Unannounced Care Inspection Report
28 September 2018

North Down & Ards Supported Living

Type of Service: Domiciliary Care Agency
Address: 11-13 Ballyholme Road, Bayview Centre, Clifton Road, Bangor, BT20 5JH
Tel No: 02891511190
Inspector: Marie McCann
User Consultation Officer: Clair McConnell

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a supported living type domiciliary care agency which provides services to adults with learning disabilities who live at a number of properties in the Bangor and Newtownards area. Staff provide support to service users to enable them to live full and valued lives as independently as possible and are encouraged to be part of the community they live in. All service users are tenants of the properties in which they live and the properties are owned by housing associations, private landlords, the Northern Ireland Housing Executive and the South Eastern Health and Social Care Trust (SEHSCT). The agency is operated by the SEHSCT.

3.0 Service details

Organisation/Registered Provider: South Eastern HSC Trust **Responsible Individual:** Hugh McCaughey	**Registered Manager:** Heather Cruise
Person in charge at the time of inspection: Heather Cruise	**Date manager registered:** 19 November 2012

4.0 Inspection summary

An unannounced inspection took place on 28 September 2018 from 10.00 to 18.30.

This inspection was underpinned by the Domiciliary Care Agencies Regulations (Northern Ireland) 2007 and the Domiciliary Care Agencies Minimum Standards, 2011.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the agency was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staff induction, supervision and appraisal, adult safeguarding and risk management. The care records evidenced a person centred approach to care delivery and good communication between service users and agency staff and other key stakeholders. The culture and ethos of the agency promoted the provision of individualised care and service user involvement in all decisions affecting them. There was evidence of good governance and management systems in place.

Two areas requiring improvement were identified with regards to the management of complaints and rota information maintained. One area for improvement was stated for a second time with regards to the review of a number of policies and procedures within a minimum of a three year period.

Service users' comments will be reflected throughout the report.

The findings of this report will provide the agency with the necessary information to assist them to fulfil their responsibilities, enhance practice and service users' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Heather Cruise, registered manager, deputy manager and the regulated services manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection dated 7 December 2017

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 7 December 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- The registration details of the agency.
- Information and correspondence received by RQIA since the last inspection.
- Incident notifications which highlighted three incidents had been notified to RQIA since the last care inspection 7 December 2017.
- Unannounced care inspection report and quality improvement plan from 7 December 2017.
- User Consultation Officer (UCO) report.

On 27 September 2018 the UCO spoke with seven service users who live in the community with support provided by staff. The UCO also spoke informally with three members of staff and the deputy manager; as well as observing interactions between the service users and staff on duty.

During the inspection the inspector met with the registered manager, deputy manager, regulated services manager, one service user and three staff.

The following records were examined during the inspection:

- two service users' care records and risk assessments
- a sample of service users' daily records
- two staff induction records
- staff training records
- three long term staff supervision and appraisal records
- a sample of staff roster information
- a sample of minutes of staff meetings
- the agency's record of incidents and accidents since the last inspection
- a sample of monthly quality monitoring reports
- Adult Safeguarding Policy
- Data Protection Policy
- Induction of New Employees
- Whistleblowing Policy
- Supervision and Appraisal Policy
- Disciplinary Policy
- Confidentiality and Disclosure Policy
- Complaints Policy
- Statement of Purpose
- Service User Guide

At the request of the inspector, the registered manager was asked to display a poster within the agency office. The poster invited staff to provide their views electronically to RQIA regarding the quality of service provision; two responses were received from staff and two responses were received from visiting professionals. The registered manager advised that poster would be made available to the staff group.

Ten service user and/or relatives' questionnaires were provided for distribution; eight questionnaires were returned to RQIA within the timeframe for inclusion in this report.

The inspector would like to thank the registered manager, deputy manager, regulated services manager, service users, relatives and staff for their support and co-operation throughout the inspection process.

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met or not met.

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 7 December 2017

The most recent inspection of the agency was an unannounced care inspection.

The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 7 December 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 23 (1) (2) (3) **Stated:** First time	23.—(1) The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided. In accordance with Regulation 23 (2) (3), the registered person must forward to RQIA reports of quality monitoring undertaken on a monthly basis until further notice.	**Met**
	Action taken as confirmed during the inspection: The inspector confirmed that the agency forwarded to RQIA reports of quality monitoring undertaken on a monthly basis	

	since the previous inspection. The inspector confirmed at this inspection that the agency were no longer required to forward the reports to RQIA. The reports evidenced consultation with service users and other key stakeholders, a review and audit of the conduct of individual premises within the agency each month and included comprehensive action plans which were reviewed accordingly.	
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 12.3 **Stated:** First time	Mandatory training requirements are met. **Action taken as confirmed during the inspection**: A review of the agency's training matrix confirmed that the majority of staff had undergone mandatory training in line with expected timescales. While a small number of staff were awaiting updated mandatory training in a limited number of areas, sufficient assurances were provided to the inspector that arrangements were in place to address this as part of existing and ongoing training being provided to staff.	**Met**

Area for improvement 2 **Ref**: Standard 9.5 **Stated:** First time	Policies and procedures are subject to a systematic 3 yearly review, and the registered person ratifies any revision to or the introduction of new policies and procedures. (in respect of appraisal, disciplinary, safeguarding and data protection policies)	**Partially met**
	Action taken as confirmed during the inspection: Review of a sample of policies and procedures evidenced that some had been reviewed within expected timescales, for example, the policy relating to induction of new staff, adult safeguarding and whistleblowing. However, other policies and procedures were either out of date, for example, the supervision policy for social care workers (dated 2012), the complaints policy (dated 2014) and the confidentiality policy (dated 2014) or not dated as with the disciplinary policy. This area for improvement has not been met and is stated for a second time.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to service users from the care, treatment and support that is intended to help them.

The inspection reviewed the agency's systems in place to avoid and prevent harm to service users; it included a review of staffing arrangements in place within the agency.

The deputy manager described the procedure for ensuring that staff are not provided for work until all necessary checks has been completed and a verification email is received by the registered manager from the SEHSCT human resources (HR) department. The HR department oversees the recruitment process, including the completion of appropriate pre-employment checks in keeping with the trust policy/procedures and legalisation. The deputy manager confirmed that these checks are retained by the HR department. A review of staff recruitment records within the SEHSCT HR department by RQIA prior to inspection confirmed records were satisfactory.

The agency has an induction process which includes a corporate induction, a local induction checklist with components to be met at varying intervals and a three day induction consistent with domiciliary agency regulations. The inspector reviewed the local and three day induction records of two recently appointed staff, the records evidenced that they had been signed off by the employee and the line manager.

The UCO confirmed that both staff and service users felt that consistency in staffing is very important as it allows the service users to develop a good relationship with staff; discussion with the registered manager confirmed that the service tries to provide consistent staff as much as possible. The service users confirmed that they have good rapport with staff and know who to contact if they had any concerns. This was further verified when the inspector spoke with three members of staff and a service user on the day of inspection.

Feedback from staff members and the deputy manager during both the UCO visit and on the day of inspection, confirmed that they have worked in the service for a significant period of time. It was evident from discussions and the UCO's observations that they were very knowledgeable regarding each service user and the level of support required to ensure their safety.

Review of a sample of rota information in addition to feedback from the registered manager provided assurance that staffing levels had been assessed as necessary to provide a safe service and that additional staff are rostered at times depending on the specific needs of service users. Senior support workers were noted to email rota information to the deputy manager, registered manager and regulated services manager to review and ensure sufficient staffing levels/skill mix and obtain authorisation for any additional staff if needed. The inspector was able to see evidence of the additional staffing levels being approved in a timely manner to meet the needs of a specific service user. The inspector identified that on two occasions when a staff member had been redeployed to another property, the staff member who replaced the redeployed staff member, to ensure sufficient staffing levels was not reflected on the rota. Discussions with the deputy manager, registered manager and regulated services manager provided sufficient assurances that there were appropriate staffing levels in the specific property on the two dates identified despite the rota not being updated accordingly. An area for improvement was made in this regard.

Discussions with staff confirmed that they considered staffing levels were sufficient to ensure the safety of service users. However, they suggested that the service could benefit from more staff to create better flexibility for service user outings and enabling staff to complete administrative tasks. This was discussed with the management team during inspection who confirmed that there is a recruitment drive planned for the service.

Discussions with the deputy manager and staff confirmed that there were systems in place to monitor staff performance and ensure that staff received support and guidance. Staff spoken with on the day of inspection confirmed the availability of continuous update training alongside supervision and appraisal processes and an open door policy for discussions with the management team. A review of a sample of records evidenced that staff received supervision and appraisal in compliance with the agency's supervision and appraisal policy. It was positive to note that the deputy manager maintained a matrix for monitoring staff appraisals for senior support workers. The inspector advised that it would be beneficial to include a matrix to monitor the appraisal dates for support workers which are currently scheduled by their respective line manager's, with the aim of making the agency's governance arrangements more robust. The deputy manager agreed to review this.

The inspector reviewed the agency's training matrix for 2018, which confirmed that the majority of mandatory training had been completed; however some gaps were noted with respect to a small number of staff. The registered manager and deputy manager reported that this was due to the master training matrix not having been updated by the relevant senior support workers rather than the training updates not having been completed. An updated training matrix was forwarded to RQIA post inspection and evidenced that the majority of staff have received updated training in line with expected timescales; assurances were provided to the inspector that arrangements are in place for the remaining staff to receive the training updates as part of a rolling programme of training.

Discussions with staff on the day of inspection identified that although training received was of a good standard and supported staff to fulfil their roles and responsibilities, there was recognition that additional training would be valuable to staff, in areas such as mediation and negotiation skills, understanding and recognising side effects of any prescribed medications and the impact of childhood trauma. Discussions with the deputy manager acknowledged that the agency is continuing to review the support and guidance given to staff to develop their understanding, knowledge and skills to provide care and support to service users with diverse needs. The deputy manager advised that there is a bi-monthly positive support behaviour meeting with a focus on preventative interventions, which staff can access if they need to discuss the support needs of a specific service user. In addition, the deputy manager confirmed that steps have been taken to improve staff knowledge regarding the various medical conditions of service users with the use of information fact sheets. This information was noted in one of the service user files viewed on the day of inspection.

It was positive to note that staff did receive some training specific to the needs of the service users; examples given included epilepsy, stoma care and Positive Behaviour Support and Management of Actual or the Management of Actual or Potential Aggression (MAPA) training. The UCO noted the steps taken by the staff to ensure service users' safety, for example one house carries out regular fire drills so that service users are aware of the procedure to follow in the event of a fire.

The inspector discussed how to improve the governance arrangements for reviewing staff compliance with mandatory training. Training records are reviewed as part of the monthly quality monitoring visits; however, as the service has 19 properties, the monitoring officer typically visits one property per month and it is the specific staff group training records in that property that are audited. Therefore, issues regarding non-compliance with mandatory training may not be highlighted as part of the monthly monitoring visit for all staff employed by the agency in a timely manner. It was agreed that the overall agency training matrix would be available for the monitoring officer to review as part of the monthly quality monitoring visits to facilitate a more comprehensive audit of the agency's training needs with any necessary action plans highlighted and progress monitored at subsequent visits. This arrangement will help improve governance arrangements to identify and meet ongoing training needs as part of a rolling programme of training. An updated monthly monitoring visit report template was forwarded to RQIA post inspection reflecting this new arrangement and was noted to be satisfactory. The inspector also advised the deputy manager to review the updated mandatory training guidelines available on the RQIA website to ensure ongoing compliance with best practice standards.

Discussion with the management team and staff spoken with on the day of inspection clearly demonstrated knowledge of their specific roles in relation to adult safeguarding and their obligations to report concerns and maintain factual records. Staff were aware of the Adult Safeguarding Prevention and Protection in Partnership Policy, July 2015 and the associated Operational Procedures and the organisation has an identified Adult Safeguarding Champion (ASC).

The inspector reviewed reporting and management of incidents within the agency. The registered manager confirmed that a record of all incidents and accidents are maintained. Staff are also required to update the registered manager and the deputy manager concerning any incident and agreement is sought in relation to any subsequent and necessary actions to be taken. All incidents and accidents are audited on a monthly basis by a senior manager and are sent to the SEHSCT governance department for review and audit. A review of a sample of records evidenced that appropriate management of incidents and follow up actions, including liaison with service users' relatives and SEHSCT representatives was undertaken. Staff spoken with on the day of inspection provided feedback which evidenced that they had a good understanding of the management of risk, and the importance of reporting any issues to the deputy manager or registered manager in a timely manner.

The deputy manager described the governance arrangements in place when staff are required to support service users through the use of MAPA techniques. A review of a sample of records evidence that the agency's reporting systems were transparent and that de-escalation techniques were the most commonly used intervention. Discussions with staff confirmed that they aimed to support service users make positive behaviour choices and build upon their coping skills in difficult situations. Staff comments included: "we have good relationships with service users; we use a lot of other skills and expertise before we ever use MAPA." "MAPA is very much a last resort."

In addition, discussions with staff confirmed that they were aware of their obligations in relation to raising concerns with respect to service users' wellbeing and poor practice, and were confident of an appropriate management response. Staff confirmed that they were aware of the agency's whistleblowing policy and were able to access it.

Eight service users and/or relatives returned questionnaires to RQIA. Six respondents indicated that they were very satisfied, one respondent was satisfied and one respondent did not verify if they were satisfied or dissatisfied that the care provided was safe. One relative commented: "Staff are excellent."

Two staff questionnaires were received post inspection, both respondents indicated that they were very satisfied that the care provided to service users was safe. One respondent commented: "This is a very valuable service to the people we support and as a staff member I feel proud to be part of it."

Two questionnaires were received post inspection from visiting professionals; responses indicated that they were very satisfied and satisfied that the care provided to service users was safe.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, staff induction, supervision and appraisal, adult safeguarding and risk management.

Areas for improvement

One area for improvement was highlighted in relation to management of the staff rota.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The agency's arrangements for responding appropriately to and meeting the assessed needs of service users were examined during the inspection. The full range and nature of the provision is laid out in the agency's Statement of Purpose, 2017.

The service provides care in the community to 49 service users with a wide range of needs. Support is tailored to suit the needs of the individuals to enable them to live as independently as possible for example personal care, money management, emotional support and management of medication. The service users spoken with confirmed that they are encouraged by staff to carry out as much as possible for themselves and staff assist as necessary.

All of the service users spoken with have lived in the service for a significant period of time and have developed a good relationship with one another and staff. Confirmation was received that the service users have an allocated key worker who they meet with regularly to discuss activities that they would like to participate in or if they have any concerns. Tenant or house meetings also take place regularly. Service users confirmed that they felt that they could raise any concerns with staff or management.

The inspector reviewed a sample of two service users' care records. The care records were noted to be comprehensive and maintained in an organised manner. The care records evidenced referral information, multi-disciplinary assessments, risk assessments, support plans, finance plans and tenancy agreements. In addition, and as relevant, service users had a Hospital Passport and alert notifications. It was positive to note that information was person centred and there was evidence of service user and/or their relative's consultation. The inspector advised that on those occasions whenever a service user is unwilling or unable to sign a document this should be recorded on the document. The deputy manager agreed to communicate this with the staff team.

It was noted in one of the care records reviewed that the restrictive practices in place had been assessed as the least restrictive intervention necessary and had been agreed in consultation with the service user and the multi-disciplinary team. The records had also been completed in a concise and transparent manner. The restrictive practice assessments were written in user friendly language to promote and facilitate service user understanding and involvement.

The inspector noted that there were arrangements in place within the agency to monitor, audit and review the effectiveness and quality of care delivered to service users. Service users were noted to be consulted regularly regarding the quality and effectiveness of care provided by the agency using various methods such as: an annual quality satisfaction survey; monthly quality monitoring visits undertaken by a senior manager; service users' meetings and annual care reviews. It was positive to note that in addition to annual care reviews, service users' keyworkers had a monthly individual meeting with service users and completed a monthly keyworker report to review progress and identify any issues which needed to be addressed.

The deputy manager stated that a matrix was maintained for all the service users which enabled the service to monitor any scheduled service user review dates and liaise as appropriate with the relevant community SEHSCT keyworker to ensure care reviews are undertaken in a timely manner. It was positive to note in one of the care records reviewed that review preparation was undertaken with the service user and their supported living keyworker which took into consideration how their goals and objectives had been met so far, action plans for the next twelve months and the service user's wishes for the future. The deputy manager described how one service user chose not to have a formal care review and how the agency adapted to the service user's wishes and are currently working with the service user in completing a Life Star, which the service user is happy to do. The regulated services manager advised that Life Star is a new outcome based assessment process and the agency is one of a number of services within the SEHSCT that are being trained to implement it. The aim is to make the assessment and review process more meaningful for service users. It was noted in discussion with the management team that on occasions multi-disciplinary meetings have been held with respect to a service user and there is no reference of these meetings in the service user file held by the agency. The inspector advised that any meeting held with respect to the service user which relates to the support they receive in the supported living setting should be evidenced within the service user record to ensure records are contemporaneous and accurate. The deputy manager agreed to action this.

It was positive to note that the agency has a robust system in place to review the use of PRN (as needed) medication which is part of a service users' positive behaviour plan. Each service user property has an identified medication officer and an audit of the use of PRN medication is undertaken on a monthly basis. The deputy manager who is the medication lead for the agency then meets quarterly with a medication steering group to review the audits and consider lessons learnt.

No concerns were raised during the inspection with regards to communication between service users, staff and other key stakeholders. Review of service users' care records evidenced that collaborative working arrangements were in place with service users' relatives and relevant professionals to support the needs of the service users.

The deputy manager described the process in place to ensure effective communication between staff relating to the needs of service users and any staff issues during shift changes. A review of records evidenced that a written handover report is provided and a copy sent to the management team to ensure they are also up to date with any pertinent issues. Discussions with staff also evidenced that there were effective communication systems in use within the staff team to ensure that staff receive information relevant to the care and support of service users. Staff confirmed that they had access to regular staff meetings and had access to the management team as needed during working hours and out of working hours. Staff commented: "We are very fortunate to have managers that will come if there is a crisis."

Eight service users and/or relatives returned questionnaires to RQIA. Six respondents indicated that they were very satisfied and two respondents indicated that they were satisfied that the care provided was effective.

Two staff questionnaires were received post inspection, responses indicated that they were very satisfied and satisfied that the care provided to service users was effective.

Two questionnaires were received post inspection from visiting professionals; responses indicated that they were very satisfied and satisfied that the care provided to service users was effective.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records, communication between service users and agency staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified in this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Service users are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The inspection sought to assess the agency's ability to treat service users with dignity and respect, and to fully involve service users/their representatives in decisions affecting their care and support. On the day of inspection the inspector found that an ethos of dignity and respect, choice, independence, rights, equality and diversity was reflected throughout the expression of staff attitudes and the delivery of the service.

The UCO had a tour of three premises, with permission of the service users and it was noted that the service users had personalised their homes to their individual tastes. The service users spoken with confirmed that they had been given choice regarding the decoration of their homes.

There were discussions with the service users and staff regarding the activities that the service users are supported to do. Below are a number of activities that the service users have carried out with the assistance of staff:

- shopping
- cooking
- cleaning
- day trips i.e. Belfast
- holidays i.e. Dublin, Florida, Paris
- day care centres and work placements
- visiting family
- plays and pantos
- music and DVDs
- cinema
- gateway Club
- choir and dance clubs
- horse riding

- pool
- basketball
- birthday parties and BBQs
- nightclubs

Discussions with the deputy manager reflected a variety of formal and informal systems to ensure that's service uses' views and opinions were taken into account in all matters affecting them. This included informal discussions on a day to day basis, monthly keyworker and service user meetings, house meetings, access to agency complaints process, annual review process, service user engagement during monthly quality monitoring visits and annual service user satisfaction survey.

The inspector was provided with a number of examples of how the agency supported service users to make informed decisions, through the use of user friendly training information packs. Staff confirmed that this promoted their knowledge and understanding in areas such as human rights, how to keep safe, recognise types of abuse and how to seek help. The agency also evidenced how they aimed to empower service users to understand their rights, with a user friendly complaints and compliments leaflet and sharing of a supported people document explaining the things you should expect your support service to do for you. In addition, the deputy manager evidenced how staff helped to support service users understand the medications they are prescribed, through the use of Health and Social Care Board user friendly medication guides.

The deputy manager was able to provide examples when staff reassessed and adapted the care and support plans for service users to promote their independence and emotional wellbeing. Service users were supported to engage in activities and resources successfully within the local community. It was evident to the inspector that service users had individual plans and goals, which the agency staff were enabling them to progress.

Examples of some of the comments made by the service users spoken with are listed below:

- "…like living here."
- "We take it in turns to cook and choose what we have to eat."
- "Staff are really good."
- "We have house and tenant meetings to decide group activities."
- "I decide what I do and don't have to go if I don't want to."

During the home visits the UCO observed interactions between the staff and service users. No concerns were noted during the interactions. The same was noted during the inspector's visit to another premise on the day of inspection.

Eight service users and/or relatives returned questionnaires to RQIA. All respondents indicated that they were very satisfied that the care provided was compassionate.

Two staff questionnaires were received post inspection, both respondents indicated that they were very satisfied that the care provided to service users was compassionate.

Two questionnaires were received post inspection from visiting professionals; one respondent was satisfied and one respondent did not verify if they were satisfied or dissatisfied that the care provided to service users was compassionate.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the provision of individualised care and the promotion of service user involvement in all decisions affecting them.

Areas for improvement

No areas for improvement were identified in this domain during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The inspector sought to assess the agency's leadership, management and governance arrangements to meet the assessed needs of service users. The agency is managed/staffed on a day to day basis by the registered manager, deputy manager, sixteen senior support workers and a team of support workers. This system was noted to provide a consistent staff team who were knowledgeable about service users' support needs, which enabled appropriate responses to be taken to any changes in service users' needs.

The agency has a range of policies and procedures in place to guide and inform staff, which were available for the inspection to review electronically. Review of a sample of policies and procedures evidenced that some had been reviewed within expected timescales, for example, the policy relating to induction of new staff, adult safeguarding and whistleblowing. However, other policies and procedures were either out of date, for example, the supervision policy for social care workers (dated 2012), the complaints policy (dated 2014) and the confidentiality policy (dated 2014) or not dated as with the disciplinary policy. An area for improvement has been stated for a second time in this regard.

All staff providing care and support to service users are required to be registered with the Northern Ireland Social Care Council (NISCC) or other regulatory body as appropriate. The deputy manager confirmed that information regarding registration and renewal dates was maintained by the agency and described the system in place for monitoring renewal of NISCC registration. The deputy manager provided assurances that all staff are currently registered with the relevant regulatory body and all staff are aware that they are not permitted to work if their NISCC registration has lapsed.

The Statement of Purpose outlines the agency's informal and formal complaints process, the role of RQIA, the Northern Ireland Public Service Ombudsman and the Patient Client Council. Discussions with staff confirmed that they were aware of how to respond to complaints sensitively and ensure that the information is reported to the management team to ensure an appropriate response. The inspector was unable to review the agency's complaints record as a centralised complaints record was not maintained by the agency; the registered manager advised that complaints are held within individual service user's records. The inspector advised that a record of all complaints including informal complaints should be also be maintained centrally which details all communications with complainants, the results of any investigations and the action taken. This central record should also evidence how outcomes from complaints

are used to improve the quality of services and how, where applicable, the registered manager shares any learning derived from the complaints analysis. An area for improvement was made.

No concerns regarding the management of the agency were raised during the discussions with service users and staff on the day of inspection.

The inspector discussed the monitoring arrangements under regulation 23 of the Domiciliary Care Agencies Regulations (Northern Ireland) 2007. Monthly quality monitoring visit reports were available to be examined since the previous inspection, with the exception of August 2018 and September 2018 which were subsequently forwarded to RQIA post inspection. As discussed in section 6.4, the monitoring officer visits one of the agency's 19 properties each month. It was positive to note that the agency had implemented the advice given during the inspection within the submitted report which had been completed for September 2018. This report clearly referenced the action plans identified for each premises visited, to enable their progress to be effectively monitored. The deputy manager confirmed this arrangement would be ongoing.

The registered manager advised that staff had not received any information or training in relation to the introduction of the General Data Protection Regulation (GDPR) to support staff to be aware if and understand recent changes in this area. The inspector advised the registered manager to review guidance available on the RQIA website and to liaise with senior management regarding the agency's GDPR responsibilities. The registered manager agreed to action this.

The inspector discussed arrangements in place that relate to the equality of opportunity for service users and the importance of the staff being aware of equality legislation whilst recognising and responding to the diverse needs of service users. The deputy manager confirmed that this was addressed with staff through their training, supervision and appraisal process. In addition, the deputy manager confirmed that the agency had not received any complaints with respect to equality issues from service users and/or their representatives.

The inspector noted that the agency collects equality information in relation to service users, during the referral and assessment process. The data is used effectively and with individual service user involvement when a person centred care/support plan is developed.

Some of the areas of equality awareness identified during the inspection include:

- effective communication
- service user involvement
- adult safeguarding
- advocacy
- equity of care and support
- individualised person centred care
- individualised risk assessment
- disability awareness

Eight service users and/or relatives returned questionnaires to RQIA. Six respondents indicated that they were very satisfied, one respondent was satisfied and one respondent did not verify if they were satisfied or dissatisfied that the service was well led.

Two staff questionnaires were received post inspection, both respondents indicated that they were very satisfied that the service was well led. One respondent commented: "I feel very valued and happy to be part of North Down and Ards team. Management is approachable and

always strive to improve service and service user experiences. Deputy manager helped me on numerous occasions and always is going the extra mile to help both staff and service users."

Two questionnaires were received post inspection from visiting professionals; one respondent was satisfied and one respondent did not verify if they were satisfied or dissatisfied that the service was well led.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, quality improvement and maintaining good working relationships.

Areas for improvement

Two areas for improvement were identified in relation to the management and auditing of complaints and policies and procedures.

	Regulations	Standards
Total number of areas for improvement	0	2

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Heather Cruise, registered manager, deputy manager and the regulated services manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the agency. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 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/or the Domiciliary Care Agencies Minimum Standards, 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, 2011	
Area for improvement 1 **Ref**: Standard 9.4 **Stated**: Second time **To be completed by**: 21 December 2018	Policies and procedures are subject to a systematic three yearly review, and the registered person ratifies any revision to or the introduction of new policies and procedures. (In respect of supervision and appraisal policy, complaints policy, confidentiality policy or not dated as with the disciplinary policy). Ref: 6.7
	Response by registered person detailing the actions taken: The Senior Management Team will ensure that all Policies and Procedures will be reviewed, updated and signed as required.
Area for improvement 2 **Ref**: Standard 10.4 **Stated**: First time **To be completed by**: With immediate effect	The registered person shall ensure the information held on record is accurate, up-to-date and necessary. This relates to, but is not limited to ensuring that rota information held in the office is accurate and up to date. Ref: 6.4
	Response by registered person detailing the actions taken: Following inspection, a number of meetings with Senior satff and training sessions were held regarding the accuracy of duty rosters. Full senior staff team attended E-roster training held on 25th October 2018 and further training sessions are arranged as North Down & Ards are moving toward implementing electronic rostering throughout the whole service. Electronic rostering will ensure accuracy of daily / weekly and monthly duty rosters and it will also identify “person in charge” in all housing options in North Down & Ards supported Living. Electronic Roster will also monitor staff training, appraisals, NISCC registration, annual leave, skill mix of staff and adequate staff numbers based on assessed clients’ needs and demand and ensure appropriate coverage of staff in all areas. Electronic roster will also be used as only system for staff wages.

Area for improvement 3 **Ref**: Standard 15.10 and 15.6 **Stated**: First time	The registered person shall ensure records are kept of all complaints and these include details of all communications with complainants, the results of any investigations and the action taken and how information from complaints is used to improve the quality of services. Ref: 6.7
To be completed by: With immediate effect	**Response by registered person detailing the actions taken:** The South Eastern Trust Centralised Complaints Department deals with all Complaints received both informal and formal. A request can be made to access complaints received within the NDA Supported Living Service A report about all Complaints received for each area can be produced centrally by the Complaints Team also.

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

The Regulation and Quality Improvement Authority

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