# Inspection Report

## 21 February 2022

# Mindwise

Type of service: Domiciliary Care Agency
Address: 3 Abbeyside, 2 - 3 New Park, Antrim, BT41 2DQ
Telephone number:  028 9446 0873

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:**<br>Mindwise<br><br>**Responsible Individual:**<br>Mrs Anne Doherty | **Registered Manager:**<br>Mrs Olivia Redmond Moore<br><br>**Date registered:**<br>Acting – no application required |
| **Person in charge at the time of inspection:**<br>Mrs Olivia Redmond Moore | |
| **Brief description of the accommodation/how the service operates:**<br><br>This is a domiciliary care agency supported living type which provides personal care and housing support to up to 12 service users who have experienced mental health difficulties. Service users receive support and care in relation to their daily living skills and emotional wellbeing and are encouraged to become more independent. The service users are supported by eight staff. | |

## 2.0 Inspection summary

An unannounced inspection was undertaken on 21 February 2022 between 10.00 a.m. and 1.20 p.m. by the care inspector.

The inspection focused on the review of staff recruitment and the agency's governance and management arrangements. It also focused on staff registrations with the Northern Ireland Social Care Council (NISCC), adult safeguarding, notifications, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS) including money and valuables, restrictive practices, monthly quality monitoring, Dysphagia and Covid-19 guidance.

Good practice was identified in relation to the recruitment of staff whereby appropriate pre-employment checks had been undertaken before staff started to provide care and support to the service users.

Good practice was also found in relation to systems in place for disseminating Covid-19 related information to staff.

The two areas for improvement identified at the previous inspection in relation to staffing levels and policies and procedures were not met and have been stated for the second time.

Three new areas for improvement were identified from this inspection in relation to complaints, mandatory training of staff and training in relation to Dysphagia.

## 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.

The inspection focused on:

- contacting the service users, their relatives, HSCT representatives and staff to find out their views on the service
- reviewing a range of relevant documents, policies and procedures relating to the agency's governance and management arrangements.

Information was provided to staff, service users and/or their relatives on how feedback could be provided to RQIA about the quality of the services being provided by the agency. This included service user/relative questionnaires and an electronic questionnaire for staff.

## 4.0 What people told us about the service

We spoke with two service users and two staff. In addition, feedback was received from eight service users in the questionnaires returned to RQIA. Three responses were received from staff by way of the electronic survey; one, however, was incomplete. Every respondent was either 'very satisfied' or 'satisfied' that the care being delivered was safe, effective, compassionate and the agency was well led.

**Service users' comments**

- "The staff are well mannered here."
- "I am quite happy and I feel safe living here."
- "I can come and go as I please. I just tell staff where I'm going for safety reasons."
- "The staff are very enjoyable and very helpful."
- "I have a key for my bedroom and staff ask my permission to go into my room."
- "They've done very well during the pandemic and have kept me safe."
- "I can't cook for myself so that's why I came in here. A staff member helped me make chicken curry from scratch."

**Staff comments:**

- "I'm happy within my workplace."
- "I love working here."
- "The training with Mindwise is brilliant."
- "The manager is very approachable and hands on."
- "There is an open door policy."
- "Staffing levels are low but we are managing the best we can."
- "We are a close team and can bounce ideas off each other."

## 5.0 The inspection

## 5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Due to the coronavirus (Covid-19) pandemic, the Department of Health (DoH) directed RQIA to continue to respond to ongoing areas of risk identified in services.

The last care inspection of the agency was undertaken on 10 June 2019 by a care inspector. A Quality Improvement Plan was issued. This was approved by the care inspector, however was not validated during this inspection. An inspection was not undertaken in the 2020-2021 inspection year, due to the impact of the first surge of Covid-19.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 10 June 2019</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<br><br>Ref: Regulation 16.1<br><br>Stated: First time</td><td>The registered person must ensure that at all times there are an appropriate number of suitably skilled and experienced persons employed for the purposes of the agency.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:<br>From reviewing the staff rota and through discussions with staff, this regulation was not met. On occasions there is one member of staff on shift, despite assurances being provided to RQIA that at least two staff members were on shift at all times. This agency has faced difficulties recruiting staff and currently has a number of staff members off work. This area for improvement has been stated for the second time.</td></tr>
<tr><th colspan="2">Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1<br><br>Ref: Standard 9.5<br><br>Stated: First time</td><td>The registered person shall ensure that policies and procedures are subject to a systematic three yearly review.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:<br>A review of the policies and procedures identified that they had not been reviewed on a three yearly basis. This area for improvement has been stated for the second time.</td></tr>
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## 5.2 Inspection findings

### 5.2.1 Are there 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 reflect information contained within the Department of Health's (DoH) regional policy 'Adult Safeguarding Prevention and Protection in Partnership' July 2015 and clearly outlines the procedure for staff in reporting concerns. The organisation has an identified Adult Safeguarding Champion (ASC).

Discussions with the manager demonstrated that they were knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting adult safeguarding concerns. Staff could describe the process for reporting concerns, including out of hours arrangements.

It was noted that staff are required to complete adult safeguarding training during their induction programme and required updates thereafter.

Staff indicated that they had a clear understanding of their responsibility in identifying and reporting any actual or suspected incidents of abuse. They could 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 has a system for retaining a record of referrals made in relation to adult safeguarding matters. It was noted that one adult safeguarding referral had been made since the last inspection. It was noted that this referral had been managed in accordance with the agency's policy and procedures.

A review of the training records indicated that there was a significant amount of outstanding training for staff including Manual Handling, Infection Prevention and Control, First Aid, Challenging Behaviour, Fire Awareness and Basic Health and Safety. This was discussed with the manager and assurances were provided that all staff would be booked on for the next available training session. An area for improvement was identified in this regard.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. A number of complaints had been received since the last inspection, three of which were formal complaints. The agency did not have an appropriate template which recorded the details of the complaint, the actions taken and if it was to the satisfaction of the complainant. An area for improvement was identified.

The manager confirmed that there were no service users who were subject to DoLS. Advice was given in relation to considering DoLS at each service users' care review and in relation new service users; however it was positive to note that all staff had completed DoLS training. Staff spoken with demonstrated that they have an understanding that people who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the Mental Capacity Act.

The manager confirmed they do not manage service users' monies.

There was a good system in place in relation to the dissemination of information relating to Covid-19 and infection prevention and control practices.

### 5.2.2 Is there a system in place for identifying care partners who visit the people supported to promote their mental health and wellbeing during Covid-19 restrictions?

The manager reported that there were no care partners visiting service users during the Covid-19 pandemic restrictions. It was positive to note that the service users had regular contact with family.

### 5.2.3 Is there a system in place for identifying service users Dysphagia needs in partnership with the Speech and Language Therapist (SALT)?

The manager confirmed that no service users have Dysphagia needs or swallowing difficulties. A review of the training records identified that staff had not been trained in this area. This was discussed with the manager and assurances were provided that this training would be sourced for all staff. An area for improvement was identified in this regard.

### 5.2.4 Are their robust systems in place for staff recruitment?

The review of the agency's staff recruitment records confirmed that recruitment was managed in conjunction with the agency's Human Resources (HR) Department and was in accordance with the regulations and minimum standards, and that pre-employment checks were completed before staff members commence employment and engage with service users. Records viewed evidenced that criminal record checks (AccessNI) had been completed for staff.

A review of the records confirmed that all staff provided were appropriately registered with NISCC. Information regarding registration details and renewal dates were monitored by the HR Department, the manager and through the monthly monitoring visits; this system was reviewed and found to be in compliance with Regulations and Standards. Staff spoken with confirmed that they were aware of their responsibilities for ensuring their registrations were up to date.

### 5.2.5 Are there robust governance processes in place?

There were monitoring arrangements in place in compliance with Regulation 23 of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007. Reports relating to the agency's monthly monitoring were reviewed. The process included engagement with service users, service user's relatives, staff and HSCT representatives. The reports included details of the review of service user care records, accident/incidents, safeguarding matters, complaints, staff recruitment, training, and staffing arrangements.

We noted some of the comments received:

**Service users' comments:**

- "I am fine. Everyone is looking after me well."

- “I’d be lost without the staff.”

**Staffs’ comments:**

- “Staff have been very good at rearranging shifts to ensure everyone’s needs are being met.”
- “My updated training has been completed.”
- “New service user is settling well into the service.”

**HSCT representatives’ comments:**

- “I have no concerns about the care and support being provided in the service.”

It was established during discussions with the manager that the agency had not been involved in any Serious Adverse Incidents (SAIs), Significant Event Analyses (SEAs) or Early Alerts (EAs).

## 6.0 Conclusion

Based on the inspection finding three new areas for improvement were identified in relation to complaints, mandatory training for staff and specific training in relation to Dysphagia.

Two areas for improvement identified at the previous inspection in relation to staffing levels and policies and procedures were stated for the second time.

Despite this, RQIA were assured that the service was providing safe, effective and compassionate care. Details can be found in the Quality Improvement Plan included.

## 7.0 Quality Improvement Plan/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, 2011.

| | Regulations | Standards |
|---|---|---|
| **Total number of Areas for Improvement** | 2* | 3* |

* the total number of areas for improvement includes one regulation and one standard that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Olivia Redmond Moore, 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**<br><br>**Ref:** Regulation 16(1)<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>Immediately from the date of inspection and ongoing | The registered person must ensure that at all times there are an appropriate number of suitably skilled and experienced persons employed for the purposes of the agency.<br><br>Ref: 5.1 |
| | **Response by registered person detailing the actions taken:**<br>MindWise currently has a rolling recruitment drive for Housing Support staff. Shortlisting and interviews take place monthly. Both bank and agency staff have been sourced to support the Abbeyside service to ensure there are an appropriate number of skilled and experienced staff on duty at any one time. Agency staff have completed their service induction as per standards required. |
| **Area for improvement 2**<br><br>**Ref:** Regulation 22(8)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediately from the date of inspection and ongoing | The registered person shall establish a procedure ("complaints procedure") for considering complaints made to the registered person by a service user or a service user's representative.<br><br>The registered person shall maintain a record of each complaint, including details of the investigations made, the outcome and any action taken in consequence and the requirements of regulation 21(1) shall apply to that record.<br><br>Ref: 5.2.1 |
| | **Response by registered person detailing the actions taken**:<br>An updated proforma has been created to ensure a clearer means of recording in house complaints ensuring that it is clearly identifiable the date the complaint was made, what the complaint is, who made it, who dealt with it, was the complaint resolved to the satisfaction of the complainant and the date signed off and if the complainant is unsatisfied when was the complaint escalated, who to, and were there any further actions as a result of the complaint. The updated format has been added to the in service complaints book. |

| **Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011** | |
|---|---|
| **Area for improvement 1**<br><br>**Ref:** Standard 9.5<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>Immediately from the date of inspection and ongoing | The registered person shall ensure that policies and procedures are subject to a systematic three yearly review.<br><br>Ref: 5.1 |
| | **Response by registered person detailing the actions taken:**<br>Senior Management have been made aware that this has been raised again and will lead on the programme of policy reviews as per requirements. All policies remain active until the review has taken place. |
| **Area for improvement 2**<br><br>**Ref:** Standard 12.3<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediately from the date of inspection and ongoing | Mandatory training requirements are met.<br><br>Ref: 5.2.1 |
| | **Response by registered person detailing the actions taken:**<br>The 22-23 training schedule has been completed. Staff training will be checked against the requirements and they will book onto the next available course where it has been identified that a refresher is due. New staff are booked onto the first available training session following their commencement with the service. |
| **Area for improvement 3**<br><br>**Ref:** Standard 12.4<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediately from the date of inspection and ongoing | The training needs of individual staff for their roles and responsibilities are identified and arrangements are in place to meet them.<br><br>This refers to Dysphagia training for all staff.<br><br>Ref: 5.2.3 |
| | **Response by registered person detailing the actions taken:**<br>The MindWise training department have been advised of the requirement identified and have included Dysphagia training on the 2022/2023 schedule. This will be provided to relevant staff during quarter one of the incoming year. |

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

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