The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Greystone Support Centre**

Provider: **Belfast HSC Trust**

Date of Inspection: **20 February 2025**

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation:	Belfast HSC Trust
Responsible Individual:	Mrs Maureen Edwards
Registered Manager:	Mrs Lisa-Jane Cathcart
Service Profile: Greystone Support Centre is a supported living type domiciliary care agency which provides care and support to service users with a mental health and learning disability. Service users live in their own flat or house in the community. Whilst the agency is operated by the Belfast Health and Social Care Trust (BHSCT); the Northern Health and Social Care Trust (NHSCT) fund the care of a small number of the service users.	

2.0 Inspection summary

An unannounced inspection took place on 20 February 2025 between 9.40 am and 2 pm by a care Inspector.

The last care inspection of the agency was undertaken on 28 November 2023 by a care inspector. No areas for improvement were identified. This inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

While care was found to be delivered in a safe, effective and compassionate manner, improvements were required to ensure the effectiveness and oversight of certain aspects of the agency's quality systems; such as recruitment practices, induction, medicines competencies and Tenancy Agreements.

Service users were observed to be comfortable in their interactions with staff and spoke positively about the care and support they receive. Refer to Section 3.2 for more details.

Full details, including areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the service was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about the service. This included registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning Trust.

Throughout the inspection process inspectors seek the views of service users and of staff working in the agency; and review/examine a sample of records to evidence how the service is performing in relation to the regulations and standards.

3.2 What people told us about the service and their quality of life

Through active listening, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

Service users were observed to be comfortable in their interactions with staff and indicated that they were happy with the care and support they receive. Service users described the agency as being 'very good' and they described the staff as being 'very hardworking'.

Staff spoken with said that they were very impressed with the care and support they were able to provide and that they could contact management at any time, if they had any concerns. One staff member described how 'passionate' they felt about their role and described how they aimed to promote service user independence at all times.

3.3 Inspection findings

3.3.1 Staffing arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular training and continued supervision and support.

Review of the agency's recruitment records identified that criminal records checks (AccessNI) had not been consistently undertaken on all staff. RQIA is aware that this was due to the Trust's policy and procedure in relation to Trust staff moving to other posts within the Trust, having previously had a check undertaken by the Trust. However, AccessNI checks that had been applied for, had not been followed up on in a timely manner, when the checks had not been returned as satisfactory. Additionally, there was one identified staff member who had not applied to have an AccessNI check undertaken. The manager was advised to undertake an

audit of all staff working in Greystone Support Centre, to ensure that AccessNI checks are completed, regardless of whether they commenced work in Greystone by internal transfer/expression of interest. An area for improvement has been identified.

There was a process in place to ensure that newly appointed staff completed a structured orientation and induction, to ensure they were competent to carry out the duties of their job; however, completed induction records were not consistently retained. Therefore, we were not assured that the induction had been provided in keeping with the agency's policies and procedures. An area for improvement has been identified.

Review of training records identified that the majority of training elements had been provided to staff. However, there were a small number of training elements that had yet to be completed. Following the inspection, it was confirmed to RQIA that these training needs had been addressed.

Specific training related to service users' assessed needs had also been provided to staff. For example, where a service user required a specialist emergency system for the management of a medical condition, all staff had been provided with the required training.

Medicines competency assessments were completed for those staff who administered medicines. It was advised that this proforma is further developed to include a section on anticoagulants (such as warfarin) and antipsychotics (such as clozapine). An area for improvement has been identified.

3.3.2 Care Delivery

There were systems in place to manage staffing. Despite there being a number of staff vacancies, there was no evidence that the service users' needs were not being met by the number and skill of the staff on duty. Staff said there was good teamwork and that they felt well supported in their role.

There was a daily Safety Brief (handover) which clearly outlined the daily staff allocation and the tasks each service user required support with. This system also provided an opportunity to discuss updates in relation to changes in service users' needs. A communication book was also in place, to ensure that all staff were aware of any upcoming appointments service users had.

Regular staff meetings were held and minutes of these meetings were available for staff including those unable to attend, to read. It was good to note that the meetings included a summary of all incidents which had occurred and also any updates regarding any changing needs of the service users. The staff were also required to sign that they had read the minutes of the service users meeting minutes.

Service user meetings were held on a regular basis which enabled the service users to discuss any activities they would like to become involved in and also any other matters relating to their homes. Activities service users availed of included going to the cinema, restaurants, shows/musicals, walking groups, playing pool/snooker, church social mornings and day trips. One service user had been supported to help organise a coffee morning for charity.
It was good to note that a number of service users were supported to holiday abroad.

Where a service user was at risk of falling, measures to reduce this risk were put in place.

At times some service users may require the use of equipment that could be considered restrictive or they may have items removed from them to keep them safe. Some service users may also require staff to be with them at all times. It was established that safe systems were in place to safeguard service users and to manage this aspect of care.

3.3.2 Care Records

Service users' needs were assessed when they first started to be supported by the agency. Following this initial assessment support plans were developed to direct staff on how to meet the service users' needs and included any advice or recommendations made by other healthcare professionals. Service users'care records were held confidentially.

Support plans were person centred, detailing the service users' likes and dislikes and were updated on a regular basis. The care plans were underpinned by a human rights approach which is good practice.

Regular evaluations about the delivery of care were recorded. Service users, where possible, were involved in planning their own care and the details of support plans were shared with service users' relatives, if this was appropriate.

Service users consent was sought in relation to matters such as agreeing to visits from the Trust's quality monitoring officers; and in relation to the development of support plans. Where service users needed the support of staff to administer their medicines, their consent was obtained. Service users signed that they were in agreement with the contents of their support plans; and they also consented to staff exchanging information with relevant healthcare professionals on their behalf.

Where a service user did not attend their out-patient appointments, it was good to note that the agency retained a record of these, to ensure that any pattern that may emerge could be identified in a timely manner and acted upon. This is good practice.

There was evidence that Trust care review meetings had taken place and the minutes of meetings were retained.

3.3.3 Quality of Management Systems

There has been no change in management of the agency since the last inspection. Mrs Lisa Jane Cathcart has been the Registered Manager since 02 September 2010. Staff commented positively about the manager and described them as 'very approachable'.

The agency was visited each month by a representative of the registered provider to consult with service users, their relatives and staff and to examine all areas of the running of the agency. The reports of these visits contained detailed information in relation to the areas examined and reflected the views of those consulted. The annual quality report was viewed and found to be satisfactory.

Agencies are required to have a person known as the Adult Safeguarding Champion (ASC), who has responsibility for implementing the Adult Safeguarding regional protocol and the agency's adult safeguarding policy. In the Trust, this person is called the Designated Adult

Protection Officer (DAPO). A Senior Manager was identified as the agency's DAPO. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm.

Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC) and the Nursing and Midwifery Council (NMC); there was a system in place for professional registrations to be monitored by the manager.

Additional aspects of practice within the agency were identified, such as some service users' Tenancy Agreements and entitlement to Housing Benefit. RQIA was informed that the Trust are in the process of addressing this matter. Given that there was no clear projected timeline of actions to bring the service in line with Regulation, an area for improvement has been identified to ensure that this matter is implemented.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	1	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Lisa Cathcart, 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 13 d **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that enhanced criminal records checks (AccessNI) are undertaken on all staff, regardless of whether not they are/have moved from another NHSCT post/ or have transferred internally within the Trust. Ref: 3.3.1
	Response by registered person detailing the actions taken: The registered manager has completed an audit of all staff working in Greystone (BHSCT). All staff that require an AccessNI check have applied and 70% have been completed and returned. Awaiting results of the remaining staff. No concerns highlighted by the checks.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 12.1 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that records relating to inductions are completed and retained for inspection purposes. Ref: 3.3.1
	Response by registered person detailing the actions taken: The registered manager has completed an induction audit. All inductions are now in place and retained.
Area for improvement 2 **Ref:** Standard 7.7 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that the medicines competency assessment is further developed, to ensure that it includes a section for staff on the use anticoagulants (such as Warfarin) and antipsychotics (such as Clozapine). Ref: 3.3.1
	Response by registered person detailing the actions taken: The registered manager has added the relevant section re anti-coagulants and antipsychotics to the competency assessment. The registered manager has begun the process of reassessing the revised competency for all staff.

Area for improvement 3 **Ref:** Standard 8 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that the matter pertaining to service users' Tenancy Agreements is addressed. Ref: 3.3.3
	Response by registered person detailing the actions taken: The registered manager has liaised with service manager to complete the tenancy agreements by end of June 2025

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

The Regulation and Quality Improvement Authority

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James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews