Inspection Report

16 March 2023

Greystone Support Centre

Type of service: Domiciliary Care Agency
Address: 199 Donore Crescent, Antrim, BT41 1JB
Telephone number: 028 9504 2930

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: Belfast Health and Social Trust **Responsible Individual:** Dr Catherine Jack	**Registered Manager:** Mrs Lisa-Jane Cathcart **Date registered:** 02 September 2010
Person in charge at the time of inspection: Senior Support Worker	
Brief description of the accommodation/how the service operates: Greystone Support Centre is a supported living type domiciliary care agency which is run by Belfast Health and Social Care Trust (BHSCT); four service users' care is commissioned by the Northern Health and Social Care Trust (NHSCT. The agency provides 24-hour support to 16 adults with a learning disability and complex needs who live in their own flat or house in the community. The agency's office is located in Greystone Estate, Antrim.	

2.0 Inspection summary

An unannounced inspection took place on 16 March 2023 between 9.30 a.m. and 1.30 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.

Good practice was identified in relation to service user involvement. There were good governance and management arrangements in place.

Service users consulted with spoke positively about the care and support provided.

Greystone Support Centre 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.

Having reviewed the model "We Matter" Adult Learning Disability Model for NI 2020, the Vision states, 'We want individuals with a learning disability to be respected and empowered to lead a full and healthy life in their community'.

RQIA shares this vision and want to review the support individuals are offered to make choices and decisions in their life that enable them to develop and to live a safe, active and valued life. RQIA will review how service users who have a learning disability are respected and empowered to lead a full and healthy life in the community and are supported to make choices and decisions that enables them to develop and live safe, active and valued lives.

Information was provided to service users, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included easy read questionnaires and an electronic survey.

4.0 What did people tell us about the service?

During the inspection we provided a number of easy read questionnaires for those supported to comment on the following areas of service quality and their lived experiences:

- Do you feel your care is safe?
- Is the care and support you get effective?

- Do you feel staff treat you with compassion?
- How do you feel your care is managed?

No questionnaires were returned within the timescale for inclusion within the report.

Positive comments from relatives were noted within the monthly quality monitoring reports. Comments included:

- "(Service user) loves living in Greystone …. The staff are good at arranging outings."
- "Loves the staff that support (them) …. The staff keep them on the straight and narrow."

During the inspection we spoke with a number of staff members. The information provided indicated that there were no concerns in relation to the agency. Comments received included:

Staff comments:

- "I would have no concerns."
- "I think it's great, the care they get here is brilliant."
- "All good."

No responses were received to the electronic survey.

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 4 February 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 4 February 2022		
Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 16(2)(a) **Stated:** First time	The registered person shall ensure that each employee of the agency receives training and appraisal which are appropriate to the work he is to perform. This relates to all mandatory training being undertaken by all staff and included training in relation to DoLS.	**Met**

	Action taken as confirmed during the inspection: There was evidence that this area for improvement was 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 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).

Discussions with the person in charge established that they were knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting and managing adult safeguarding concerns.

Staff were required to complete adult safeguarding training during induction and every two years thereafter. 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.

There had been no concerns relating to poor practice raised to the manager under the whistleblowing procedures.

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.

Staff were provided with training appropriate to the requirements of their role. The person in charge reported that none of the service users currently required the use of specialised equipment. They were aware of how to source such training should it be required in the future.

Care reviews had been undertaken in keeping with the agency's policies and procedures.

All staff had been provided with training in relation to medicines management. The person in charge advised that no service users required their medicine to be administered with a syringe. The 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 the inspector demonstrated their understanding that service users who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the Mental Capacity Act (MCA).

Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The person in charge reported that none of the service users were subject to DoLS. 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, it was good to note that service users had an input into devising their own plan of care. Service users were provided with easy read reports which supported them to fully participate in all aspects of their care. The service users' support 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:

- Keeping safe
- On-line shopping safety
- Matters relating to staffing.

It was evident that the agency placed a strong focus on social outings. Service users were asked for suggestions on what activities they would like to engage in. Plans were in place for the service users to attend a range of shows, including musical shows and overnight stays. On the day of the inspection the service users were enjoying an overnight stay in Colerain where they went bowling. It was good to note that staff were constantly looking at new venues for the service users to go to.

It was good to note the service users' consent was sought and that they had a choice in relation to whether or not they wanted:

- The quality monitoring officer to visit them in their flat
- Staff to access their flats in emergency situations
- Workmen to enter their flats when they were not present
- Their photograph to be used
- Staff to check on them throughout the night
- Staff to dispose of any unwanted medicines on their behalf.

It was important that service users with learning disabilities are supported to maintain their relationships with family, friends and partners during the Covid-19 pandemic.

Should individuals with learning disabilities continued to experience anxiety about the pandemic, the agency was aware of the resources available from NI Direct, HSC websites and local organisations to support service users.

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 number of service users were assessed by SALT with recommendations provided and some required their food and fluids to be of a specific consistency. 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.

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.

5.2.4 What systems are in place for staff recruitment and are they robust?

There was a system in place to ensure 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 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 a system in place to ensure that newly appointed staff completed a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care, to ensure they were competent to carry out the duties of their job in line with the agency's policies and procedures. There was a robust, structured, three-day induction programme which also included shadowing of a more experienced staff member.

A review of the records relating to staff that were provided from recruitment agencies also identified that they had been recruited, inducted and trained in line with the regulations.

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 in the process of being completed. This will be reviewed at future inspection.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAIs) or Significant Event Audits (SEAs) procedures.

The agency's registration certificate was up to date and displayed appropriately.

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.

Advice was given in relation to keeping the safe use of e-cigarette chargers as a standing item on the tenants meeting minutes.

There was a system in place for staff to gain access to the service users' accommodation in the event of an emergency.

6.0 Quality Improvement Plan (QIP)/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Lisa Cathcart, Registered Manager, who joined the inspection for feedback, as part of the inspection process and can be found in the main body of the report.

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