The Regulation and Quality Improvement Authority

Inspection Report

16 May 2022

Ardkeen Supported Living Project

Type of Service: Domiciliary Care Agency
Address: 86 Marlborough Park North, Belfast, BT9 6HL
Tel No: 028 9066 7102

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: The Cedar Foundation **Responsible Individual:** Mrs Margaret Cameron	**Registered Manager:** Miss Michelle Porter **Date registered:** 25 June 2019
Person in charge at the time of inspection: Miss Michelle Porter	
Brief description of the accommodation/how the service operates: Ardkeen Supported Living Project is a supported living type domiciliary care agency, located in Belfast. The agency provides personal care and housing support for up to 22 individuals who have tenancies and live in individual apartments. The service users have a range of needs including physical disability, sensory impairment or acquired brain injury. The services are commissioned by the Belfast Health and Social Care Trust (BHSCT) and the South Eastern Health and Social Care Trust (SEHSCT).	

2.0 Inspection summary

An announced inspection was undertaken on 16 May 2022 between 09.30 a.m. and 3.00 p.m. by two care inspectors.

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. In addition, the reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS), restrictive practices, Dysphagia and Covid-19 guidance was also reviewed.

Four areas for improvement were identified in relation to staff registration with the Northern Ireland Social Care Council (NISCC), staff training, the statement of purpose and service user's guide and record keeping.

Good practice was identified in relation to management of adult safeguarding and incidents.

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:

- consultation with the service users, their relatives/representatives, Health and Social Care (HSC) Trust 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.

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 to request feedback on the quality of service provided and this included questionnaires. In addition, an electronic survey was provided to enable staff to feedback to the RQIA.

4.0 What people told us about the service?

During the inspection we spoke with two service users and four staff members. Following the inspection we spoke with the relatives of two service users and requested feedback from HSC Trust representatives.

The information provided during and following the inspection indicated that there were no concerns in relation to the agency.

One questionnaire was returned; the respondent/s indicated that they were satisfied with the care and support provided. There was no response to the electronic survey.

Comments received during inspection process

Service users' comments:

- "Very happy, the staff are excellent."
- "I have lived here 15 years and I have no issues."
- "Staff couldn't do enough for you."
- "I can do what I want."
- "Staff are brilliant; I have no problems or complaints."

Service users' relatives/representatives' comments:

- "Happy with staff and how they treat my daughter. Some problems with staffing due to Covid understandably."
- "Easy to communicate with in person, by phone or email."
- "Problem with the hot water and it was fixed very quickly."
- "****** (service user) is very happy and content."
- "Content that my brother is well cared for. They contact us if they have any concerns about him."
- "They cannot do enough for my brother and we are very happy with Ardkeen."

Staff comments:

- "I have no issues, I can raise concerns."
- "The manager is approachable."
- "No issues with standard of care."
- "Management staff are approachable."
- "Manager has attempted to improve things such as impromptu staff meetings to sort out issues."
- "To her credit the manager is approachable and has signposted the staff to wellbeing literature."

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 1 September 2020 by a care inspector. An inspection was not undertaken in the 2020-2021 inspection year, due to the impact of the first surge of the Covid-19 pandemic.

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 adult safeguarding policy and procedures were reflective of the DoH's regional policy and clearly outlined the procedure for staff in reporting concerns. The organisation had an identified Adult Safeguarding Champion (ASC) and a number of deputy ASC's. 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 two years thereafter. However from staff training information reviewed it was identified that a number of staff are required to complete a training update with regard to adult safeguarding. An area for improvement was identified.

Staff who spoke with us demonstrated that they 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 relevant HSC Trust in relation to adult safeguarding matters. A review of records confirmed that these had been managed appropriately. It was noted that a number of records relating to adult safeguarding matters that had occurred since the last inspection had been archived; we discussed with the manager the need to ensure that records are available at all times for inspection. An area for improvement was identified.

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.

RQIA had been notified appropriately of any incidents that had been reported to the Police Service of Northern Ireland (PSNI) in keeping with the regulations. Incidents had been managed appropriately and are reviewed as part of the agency's quality monitoring process.

The manager/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.

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.

Staff had been provided with training in relation to medicines management. A review of the policy relating to medicines management identified that it included direction for staff in relation to administering liquid medicines. The manager/person in charge advised that no service users required their medicine to be administered with a syringe. The manager/person in charge 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 us demonstrated their understanding that service users who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the MCA.

The majority of staff had completed appropriate DoLS training appropriate to their job roles; there was a plan in place to ensure new staff employed completed appropriate training. There were arrangements in place to ensure that service users who required high levels of supervision

or monitoring and restriction had had their capacity considered and, where appropriate, assessed. Where a service user was experiencing a deprivation of liberty, the care records contained details of assessments completed and agreed outcomes developed in conjunction with the HSC Trust representative.

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.

It was also good to note that the agency had plans to reintroduce service users' meetings; the manager stated that on occasions service users are reluctant to attend meetings.

It was important that service users are supported to maintain their relationships with family, friends and partners during the Covid-19 pandemic. Service users were provided with information to explain Covid-19 and how they could keep themselves safe and protected from the virus.

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

New standards for the modifying of food and fluids were introduced in August 2018. This was called the International Dysphagia Diet Standardisation Initiative (IDDSI). A number of service users were assessed by the SALT with recommendations provided and a number required their food and fluids to be modified. A review of training records confirmed that staff had not completed training in Dysphagia and in relation to how to respond to choking incidents. The manager stated that they are currently in the process of completing training. An area for improvement was identified and is subsumed into the area for improvement identified in 5.2.1.

Discussions with staff and review of service users' care records reflected the multi-disciplinary input and the collaborative working undertaken to ensure service users' health and social care needs were met within the agency. There was evidence that staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate. Staff also implemented the specific recommendations of the SALT to ensure the care received in the setting was safe and effective.

Staff demonstrated a good knowledge of service users' wishes, preferences and assessed needs. These were recorded within care plans along with associated SALT dietary requirements. 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 NISCC or the Nursing and Midwifery Council (NMC) or any other relevant regulatory body. However it was noted that one staff member was not appropriately registered, action was taken during the inspection to resolve this matter. An area for improvement was identified. We discussed with the manager the need to ensure that the system for review staff registrations is completed in a robust manner. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

The manager stated that 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 evidence of a 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.

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

Staff are required to maintain their registration with NISCC whilst 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 evidenced that there was engagement with service users, their 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.

Discussions with the manager indicated that no incidents had occurred that required investigation under the Serious Adverse Incidents (SAIs) or Significant Event Audits (SEAs) procedures.

The agency's registration certificate and current certificates of public and employers' liability insurance were displayed. It was identified that the registration certificate was required to be updated to reflect accurate details of the responsible person. Following the inspection an updated registration certificate was provided to the agency.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Where complaints were received since the last inspection, these were appropriately managed and were reviewed as part of the agency's quality monitoring process.

The Statement of Purpose and Service User Guide required updating with RQIA's contact details. The person in charge agreed to submit the revised documents to RQIA within two weeks of the inspection; the information was not received prior to the issuing of this report therefore an area for improvement has been identified.

6.0 Conclusion

Based on the inspection findings, four areas for improvement were identified in relation to staff registration with NISCC, staff training record keeping and the information recorded within the Statement of Purpose and Service User's Guide. Despite this, RQIA were satisfied that this service was providing safe and effective care in a caring and compassionate manner; and that the service was well led by the manager.

7.0 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	2	2

Areas for improvement and details of the QIP were discussed with Michelle Porter, 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 21 (1)(c) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that the records specified in Schedule 4 are maintained, and that they are (c) at all times available for inspection at the agency premises by the person authorized by the Regulation and Improvement Authority. This relates specifically to records relating to adult safeguarding referrals made by the agency. Ref: 5.2.1
	Response by registered person detailing the actions taken: The agency has an Organisational electronic database in place to retain all Adult Safeguarding Referral forms for inspection purposes. Hard copies will be retained in the service.
Area for improvement 2 **Ref:** Regulation 7 (a) **Stated:** First time To be completed by: Immediate and ongoing from the date of inspection	The registered person shall (a) keep under review and, where appropriate, revise the statement of purpose and the service user's guide. This relates specifically to the ensuring that the contact details for RQIA are updated. Ref: 5.2.6
	Response by registered person detailing the actions taken: Statement of Purpose and Service User Guide have both been amended to reflect contact details for RQIA on 19th May 2022
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:** Immediate and ongoing from the date of inspection	The registered person shall ensure that staff are trained for their roles and responsibilities. This relates specifically to Adult Safeguarding and Dysphagia training and any outstanding mandatory training updates. Ref: 5.2.1 & 5.2.3
	Response by registered person detailing the actions taken: Dysphagia and Adult Safeguarding are planned through June and July 2022

Area for improvement 2 **Ref:** Standard 12.6 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that arrangements are in place to ensure that staff are able to maintain their registration with the appropriate regulatory body. This relates specifically to staff registration with NISCC. Ref: 5.2.4
	Response by registered person detailing the actions taken: Cedar has implemented a robust monthly system for monitoring NISCC registration, commencing from May 2022.

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

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