The Regulation and Quality Improvement Authority

Inspection Report

6 October 2022

Struell Lodge Supported Housing Scheme

Type of Service: Domiciliary Care Agency
Address: 2 Ardglass Road, Downpatrick, BT30 6JG
Tel No: 028 4451 3850

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: South Eastern HSCT Trust **Responsible Individual:** Ms Roisin Coulter	**Registered Manager:** Ms Kellyann Kehoe **Date registered:** Acting, no application required
Person in charge at the time of inspection: Ms Kellyann Kehoe	
Brief description of the accommodation/how the service operates: Struell Lodge Supported Housing Scheme is a domiciliary care agency supported living type located in Downpatrick. Agency staff provide care and support to a number of service users living in shared accommodation located in the local community. Service users each have their own individual bedrooms and a number of shared facilities. The service users have a range of complex needs. The agency's aim is to provided care and support to service users; this includes assisting service users with personal care needs, meals, medication, housing support and assistance to access community services with the overall goal of promoting independence and maximizing the quality of life.	

2.0 Inspection summary

An unannounced inspection took place on 6 October 2022 between 9.40 a.m. and 3.40 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 and Covid-19 guidance was also reviewed.

An area for improvement with regard to staff training identified at the last inspection was assessed as not met and has been stated for a second time.

Good practice was identified in relation to service user involvement. There were good governance and management arrangements in place.

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.

Comments received included:

Service users' comments:

- "Staff help me with my house and my laundry."
- "The manager and staff are good; they help me."
- "I am going to Belfast with staff; I love going out down the town."
- "I talk to staff if I am not happy."
- "I went with the staff to visit Coronation Street."
- "I have a buzzer to contact staff."
- "I look after my own money, I lock it away."

One matter raised by a two of the service users with regards to their current living arrangements was discussed with the manager. It was identified that there is ongoing engagement with the service users in conjunction with the HSCT keyworker.

Staff comments:

- "I love it, it is the best job."
- "I feel supported and listened to."
- "I love my job; I have seen the transition of the service users to supported living and I love it."
- "Service users have more choice, freedom and opportunities in supported living."
- "Service users can do what they want."
- "This is the best place ever; service users are living a good life."
- "I love seeing the service users be more independent."
- "Manager is supportive and listens."
- "Taking a service user to Lourdes."
- "I had a concern about consistency of staff; I have spoken to the manager. Staffing hard during Covid."

Matters raised by some staff with regards to staffing arrangements and shift patterns were discussed with the manager and will be followed up with the full staff team. The manager discussed that the staffing arrangements had recently been reviewed to ensure that the needs of the service users are consistently met; they advised that this has resulted in a change in the working patterns of some staff.

No questionnaires were returned. There were no responses 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?

The last care inspection of the agency was undertaken on 7 January 2022 by a care inspector. A Quality Improvement Plan (QIP) was issued. This was approved by the care inspector and was validated during this inspection.

Areas for improvement from the last inspection on 7 January 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 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	(1) The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided. (2) At the request of the Regulation and Improvement Authority, the registered person shall supply to it a report, based upon the system referred to in paragraph (1), which describes the extent to which, in the reasonable opinion of the registered person, the agency— (a) arranges the provision of good quality services for service users; (b) takes the views of service users and their representatives into account in deciding— (i) what services to offer to them, and (ii) the manner in which such services are to be provided; and (c) has responded to recommendations made or requirements imposed by the Regulation and Improvement Authority in relation to the agency over the period specified in the request. (3) The report referred to in paragraph (2) shall be supplied to the Regulation and Improvement Authority within one month of the receipt by the agency of the request referred to in that paragraph, and in the form and manner required by the Regulation and Improvement Authority. (4) The report shall also contain details of the measures that the registered person considers	**Met**

	it necessary to take in order to improve the quality and delivery of the services which the agency arranges to be provided. (5) The system referred to in paragraph (1) shall provide for consultation with service users and their representatives. The reports should be forwarded to RQIA by the 10th of each month until further notice. Ref: 5.2.5	
	Action taken as confirmed during the inspection: Inspector confirmed that a system is in place to monitor and evaluate the quality of the service provided. Reports were forwarded to RQIA as requested.	
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards 2021		**Validation of compliance**
Area for improvement 1 **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 and that mandatory training requirements are met. Ref: 5.2.1 and 5.2.4	**Not met**
	Action taken as confirmed during the inspection: It was noted that whilst a number of staff had completed a range of training updates there were still a number of training updates outstanding. This area for improvement was assessed as not met and has been stated for a 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 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).

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. It was noted that a number of staff are required to complete a training update in adult safeguarding. 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 in normal business hours and out of hours. 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 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.

Service users 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. It was noted that the staff in conjunction with HSCT keyworkers are supporting two service users with regards to their current living arrangements in relation to compatibility.

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.

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 need to complete training in relation to medicines management. An area for improvement has been identified. The manager advised that no service users required their medicine to be administered with a syringe. The manager was aware that should this be required, a competency assessment would be undertaken before staff undertook this task.

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 MCA.

A number of staff had completed appropriate DoLS training appropriate to their job roles; however it was noted that a number still needed to complete training. An area for improvement has been identified and is subsumed into the area for improvement in 5.1. The manager reported that none of the service users were currently subject to DoLS.

It was identified that a number of service users' finances are managed by the HSCT finance department and not directly by the agency.

5.2.2 What are the arrangements for promoting service user involvement?

From reviewing service users' care records and through discussions with service users, it was good to note that service users had an input into devising their own plan of care. The 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 provided on an annual basis, or when changes occur.

It was also good to note that the agency support service users to meet with their keyworkers on a one to one basis to discuss the provisions of their care.

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

New standards for modifying food and fluids were introduced in August 2018. This was called the International Dysphagia Diet Standardisation Initiative (IDDSI). One service user was assessed by SALT with recommendations provided; however they did not require to have their food or fluids modified. A review of training records confirmed that a number of staff need to complete training in Dysphagia. An area for improvement has been identified and is subsumed into the area for improvement in 5.1.

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 within the agency. 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 in the setting 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.

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 in conjunction with the organisation's Human Resources (HR) department 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) or any other relevant regulatory body; there was a system in place for professional registrations to be monitored monthly by the manager. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

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?

It was noted that staff have been employed for a number of years. There was evidence that all newly appointed staff would be required to complete 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.

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

All registrants must maintain their registration for as long as they are in practice. This includes renewing their registration and completing Post Registration Training and Learning. The manager was advised to discuss the post registration training requirement with staff to ensure that all staff are compliant with the requirements.

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, 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. We discussed with the manager in relation to recording information in regard to medication errors.

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.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. It was noted that no complaints had been received since the last inspection.

The Statement of Purpose required updating with RQIA's contact details and those of the manager. The manager was also signposted to Part 2 of the Minimum Standards, to ensure the Statement of Purpose included all the relevant information. The manager submitted the revised Statement of Purpose to RQIA following the inspection.

We discussed the acting management arrangements; RQIA will keep this matter under review.

6.0 Quality Improvement Plan (QIP)/Areas for Improvement

An area for improvement identified at the last inspection where action is required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021was assessed as not met and has stated for a second time.

	Regulations	Standards
Total number of Areas for Improvement	0	1*

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

The area for improvement and details of the QIP were discussed with Kellyann Kehoe, 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 Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 12 **Stated:** Second time	The registered person shall ensure that staff are trained for their roles and responsibilities and that mandatory training requirements are met. Ref: 5.1; 5.2.1 & 5.2.3
To be completed by: Immediate and ongoing from the date of inspection	**Response by registered person detailing the actions taken:** Staff following inspection were given 28 days to complete all relevant training to ensure safe practice Manager has now implememented a new personal development checklist for staff to complete prior to supervision to highlight training requirements for each indiviudual staff member and action plan created to ensure completion

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

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