The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Threshold-Cheshire House**

Provider: **Threshold Services NI**

Date of Inspection: **25 April 2025**

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Registered Provider:	Threshold Services NI
Responsible Individual:	Mrs. Fiona McCabe
Registered Manager:	Mrs. Hannah Louise Horner
Service Profile – Cheshire House is a supported living type domiciliary care agency which provides care and housing support services to service users with physical disabilities and acquired brain injury. Service users live in their own flats and have the use of a number of indoor and outdoor spaces. The management of the service moved from Leonard Cheshire Disability to Threshold Services on 1 April 2025.	

2.0 Inspection summary

An unannounced inspection took place on 25 April 2025 between 09.00 a.m. and 1.00 p.m. The inspection was carried out 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 inspection also examined the reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS), service user involvement, restrictive practices and Dysphagia management.

There were no Areas for Improvement identified during this inspection.

Good practice was identified in relation to service user involvement, relatives' feedback and training. There were good governance and management arrangements in place.

Cheshire House uses the term 'tenants' 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 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 Cheshire House 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 any previous areas for improvement issued, registration information, and any other written or verbal information received from relatives, staff or the commissioning trust.

Throughout the inspection process inspectors will seek the views of those living, working and visiting the service and review a sample of records to evidence how the service is performing in relation to the regulations and standards.

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.

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

Throughout the inspection the RQIA inspector spoke with service users, their relatives or visitors and staff for their opinions on the quality of the care and support, their experiences of using, visiting or working in the agency.

Respondents spoken to by the inspector gave positive feedback. Service users said 'I love it here and the staff are so nice'. Relatives of service users stated that the service users 'are very well cared for and have only good things to say about it'. Another relative said '[my relative] loves it here'. Staff reported that they enjoyed working in the agency and that the training was very good. Staff also reported that management and leadership was excellent.

Returned service user questionnaires indicated that there were no concerns in relation to the agency and that service users were very happy.

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 31 May 2024 by a care inspector. No areas for improvement were identified.

4.0 Inspection findings

4.1 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 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. There was an identified Adult Safeguarding Champion (ASC).

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. They could also describe their role in relation to reporting poor practice and their understanding of the day care setting's policy and procedure with regard to whistleblowing.

The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. A review of records confirmed that these had been managed appropriately.

The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

Service users said they had no concerns regarding their safety; they described how they could speak to staff if they had any concerns about safety or the care being provided. The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any concerns.

Staff were provided with training appropriate to the requirements of their role. The manager advised that there were several service users who require the use of specialised equipment to assist them with moving. A review of care records identified that moving and handling risk assessments and care plans were up to date. Care plans indicated the make and model of equipment used in the care of each service user.

Care reviews had been undertaken in keeping with the agency's policies and procedures.

All staff had been provided with training in relation to medicines management. The manager advised that all staff complete medication management training. The manager advised that there were no service users who required the administration of oral medication via syringe.

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 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 Mental Capacity Act (MCA).

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. A resource folder was available for staff to reference if needed.

The inspector viewed the agency's fire risk assessment and this was found to be within date, with no actions outstanding from the previous assessment.

4.2 What are the systems in place for the promotion of service user involvement?

From reviewing service users' care records and through discussions with service users, the inspector noted that service users had an input into devising their own plan of care where possible. Service users' care plans contained details about their likes and dislikes and the level of support they may require. 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 by both the agency and the commissioning trust. The annual quality report was reviewed by the inspector and demonstrated evidence of comprehensive service user consultation.

4.3 What are the systems in place for meeting the Dysphagia needs of service users?

A number of service users had been assessed by Speech and Language Therapy (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 how to respond to choking incidents.

Discussions with staff and review of service users' care records reflected the multi-disciplinary input and the collaborative working undertaken to ensure service users' health and social care needs were met. There was evidence that staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate. Staff also implemented the specific recommendations of the SALT to ensure the care received was safe and effective.

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.

4.4 What systems are in place for 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 NISCC 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.

4.5 What arrangements are in place for staff induction and training?

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 day care setting's policies and procedures. There was a formal induction programme of at least three days which also included shadowing of a more experienced staff member. The agency operates a buddy system for new staff. Written records were retained by the agency of the person's capability and competency in relation to their job role.

The agency has maintained a record for each member of staff of all training, including induction and professional development activities undertaken; this included staff that were supplied by agencies. The inspector reviewed the training matrix maintained by the agency and found all training to be up to date.

4.6 What are the arrangements to ensure robust managerial oversight and guidance?

There were monthly monitoring arrangements in place in compliance with regulations. A review of the reports of the agency's monthly quality monitoring established that there was engagement with service users, service users' relatives, staff and HSC Trust representatives. The reports included details of a review of service user care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

The Annual Quality report was reviewed by the inspector 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.

There was a system in place to ensure that complaints were managed in accordance with the policy and procedure of the agency. No complaints had been received since the last inspection, whereas there was a large amount of compliments. Complaints were reviewed as part of the monthly quality monitoring process.

The inspector reviewed records of regular staff supervision as well as appraisals which are carried out annually. Examination of appraisal and supervision records indicated that these were all up to date as per the policies and procedures of the agency.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs. Louise Horner, Manager, as part of the inspection process and can be found in the main body of the report.

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