Inspection Report

9 March 2023

Clare House

Type of service: Domiciliary Care Agency
Address: 51 Chanterhill Road, Enniskillen, BT74 6DE
Telephone number: 028 6632 6361

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:** Mr Neil Guckian	**Registered Manager:** Ms Stacey McCusker **Date registered:** Acting
Person in charge at the time of inspection: Ms Stacey McCusker	
Brief description of the accommodation/how the service operates: This is a domiciliary care agency supported living type 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 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 9 March 2023 between 9.15 a.m. and 3.00 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.

An area for improvement identified related to monthly quality monitoring.

Good practice was identified in relation to service user involvement. Further areas of good practice were also noted in regard to communication between service users and agency staff and other key stakeholders; staff training; and monitoring of staffs' professional registrations.

All service users spoken with indicated that they were very happy with the care and support provided by the staff.

We would like to thank the manager, service users and staff for their support and co-operation throughout the inspection process.

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.

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 staff survey.

4.0 What did people tell us about the service?

During the inspection we spoke with a number of service users and staff members.

The information provided indicated that there were no concerns in relation to the agency.

Comments received included:

Service users' comments:

- "This is a good place to live. I know all the staff and they treat me very well. Staff take time to talk to me and listen to what I have to say."
- "I have no problems here and there is nothing you could do to make this place better."
- "I get to choose how I spend my time here."
- "Staff are kind and helpful."

Staff comments:

- "Good communication and we always get informed of any changes in care or support."
- "All care records reflect service users' needs."
- "I have done my dysphagia training and there is good training provided by the Trust."

- “I get regular supervision and I am well supported by the manager. You can approach the manager at any time.”

One staff member responded to the electronic survey. The respondent indicated that they were ‘very satisfied’ that care provided was safe, effective and compassionate and that the service was well led.

No service users’ questionnaires were received.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the 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. An inspection was not undertaken in the 2021-2022 inspection year, due to the impact of the first surge of Covid-19.

The last care inspection of the agency was undertaken on 9 March 2020 by a care inspector. No areas for improvement were identified.

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 policy and 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 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. 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. A review of records confirmed that these had been managed appropriately.

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.

The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any concerns.

The agency's governance arrangements in place for identifying, managing and where possible, eliminating unnecessary risk to service users' health, welfare and safety was reviewed during the inspection. This indicated 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.

The manager 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.

Staff consulted with on the day of inspection spoke positively about the training they receive and confirmed that they received sufficient training to enable them to fulfil the duties and responsibilities of their role and that training was of a good standard.

Review of a sample of staff training records concluded staff had received mandatory and other training relevant to their roles and responsibilities since the previous care inspection such as risk management and incident reporting and complaints management.

All staff had been provided with training in relation to medicines management. The manager advised that no service users required their medicine to be administered with a syringe. The manager 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 MCA.

Staff had completed Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The manager 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 and through discussions with service users, it was positive 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 on an annual basis, or when changes occur.

Discussion with the staff and service users provided assurance that the staff had responded to service users' wishes, feelings, opinions and concerns with the aim of ensuring service users received an effective service.

It was also positive 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 and support. Some matters discussed included fire safety, menus, activities and outings.

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 thickening 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 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. 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?

The manager advised that there were no newly recruited staff to the agency since the previous care inspection. The manager confirmed that all pre-employment checks, including criminal record checks (AccessNI), would be completed and verified before staff members would commence employment and have direct engagement with service users.

Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC) or the Nursing and Midwifery Council (NMC); 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 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?

The manager advised that there was a structured orientation and induction programme in place, 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.

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

5.2.6 What are the arrangements to ensure robust managerial oversight and governance?

We reviewed the monitoring arrangements in line 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. Review identified that the monitoring visits weren't always undertaken monthly. For example, there was a six-week timeframe between one monitoring visit and a 10-day timeframe between another. An area for improvement has been identified in this regard.

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

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. The review of records and discussion with the manager confirmed that one complaint was received since the date of the last inspection. Review of the complaint records confirmed that this complaint had been managed appropriately.

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 the manager and staff described positive working relationships in which issues and concerns could be freely discussed; staff reported they were confident that they would be listened to. In addition, staff confirmed that they felt supported by management.

Discussions with the management and staff confirmed that systems were in place to monitor staff performance and ensure that staff received support and guidance. This included the availability of continuous training updates, supervision/appraisal processes, team meetings and an open door policy for discussions with the management team and observation of staff practice.

We discussed the acting management arrangements which have been ongoing since 4 August 2021; RQIA will keep this matter under review.

6.0 Quality Improvement Plan (QIP)/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

The area for improvement and details of the QIP were discussed with Ms Stacy 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 23 **Stated:** First time	The registered person shall ensure that the quality monitoring visit by or on behalf of the registered provider takes place at least once a month. Ref: 5.2.6
To be completed by: Immediate and ongoing from the date of inspection	**Response by registered person detailing the actions taken:** To ensure full compliance with regulation 23 under The Domiciliary Care Agencies Regulations (Northern Ireland) 2007, new Monthly Monitoring guidance has been issued to Claire House & Magee Court. This guidance requires Supported Living Managers to ensure Monthly Monitoring visits are arranged and completed within the first 3 weeks of each month. This guidance is accompanied by a Monthly Monitoring rota and Supported Living Managers have been allocated a new Trust Supported Living Facility within Adult Mental Health to complete Monthly Monitoring. There is an additional 'backup' rota created to ensure compliance continues at times with Supported Living Managers are on Annual Leave during the first 3 weeks of a month when they are due to complete Monthly Monitoring. This 'backup' rota also accounts for sick leave, should this arise. Additionally, a flow chart has been created to provide Supported Living Managers with an additional tool to ensure full compliance with regulation 23. Compliance will be audited by Service Manager on a monthly basis.

	The guidance and flow chart will be communicated to all Trust Supported Living facilities within Adult Mental Health, and also communicated at Supported Living Managers Meetings

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

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