Inspection Report

8 November 2023

Inspire Altigarron Court

Type of service: Domiciliary Care Agency
Address: 6 Westrock Gardens, Belfast, BT12 7RF
Telephone number: 028 9692 8799

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 Kerry Anthony	**Registered Manager:** Ms Isobel Weir **Date registered:** 4 May 2022
Person in charge at the time of inspection: Ms Isobel Weir	
Brief description of the accommodation/how the service operates: Altigarron Court is a supported living type domiciliary care agency. The agency offers domiciliary care and housing support to thirteen 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 took place on 8 November 2023 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, Dysphagia management and Covid-19 guidance was also reviewed.

Areas for improvement related to the Incidents the agency are required to notify RQIA; Dysphagia care plans and Emergency access to service users' accommodation. Two areas for improvement related to Staff training. Additional areas for improvement related to Risk Management policies and in relation to record keeping.

Good practice was identified in relation to service user involvement.

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 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.

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:

- "Staff are brilliant; they would do anything for you. I have no concerns and I'm well looked after"

Staff comments:

- "I had a good induction and my online training is complete"
- "I love my work. There is good support and staff meetings every 4 – 6 weeks"
- "There is plenty of support and I have no concerns"

Returned questionnaires indicated that service users were very satisfied with the care and support provided. No written comments were included.

One staff member responded to the electronic survey. The respondent indicated that they were dissatisfied with regard to the safety of the care provided, however they were 'very satisfied' or 'satisfied' that the care was effective and compassionate and that the service was well led. Written comments included:

- "Staffing issues. Inspire are aware and working with agencies and relief workers to alleviate pressures".

The feedback provided by staff was discussed with the manager for follow up as appropriate.

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 28 November 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 28 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 15(3)(b) **Stated:** First time	The registered person shall ensure that every service user's care plan is kept under review. This should be completed on an annual basis or if the service users' needs change.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement had been met.	
Area for Improvement 2 **Ref:** Regulation 15(2)(a) **Stated:** First time	The registered person shall ensure that the risk assessments and care plans are reflective of the International Dysphagia Diet Standardisation Initiative (IDDSI), as indicated on the Speech and Language Therapist (SALT) care plan.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement had been met.	

Area for Improvement 3 **Ref:** Regulation 23(2)(a)(4) **Stated:** First time	The registered person shall ensure that the monthly quality monitoring reports 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. The reports should also contain a review of NISCC and NMC registrations, agency staff recruitment and training and information relating to the MCA.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement had been met.	

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 year 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). It was noted that not all incidents

had been notified to RQIA, in accordance with the regulations. An area for improvement has been identified.

Policies and procedures were not in place to guide staff in relation to the management of risks associated with the care of individual service users, specifically in relation to drug and alcohol misuse, managing aggression/anti-social behaviour, self-harm/suicide and missing persons. An area for improvement has been identified.

Staff had completed mandatory training; however, it was noted that not all staff had completed additional training relevant to the assessed needs of service users. In addition, an overall training matrix was not in place for all staff. Two areas for improvement has been identified accordingly.

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.

All staff had been provided with training in relation to medicines management. The manager advised that no service users required their medicine to be administered with an oral 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 Mental Capacity Act (MCA).

Staff had completed appropriate 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.

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 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 had service users' meetings on a regular basis which enabled the service users to discuss the provisions of their care. Some matters discussed included:

- Activities and events in the local community
- Housekeeping issues
- Keeping safe

Some comments included:

- "A Sunday roast, say the first Sunday of every month to bring tenants together and socialise as well as having a properly prepared dinner"
- "Trips away when the weather gets better or a weekend stay somewhere"
- "Could not think of any suggestion for activities as happy with everything"

Staff informed the inspector that service user meetings are held monthly, however not all minutes of meetings had been completed. An area for improvement has been identified.

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

A review of training records confirmed that staff had completed training in Dysphagia and in relation to 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 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. There was evidence that staff had incorporated the SALT recommendations into the service user care plan, however it is recommended that a copy of the original SALT recommendations is also retained in the service user care records. An area for improvement has been identified in this regard.

Staff demonstrated a good knowledge of service users' wishes, preferences and assessed needs. These were recorded within care plans. Staff were familiar with how food and fluids should be modified.

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.

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 professional registrations to be monitored by the manager.

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, induction programme which also included shadowing of a more experienced staff member. The staff members remain on probation for a six-month period and, if appropriate, are then are signed off by the manager as competent. 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 recruitment agencies.

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.

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.

The Annual Quality Report was reviewed and was satisfactory.

RQIA is aware of a Serious Adverse Incident (SAI) that is being investigated by the Belfast HSC Trust. Whilst RQIA is satisfied that measures have been put in place to reduce the risk of recurrence, RQIA awaits the SAI reports which will be available when the investigations are concluded. These will be reviewed at future inspections to ensure that any recommendations are embedded into practice.

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. No complaints had been received since the last inspection.

Where staff are unable to gain access to a service users home, the manager advised that staff are aware of what actions they should take in such situations. Following discussions with the manager, it was reported that a statement of intent is included in the service users guide with regard to staff entering service user's accommodation in the event of an emergency. There

was no evidence of written direction for staff on how to manage such situations. An area of improvement has been identified accordingly.

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	4	3

Areas for improvement and details of the QIP were discussed with Ms Isobel Weir, 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 15 (12)(b) **Stated:** First 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: 5.2.1
	Response by registered person detailing the actions taken: The Registered Manager will ensure that all incidents requiring notification are reported in accordance with Jan 2023 Guidance on Notifications of Incidents and Deaths.
Area for improvement 2 **Ref:** Regulation 16 (2)(a) **Stated:** First time **To be completed by:** 29 February 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: 5.2.1

	Response by registered person detailing the actions taken: A training needs analysis has been completed for the service taking into account the needs of service users supported by the service. The Registered Manager has devised a service improvement plan detailing the arrangements required to close non-compliance in the team. Full compliance is targeted by 08/03/24.
Area for improvement 3 **Ref:** Regulation 15 (9) **Stated:** First time **To be completed by:** 31 December 2023	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: 5.2.6
	Response by registered person detailing the actions taken: An organisational procedure in relation to access, associated with Inspires Service Delivery Policy has been implemented.
Area for improvement 4 **Ref:** Regulation 15 (4) **Stated:** First time **To be completed by:** Immediately from the date of inspection and ongoing	The registered person shall ensure that a copy of the original SALT recommendations and treatment plan is included in the service users care plan. Ref: 5.2.3
	Response by registered person detailing the actions taken: The Registered Manager has ensured original SALT assessments and recommendations are in place within service users files where the need has been identified.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 31 December 2023	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: 5.2.1
	Response by registered person detailing the actions taken: A training matrix is provided indicating the required training for all those working in the service. The Registered Manager is provided with a regular training compliance report detailing the compliance status of those working in the agency. The registered manager has commenced the practice of completing and actioning a service improvement plan when a training compliance report indicates noncompliance or the Manager identifies an error in the report.

<table>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 9

Stated: First time

To be completed by:
31 January 2024</td><td>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
self-harm/suicide
managing aggression/anti-social behaviour
missing persons
Ref: 5.2.1</td></tr>
<tr><td>Response by registered person detailing the actions taken:
The Registered Person has reviewed operational policy and procedures relating to the delivery of care and support services. The following changes are being instigated no later than the 31/01/2024. Management of risk will be further described and incorporated into the Service Delivery Policy for Care and Support Services. A harm reduction guidance document associated with Inspire's Service Delivery Policy detailing Inspire's approach to supporting people with addictions will be implemented. A self harm / suicide guidance document associated with Inspire's Service Delivery Policy detailing Inspire's approach to supporting people with addictions will be implemented. Inspire's existing procedures for managing behavior that challenges and responding to missing persons will be reviewed and strengthened.</td></tr>
<tr><td rowspan="2">Area for improvement 3

Ref: Standard 1.3

Stated: First time

To be completed by:
Immediately from the date of inspection and ongoing</td><td>The registered person shall ensure that a contemporaneous record is kept of all service user meetings.

Ref: 5.2.2</td></tr>
<tr><td>Response by registered person detailing the actions taken:
The Registered Person will ensure that a record of all service user meetings are maintained available for inspection and quality monitoring.</td></tr>
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