The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Clare House**

Provider: **Western Health and Social Care Trust**

Date of Inspection: **2 January 2025**

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:	Western Health and Social Care Trust
Responsible Individual/Responsible Person:	Mr Neil Guckian
Registered Manager:	Mrs Stacey McCusker
Service Profile This is a domiciliary care agency, supported living type service, which provides services to 25 service users living at two locations within the Western Health and Social Care Trust (WHSCT) and who require care and support with mental health and wellbeing. Service users live in their own homes and have the use of communal indoor and outdoor space.	

2.0 Inspection summary

An unannounced inspection took place on 2 January 2025, between 9.40 a.m. an 3.05 p.m. 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 and dysphagia management were also reviewed.

An area for improvement identified related to recruitment practices.

It was evident that staff promoted the dignity, independence and well-being of service users.

Service users spoke positively about their experience of the care and support they received from staff. Refer to Section 3.2 for more details.

We would like to thank the manager, service users and staff team for their help and support in the completion of the inspection.

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 this agency. This included the previous area for improvement issued, registration information, and any other written or verbal information received from service users, relatives, staff or the Commissioning Trust.

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

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

We spoke to a range of service users and staff to seek their views of the agency.

Service users said that they were happy with the care and support provided and that staff were approachable and kind. Two comments included the following statements; "I am very happy living in Clare House." and "Staff are very good to me".

Staff spoke very positively in regard to the care delivery and management support in the agency. Two comments included the following statements; "Care and support plans are kept up to date and shared with all staff." and "Good training provided".

The information provided indicated that those who engaged with us had no concerns in relation to the agency.

We did not receive any responses from the questionnaires or staff electronic survey.

3.3 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 25 March 2024 by a care inspector. No areas for improvement were identified.

3.4.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the skill of staff meets the needs of service users.

A review of staff recruitment records evidenced that Enhanced AccessNI pre-employment checks had not been satisfactorily completed before three ancillary staff had commenced employment. It was explained that this was due to the Trusts' policy and procedure in relation to the employment of Trust ancillary staff. This was discussed with the manager, who took immediate action to address the matter. An area for improvement has been identified. Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC); there was a system in place for professional registrations to be monitored by the manager. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

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 a robust, structured, 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. Advice was given to the manager regarding the level of detail included when completing competency assessments. In particular, it was suggested that the comments section should include some detail on how competence was achieved before signing off on the identified task. The manager agreed to implement this in the future.

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

There was evidence of effective systems in place to manage staffing. Sufficient staff were on duty to support the service users. Staff said there was good teamwork and that they felt well supported in their role by the manager. Staff said that there were enough staff to meet the needs of the service users. It was evident that staff had a good understanding of the needs, likes and dislikes of individual service users.

Regular staff meetings were held and minutes maintained of the meetings for staff, unable to attend, to read for information sharing.

3.4.2 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 policy and procedures reflected information contained within the Department of Health's (DoH) regional policy 'Adult Safeguarding Prevention and Protection in Partnership' July 2015 and clearly outlined the procedure for staff in reporting concerns. The organisation had an identified Adult Safeguarding Champion (ASC). The safeguarding champion was known to the staff team.

Staff were required to complete adult safeguarding training during induction and every two years thereafter. Staff who spoke with the inspector 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 HSC Trust in relation to adult safeguarding. Review of safeguarding records evidenced that these were managed appropriately.

The agency's governance arrangements for the management of accidents/incidents were reviewed. The review confirmed that an effective incident/accident reporting policy and system was in place. Staff are required to record any incidents and accidents in a centralised electronic record, which is then reviewed and audited by the manager and the WHSCT governance department. A review of a sample of accident/incident records evidenced that these were managed appropriately.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

All staff had been provided with training in relation to medicines management. The manager advised that no service users required their liquid medicine to be administered orally with a syringe. The manager was aware that should this be required; a competency assessment would be undertaken before staff undertook this task.

A service user had been assessed by the Speech and Language Therapist (SALT) with recommendations provided. Staff demonstrated a good knowledge of the service user's wishes, preferences and assessed needs. These were recorded within the care plan along with associated SALT dietary requirements. Staff were familiar with how food and fluids should be modified.

A review of training records confirmed that staff had completed training in dysphagia and in relation to responding to choking incidents.

3.4.3 The arrangements for promoting service user involvement

Service users, where possible, were encouraged and supported to be involved in their own care and the details of care and support plans were shared with relatives, where appropriate.

Care and support plans were person centred and are kept under regular review. There was evidence that staff record regularly the details of care and support provided or any changes to the service users' needs and regularly reviewed and updated to ensure they continued to meet the service users' needs. Services users and /or their relatives participate, where appropriate, in the review of the care provided on an annual basis, or when changes occur.

Service user meetings were held on a regular basis which enabled the staff to keep service users updated on any issues arising that may affect them. Some matters discussed included

activities and outings, fire safety and shared living arrangements. The meetings also enabled the service users to discuss any activities they would like to become involved in.

3.4.4 The arrangements to ensure robust managerial oversight and governance

The manager had been registered since 21 November 2023. Staff commented positively about the manager and described them as supportive, approachable and always available to provide guidance.

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 and staff. The reports included details of a review of service user care records; accident/incidents; safeguarding matters and staff recruitment and training.

The Annual Quality Report was reviewed and was satisfactory.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure.

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. Records reviewed and discussion with the manager indicated that no complaints were recorded since the previous care inspection. Discussion with staff confirmed that they knew how to receive and respond to complaints sensitively and were aware of their responsibility to report all complaints to the manager or the person in charge.

Discussions with service users concluded they are aware of the agency's complaints process. The service user said they would have no difficulty raising any areas of dissatisfaction, concern or complaint with staff or the manager.

Our discussion with staff revealed they had a clear view about their role and responsibility to meet service user's individual needs and promote their rights, choices, independence and future outcomes. They identified staff training, policies and procedures, staff support mechanisms and the management team supported them to provide safe, effective and compassionate care in this setting.

4.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007.

	Regulations	Standards
Total number of Areas for Improvement	1	0

An area for improvement and details of the Quality Improvement Plan were discussed with Mrs Stacey McCusker, 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	The Registered Person shall ensure that Enhanced AccessNI pre employment checks are satisfactorily carried out for all staff before they commence employment. Ref: 3.4.1
To be completed by: Immediate from the date of the inspection	**Response by registered person detailing the actions taken:** Enhanced Acess NI Checks are in place for all staff providing care and support to service users. Enhanced Access NI reference numbers and certificate dates are retained by HR and in the facility. Following inspection,an immediate Risk Management Plan was put in place to ensure supervision of support services staff (carrying out domestic duties within the communal areas of the facilty), who did not have an Enhanced Access NI check. This was provided to the inspector. This remained in place until their Enhanced Access NI checks were completed and satisfactory. WHSCT HR dept. provided the facility manager with a record of Enhanced Access NI reference numbers and certificate dates. A plan is now in place with Domestic Services to ensure that staff are only employed in the facility when an Enhanced Acess NI Checks are completed and satisfactory.

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

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