Inspection Report

Name of Service: Inspire Altigarron Court

Provider: Inspire Wellbeing

Date of Inspection: 12 November 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:	Inspire Wellbeing
Responsible Individual/Responsible Person:	Ms Kerry Anthony
Registered Manager:	Ms Isobel Weir

Service Profile
Altigarron Court is a supported living type domiciliary care agency. The agency offers domiciliary care and housing support to fourteen service users with enduring mental health needs. The registered office is located within the same building as the service users' homes. The agency's aim is to provide care and support to service users; this includes helping service users with tasks of everyday living, emotional support and assistance to access community services, with the overall goal of promoting good mental health and maximising quality of life. Staff are available to support service users 24 hours a day and each service user has an identified 'key worker'. Referrals are made by the Belfast Health and Social Care Trust (BHSCT) and Western Health and Social Care Trust (WHSCT).

2.0 Inspection summary

An unannounced inspection was conducted on 12 November 2024, from 9.45 a.m. to 5:30 p.m. by care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards. The inspection also sought to determine if the agency is delivering safe, effective and compassionate care and if the agency is well led.

This 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 was also examined. The inspection also sought to assess progress with areas for improvement identified within the quality improvement plan (QIP) from the last inspection on 8 November 2023. Details of the previous QIP assessment can be found section 3.3 and in the main body of the report.

It was established that staff treated service users with dignity and respect, effective and compassionate care was delivered to service users receiving support from the agency and care records were person centred and provided evidence of service user involvement.

Good practice was identified in relation to service user involvement and staffs' knowledge in relation to safeguarding and SALT recommendations.

There were no new areas for improvement (AfI) identified. Four AfI identified at the previous inspection on 8 November 2023, in relation to staff training, training records, reporting notifiable incidents to RQIA, and the policy and procedure in relation to gaining access to a service users home have been stated for a second time.

Inspire Altigarron Court 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 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 service. This included the previous areas for improvement issued, 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 survey.

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

Throughout the inspection the RQIA inspector will seek to speak with service users, their relatives or visitors and staff for their opinions on the quality of the care and support, their experiences of living, visiting or working in this service to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

Service users spoke positively about their experience of the support provided by the agency; they said they enjoyed living in the supported living service and that the staff supported them well. Observations of staff interacting with service users was noted to be person centred and respectful.

Staff spoke very positively in regard to the care delivery in the agency. They confirmed they enjoyed working in the service and everyone worked together as a team. Staff indicated that the induction and training provided was good. Staff describe the support they provided to service users to help them participate in activities of their choice.

HSC Trust representatives were very complimentary of the staff and advised that they were very impressed at how well the agency's staff knew the service users. They were prompt to notify them of changes and communication was good.

Returned questionnaires indicated that the respondents were very satisfied with the care and support provided. Some comments related to suggestions for social activities. No responses were received to the electronic survey.

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

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 8 November 2023 by a care inspector. A Quality Improvement Plan (QIP) was issued. This was approved by the care inspector and was validated during this inspection.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 8 November 2023</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Regulation 15 (12) (b)

Stated: First time</td><td>The registered person shall ensure that RQIA have been notified of any incident reported to the PSNI not later than 24 hours after the registered person—
(i) has reported the matter to the PSNI or
(ii) is informed that the matter has been reported to the PSNI.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This area for improvement has been assessed as not met, further detail provided in section 3.4.1.</td></tr>
<tr><td>Area for Improvement 2

Ref: Regulation 16 (2) (a)

Stated: First time</td><td>The registered person shall ensure that staff receive training appropriate to the work they are to perform and relevant to the assessed needs of service users including:
Mental health awareness
Drugs, alcohol and other substances
Suicide awareness
Epilepsy awareness
Awareness of the needs of service users living with a learning disability
Naloxone in the management of drug overdose</td><td>Partially met</td></tr>
</table>

	Action taken as confirmed during the inspection: This area for improvement has been assessed as partially met, further detail provided in section 3.4.2	
Area for Improvement 3 **Ref:** Regulation 15 (9) **Stated:** First time	The registered person shall ensure that an operational policy and procedure is in place and staff are fully trained and competent in relation to the actions required in the event of being unable to gain access to a service users home	**Not Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as not met, further detail provided in section 3.4.1.	
Area for Improvement 4 **Ref:** Regulation 15 (4) **Stated:** First time	The registered person shall ensure that a copy of the original SALT recommendations and treatment plan is included in the service users care plan.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met, further detail provided in section 3.4.3.	
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure that a training matrix is in place and kept up to date to enable the manager to have an overview of the training status of all staff working in the agency	**Not met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as not met, further detail provided in section 3.4.2.	
Area for improvement 2 **Ref:** Standard 9 **Stated:** First time	The registered person shall ensure that the following policies and procedures are in place that direct the quality of care and services provided: • management of risks associated with the care of individual service users • drug and alcohol misuse	**Met**

	• self-harm/suicide • managing aggression/anti-social behaviour • missing persons	
	Action taken as confirmed during the inspection: This area for improvement had been assessed as met, further detail provided in section 3.4.1.	
Area for improvement 3 **Ref:** Standard 1.3 **Stated:** First time	The registered person shall ensure that a contemporaneous record is kept of all service user meetings.	**Met**
	Action taken as confirmed during the inspection: This area for improvement had been assessed as met, further detail provided in section 3.4.1	

3.4 Inspection findings

3.4.1 Governance and Managerial Oversight

The agency's registration certificate was up to date and displayed appropriately along with current certificates of public and employers' liability insurance.

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.

The Annual Quality Report was reviewed and was satisfactory; it included the views of service users and other key stakeholders.

Staff had managed incidents appropriately, however, RQIA had not been notified of several incidents, within appropriate timeframes, which were required to be reported in keeping with the regulations. The AfI, as stated in section 3.3 of this report, has been assessed as not met and will therefore be stated for a second time.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Staff demonstrated a good awareness of both the complaints procedure and whistleblowing policy. They stated a record of a complaint would include nature, type of complaint, individuals involved, outcome and complainant satisfaction. A register of complaints is retained by the service. There had been no complaints received since the last inspection to view. Details relating to the complaints process were included in the statement of

purpose and service users guide. The agency also has an easy read complaints guidance leaflet for service users if required. There was evidence of a system to ensure oversight of complaints which included a review of complaints during the monthly quality monitoring visits

It was good to note that the agency held service users' meetings on a regular basis which enabled the service users to discuss the provisions of their care. A contemporaneous record was available to review. The AfI as stated in section 3.3 of this report has been assessed as met, however, the quality of the minutes of these meeting could be enhanced by the use of a standard recording template to ensure consistency and which clearly identifies actions to be taken by staff in response to service users comments. This was discussed at feedback; staff acknowledged the benefits and agreed to consider implementing this in future.

Staff confirmed they had opportunity to attend staff meetings where they are provided with updates on policies and additional training requirements. They stated they could add to the meeting agenda if there were items they wished to discuss. Staff told us that they would have no issue in raising any concerns regarding service users' safety or care practices and that they were confident that the manager or person in charge would address their concerns.

The Inspire Service Delivery Policy, dated 2024, was reviewed in conjunction with several related policies that direct the quality of care and services provided. These included:

- management of risks associated with the care of individual service users;
- drug and alcohol misuse;
- self-harm/suicide;
- managing aggression/anti-social behaviour; and
- missing persons.

These policies direct staff to promote rights based practice and an outcome-based approach to care and support planning based on individual risk assessments. Staff confirmed they had access to policies and that those relevant to individual service users would be reflected in their care plans. The AfI as stated in section 3.3 of this report has been assessed as met.

A review of the policy on gaining access to service users' properties does not provide the level of detail required to clearly direct staff from the agency as to what actions they should take to manage and report such situations in a timely manner. Whilst there is reference to staff being required to complete a dynamic risk assessment when prioritising the prevention of harm, this statement is not supported with any risk tools/templates for staff to reference or to use. The AfI as stated in section 3.3 of this report has been assessed as partially met and is therefore stated for a second time.

3.4.2 Staffing (recruitment and selection, induction and training).

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of service users.

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. Written records were retained by the agency of the person's capability and competency in relation to their job role.

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) or the Nursing and Midwifery Council (NMC) or any other relevant regulatory body; 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.

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. Staff said they get an opportunity to discuss the post registration training requirements during supervision and appraisal meetings.

Review of the staff training records evidenced that not all training was captured on the agency's training matrix, hence it did not support sufficient managerial oversight and assurances in relation to training compliance. Following the inspection, the manager provided compliance figures for training specific to service users' needs as stated in section 3.3. It was noted good compliance was achieved in all, apart from Naloxone in the management of drug overdose training. The manager confirmed that Inspire does not currently have a procedure on the use of Naloxone which potentially could be a barrier to rolling out the training at present. There was no evidence provided to indicate progress with this training since the last inspection. The AfI related to the training matrix, as stated in section 3.3 of this report, has been assessed as not met and the AfI related to training has been assessed as partially met, therefore both will be stated for a second time.

There were no volunteers deployed within the agency.

3.4.3 Care Records

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.

The person in charge 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 person in charge also advised that no service users required their oral medicine to be administered with a syringe. The person in charge was aware that should this be required, a competency assessment would be completed before staff would undertake this task.

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.

Speech and Language Therapy (SALT) recommendations and treatment plans were available in the service users care plan at the time of inspection. 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. The AfI as stated in section 3.3 of this report has been assessed as met.

3.4.4 Safeguarding

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 person in charge 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 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 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.

The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI), however there were delays in reporting to RQIA as noted previously in section 3.4.1.

3.4.5 Deprivation of Liberty Safeguards (DoLs)

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 person in charge reported that none of the service users were subject to DoLS, but some restrictive practises were in place. A register of restrictive practices was retained and these practices were based on risk assessments and evident in service users care records.

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	3*	1*

* the total number of areas for improvement includes four that have been stated for a second time

Areas for improvement and details of the Quality Improvement Plan were discussed with the Senior Project Worker 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 15 (12) (b) **Stated:** Second time **To be completed by:** Immediately from the date of inspection and ongoing	The registered person shall ensure that RQIA have been notified of any incident reported to the PSNI not later than 24 hours after the registered person— (i) has reported the matter to the PSNI or (ii) is informed that the matter has been reported to the PSNI. Ref: 3.4.1 **Response by registered person detailing the actions taken:** The Registered Manager will ensure, with immediate effect, that relevant events are reported in line with the regulation. This will be validated through quality monitoring and supervision arrangements.
Area for improvement 2 **Ref:** Regulation 16 (2) (a) **Stated:** Second time **To be completed by:** 30 December 2024	The registered person shall ensure that staff receive training appropriate to the work they are to perform and relevant to the assessed needs of service users including: • Mental health awareness • Drugs, alcohol and other substances • Suicide awareness • Epilepsy awareness • Awareness of the needs of service users living with a learning disability • Naloxone in the management of drug overdose Ref: 3.4.2 **Response by registered person detailing the actions taken**: A guidance document on the use of naloxone has been published to complement guidance provided within Inspire's medication procedure. A training plan for naloxone administration has been implemented with all staff to be trained no later than 31st March 2025.
Area for improvement 3 **Ref:** Regulation 15 (9) **Stated:** Second time **To be completed by:**	The registered person shall ensure that an operational policy and procedure is in place and staff are fully trained and competent in relation to the actions required in the event of being unable to gain access to a service users home. Ref: 3.4.1

30 December 2024	**Response by registered person detailing the actions taken:** The Responsible Person will ensure the relevant Policy and Procedure is reviewed and updated no later than the 31/01/25.

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 a training matrix is in place and kept up to date to enable the manager to have an overview of the training status of all staff working in the agency Ref: 3.4.2
To be completed by: Immediately from the date of inspection and ongoing	**Response by registered person detailing the actions taken:** The Registered Manager will ensure the training matrix will be updated on a monthly basis. This will be further reviewed through quality monitoring and supervision.

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

The **Regulation** and **Quality Improvement** Authority

The Regulation and Quality Improvement Authority

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