completion of Inspires Quality Monitoring Report. This includes the review of professional registrations and the implementation of DoLs. Additional guidance has also been provided on the inclusion of all identified improvement actions within the report for follow on checks. Inspires Quality & Compliance team in conjunction with the services allocated Assistant Director will undertake additional review of the services monitoring.
Area for improvement 2 **Ref:** Regulation 16 (2)(a) **Stated:** First time **To be completed by:** DD Month Year	The registered person shall implement a robust system to oversee staff' compliance with training requirements; this should include all mandatory training, including DoLS, First Aid and Swallow awareness. Records pertaining to training must be kept up to date. Ref: 5.2.1 and 5.2.3
	Response by registered person detailing the actions taken: The registered manager has implemented regular review of the services training compliance records held with Inspires' staff records management software. Any discrepancy or out of date records will be identified and corrected in conjunction with Inspires Organisational Development Team. Any compliance issues will be identified and action taken to address. This will

	be reported on through the service monthly compliance report and reviewed at monitoring.
Area for improvement 3 **Ref:** Regulation 13 (d) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that a system is developed and implemented to demonstrate robust oversight of staffs' NISCC registrations; this should include the registration status of all agency staff supplied by recruitment agencies. Ref 5.2.6
	Response by registered person detailing the actions taken: The Registered Manager has implemented monthly checks on the services professional registrations report contained within inspires staff records management software. This will be reported on through the organisations monthly compliance report and quality monitoring. The registered manager will ensure the professional registration of agency workers is checked against their agency profile on commencement at the service with the profile being maintained as a record available to monitoring and inspection.

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 8.10 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall further develop the auditing processes to ensure that service users' behaviour charts are audited on a regular basis; this refers specifically to the need to audit the practice of staff' withdrawal from service users' accommodation, where their presence may be contributing to a service user's behaviour; such incidents should be recorded separately from the daily notes to enable effective auditing. Ref: 5.2.6
	Response by registered person detailing the actions taken: Guidance has been provided to the team to ensure records provide adequate detail of the use of 'staff withdrawal' within ABC charts. Records are separate from care notes. An additional audit of these records has been implemented. The audit is completed monthly to ensure the practice of 'staff withdrawal' is appropriately used at all times. The records and audit are shared with the person's multidisciplinary team including behavioural specialists.

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

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA