Inspection Report

16 August 2024

Beechcote Supported Living

Type of service: Domiciliary Care Agency
Address: 15 Beechcote Avenue,
Killycomaine Road, Portadown, BT63 5DG
Telephone number: 028 3829 8901

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: Praxis Care **Responsible Individual:** Mr Greer Wilson	**Registered Manager:** Mrs Sharon Livingstone **Date registered:** 11 August 2023
Person in charge at the time of inspection: Mrs Sharon Livingstone	
Beechcote Supported Living is a domiciliary care agency, supported living type. The agency provides care and support to a number of service users who have a range of health needs. The service users reside in two houses located in Portadown; the agency office is located in the home of a number of the service users. The service is commissioned by the Western, Southern and Belfast Health and Social Care (HSC) Trusts.	

2.0 Inspection summary

An unannounced inspection took place on 16 August 2024 between 10.00 a.m. and 5.00 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), Service user involvement, Restrictive practices and Dysphagia management were also reviewed.

Areas for improvement identified related to staff training, care planning, the storage of medicines, restrictive practices and adult safeguarding records.

Good practice was identified in relation to service user involvement and staff recruitment.

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 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.

Information was provided to service users, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included easy read 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 they had generally no concerns in relation to the agency. Comments made by some staff were discussed with the manager for further review and follow up.

Comments received included:

Service users' comments:

- "Good, I like it here and staff are good."
- "I am alright; staff taking me out for a coffee."
- "No problems."
- "Like it here, I am going out today."
- "Staff good."

Staff comments:

- "I love it here and I enjoy it. I am well supported and can raise issues."
- "It has been a big change for service users and staff."
- "I feel listened to and things are dealt with."

- “All good, service users have choice and are safe.”
- “We are supporting service users to adjust to supported living.”
- “This is great for service users, they have more freedom, choice and the environment is better.”
- “I feel well supported by the manager and the deputy.”
- “This is a great place; I have no issues.”

No questionnaires were returned.

There were no responses to the electronic survey.

5.1 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 a pre-registration inspection undertaken on 21 July 2023 by a care inspector. No areas for improvement were identified.

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. 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.

It was identified from discussions with the manager and the review of information that the agency did not have a robust or effective system in place for retaining records relating to any referrals made to the HSC Trust in relation to adult safeguarding, the actions taken or the outcomes. It was noted that information relating to referrals made was not readily available for staff. We discussed with the manager the need to ensure that records relating to adult protection should be retained in a format that is accessible for staff. An area for improvement was identified.

Service users said they had no concerns regarding their safety; they described how they could speak to staff if they had any concerns.

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. The review of information relating to incidents indicated that they had been managed appropriately.

It was identified that a large number of staff needed to complete an update in Moving and Handling training. An area for improvement was 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.

Care reviews had been undertaken in keeping with the agency's policies and procedures. There was also evidence of regular contact with service users and their representatives, in line with the commissioning trust's requirements.

It was identified that a number of staff needed to complete a training update/competency assessment in relation to medicines management. An area for improvement was identified and is subsumed into the area for improvement above. 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.

It was noted that a medicine trolley was being used to store the medicines of one of the service users, we discussed with the manager the need to review this arrangement to make it more individualised and in keeping with the supported living ethos. An area for improvement has been identified.

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 taken 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.

The manager reported that none of the service users were subject to DoLS. It was noted that a number of staff needed to complete DoLS training appropriate to their job roles. An area for improvement was identified and is subsumed into the area for improvement above.

We discussed with the manager practices that may be deemed as restrictive. It was identified that the agency needed to review practices that may be deemed restrictive. They should ensure that any restrictive practices are agreed with the service user and/or their representatives and included within the individual service users care plan. In addition, the agency should develop and maintain a register for any practices deemed to be restrictive. An area for improvement was identified.

5.2.2 What are the arrangements for promoting service user involvement?

From reviewing service users' care records and through discussions with staff, it was identified that the care and support plans for three of the service users needed to be reviewed and updated in line with the supported living model. An area for improvement was identified.

It was also good to note that the agency had facilitated service users' meetings on a monthly basis which provided that opportunity for the service users to discuss the provisions of their care. Some matters discussed included:

- Holidays
- Service Improvement
- Outings

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

The manager advised that none of the service users had swallowing difficulties or been assessed by a SALT with recommendations. 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. Staff demonstrated a good knowledge of service users' wishes and preferences with regards to nutritional intake.

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 was evidence that checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC) or any other relevant regulatory body; there was a system in place for professional registrations to be monitored by the manager. We discussed with the manager the benefits of recording staff registration numbers on the checklist. A spot check completed during the inspection indicated that staff were registered appropriately. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

The manager advised that there were no volunteers supporting within 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 lasting at least three days; this 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.

A review of the records relating to staff that were provided from recruitment agencies also indicated that they had been recruited, inducted and trained in line with the regulations.

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

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

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; finance; safeguarding matters; staff recruitment and training, and staffing arrangements. There was a detailed action plan for any matters requiring attention; this was linked with a Service Improvement Plan which was in place for the agency. Following the inspection, a senior manager from the organisation advised that they were supporting the manager to effective address all the matters identified within the action plan.

The manager advised that 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. It was identified that no complaints were received since the last inspection.

The Statement of Purpose required updating with RQIA's contact details; the manager advised that this would be actioned immediately following the inspection; this will be reviewed at the next inspection.

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	2	3

The areas for improvement and details of the QIP were discussed with Sharon Livingstone, 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 14(c) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	Where the agency is acting otherwise than an employment agency, the registered person shall make suitable arrangements to ensure the agency is conducted, and the prescribed services arranged by the agency, are provided- (c) so as to promote the independence of service users. This relates specifically to ensuring that the current arrangements for the safe storage of medicines is reviewed to make it individualised and in keeping with the supported living environment. Ref: 5.2.1
	Response by registered person detailing the actions taken: The medication for all service users has been moved into locked cabinets in their own bedrooms. Currently all service users have been assessed as Level 3, each Service user to be reassessed within the next quarter .
Area for improvement 2 **Ref:** Regulation 15 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that there is a review of any practices that may be deemed as restrictive. Any practices deemed to be restrictive should be agreed with the service user and/or their representative and included within their individual care plan. In addition, the agency should develop and maintain a register for any practices deemed to be restrictive. Ref: 5.2.1
	Response by registered person detailing the actions taken: There is now restrictive register in place for all service users with restrictivce practices being implemented and referenced within their every day living plans and risk assessment and management plans.

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 14.7 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that there is a robust and effective system implemented to retain a written record of all suspected, alleged or actual incidents of abuse and include details of the referral, the investigation, the outcome and actions taken. Ref: 5.2.1
	Response by registered person detailing the actions taken: There have been 3 recorded safeguarding incidents. All safegaurding related incidents are now filed (3 in total) in safeguarding file. One incident awaiting an ABE interview and remains open. Two awaiting closure from the Trust.
Area for improvement 2 **Ref:** Standard 12 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that staff are trained for their roles and responsibilities. This relates specifically to Moving and Handling, Medicines management and DoLS training. Ref: 5.2.1
	Response by registered person detailing the actions taken: Relief staff informed to complete training before next shift. Night duty staff to complete two outstanding elearing trainings.
Area for improvement 3 **Ref:** Standard 3.3 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that a care plan is in place for each individual service user. The care plan should include information on: • the care and services to be provided to the service user; • directions for the use of any equipment; • the administration or assistance with medication; • how specific needs and preferences are to be met; and • the management of identified risks. Ref: 5.2.2
	Response by registered person detailing the actions taken: Files has been allocated out and work is ongoing alongside the people we support to develop individualised outcome based assessments, plans and risk assessments. Staff are working in a co productive manner with the service users in Beechcote to best support their individualised needs. This work will be completed by 31.10.24

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

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