The Regulation and Quality Improvement Authority

Inspection Report

21 July 2021

Cedar Court Supported Housing Facility

Type of Service: Domiciliary Care Agency
Address: 100a Bridge Street, Downpatrick BT30 6HD
Tel No: 028 4461 7260

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: South Eastern HSC Trust **Responsible Individual:** Mr Seamus McGoran, Acting-No application required	**Registered Manager:** Mr Mark Baker **Date registered:** 8 September 2014
Person in charge at the time of inspection: Band 5 Support Worker	
Brief description of the accommodation/how the service operates: Cedar Court Supported Housing Facility is a domiciliary care agency supported living type located in Downpatrick, which provides domiciliary care and housing support to individuals. Staff are available to support service users 24 hours per day. The agency provides care and support to service users; this includes help with tasks of everyday living and emotional support with the overall goal of promoting independence and maximising quality of life. The agency's office is located at the entrance to the homes of the service users.	

2.0 Inspection summary

An unannounced inspection was undertaken by a care inspector on 21 June 2021, between 10.20 am and 16.20pm.

This inspection focused on staff recruitment, Northern Ireland Social Care Council (NISCC) registrations, adult safeguarding, incident reporting, complaints and whistleblowing. Other areas reviewed included Deprivation of Liberty Safeguards (DoLS) including money and valuables, restrictive practice, management of Dysphagia, Care Partners and monthly quality monitoring and Covid-19 guidance.

There was evidence of robust governance and management oversight systems in place. Good practice was found in relation to system in place of disseminating Covid-19 related information to staff.

3.0 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 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:

- contacting the service users, their relatives, HSC Trust representatives and staff to obtain their views of the service
- reviewing a range of relevant documents, policies and procedures relating to the agency's governance and management arrangements.

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

Four questionnaires were returned and the respondents' comments indicated that they were satisfied that the service provided was safe, effective and compassionate. There was no response to the electronic survey.

We spoke with five service users a care partner and four staff during the inspection; comments received are detailed below.

Service users' comments:

- "I am happy."
- "Staff are excellent, I have no problems."
- "It is great living here."
- "Staff are brilliant."
- "I enjoy the company."
- "I have no complaints."

Staff comments:

- "I like working here. The needs of the service users are increasing."
- "We could do with more permanent staff; we have regular bank staff to cover gaps."
- "I can raise issues in supervision."
- "The Band 5 is supportive."
- "I like it here; I feel supported."
- "I have no issues or concerns."
- "Staffing has been challenging due to staff isolating during the pandemic."
- "I think we do ok here."

Care partner comments:

- "I am delighted to be able to support the tenants; I enjoy working here."

A comment made by staff with regard to workload was discussed with the person in charge and the manager; assurances were provided that the matter would be discussed with staff. The manager stated that they would feedback any further update.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to Cedar Court was undertaken on 11 June 2019 by a care inspector; no areas for improvement were identified. An inspection was not completed during the 2020-2021 inspection year due to the impact 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 policy and procedures reflect information contained within the Department of Health's (DOH) regional policy 'Adult Safeguarding Prevention and Protection in Partnership' July 2015 and clearly outlines the procedure for staff in reporting concerns. The organisation has an identified Adult Safeguarding Champion (ASC).

Discussions with the person in charge demonstrated that they were knowledgeable in matters relating to adult safeguarding and the process for reporting adult safeguarding concerns. Staff could describe the process for reporting concerns including out of hours arrangements.

It was identified that staff are required to complete adult safeguarding training during their induction programme and required updates thereafter.

Staff indicated that they had a clear understanding of their responsibility in identifying and reporting any actual or suspected incidents of abuse. They could 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 has a system for retaining a record of referrals made in relation to adult safeguarding matters. Records viewed and discussions with the person in charge indicated that referrals made to HSC Trust adult safeguarding teams since the last inspection had been managed appropriately. Adult safeguarding matters are reviewed as part of the monthly quality monitoring process.

Service users who spoke to us stated that they had no concerns regarding their safety; they described how they could speak to staff if they had any concerns in relation to safety or the care being provided.

The agency has provided service users with information in relation to keeping themselves safe and the details of the process for reporting any concerns.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. It was noted that incidents had been managed in accordance with the agency's policy and procedures. Details of incidents /accidents are recorded electronically and reviewed by the HSC Trust's risk management team.

It was noted that a number of staff have completed appropriate DoLS training appropriate to their job roles; however, five staff have not completed the training. An area for improvement has been identified.

Staff spoken with demonstrated that they have an understanding that people who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the Mental Capacity Act. There are arrangements in place to ensure that service users who require high levels of supervision or monitoring and restriction have had their capacity considered and assessed appropriately.

It was noted that where restrictive practices are in place, appropriate risk assessments had been completed in conjunction with the service user, relatives and HSC Trust representatives.

The person in charge stated that the organisation has a system in place for notifying RQIA if the agency is managing individual service users' monies in accordance with the guidance.

There was a clear system in place in relation to the dissemination of information relating to Covid-19 and infection prevention and control practices.

5.2.2 Is there a system in place for identifying care partners who visit service users to promote their mental health and wellbeing during Covid-19 restrictions?

It was identified that there have been two care partners visiting and supporting service users during the Covid-19 pandemic restrictions. It was positive to note that a number of service users had regular contact with family and friends.

5.2.3 Are their robust systems in place for staff recruitment?

The review of the agency's staff recruitment records confirmed that recruitment was managed in accordance with the regulations and minimum standards, and in conjunction with the organisation's Human Resources (HR) department and Business Services Organisation (BSO). It was evidenced from information provided following the inspection that pre-employment checks are completed before staff commence direct engagement with service users.

A review of the records confirmed that all staff are appropriately registered with NISCC. Information regarding registration details and renewal dates are monitored monthly by the manager in conjunction with the organisation's human resources department. Staff spoken with

confirmed that they were aware of their responsibilities to ensuring that their registration with NISCC was up to date.

5.2.4 Are there robust governance processes in place?

There were monitoring arrangements in place in compliance with Regulation 23 of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007. Reports relating to the agency's monthly monitoring were reviewed. The process included evidence of engagement with service users, service users' relatives, staff and HSC Trust representatives on the majority of the visits.

The reports included details of the review of service user care records; accident/incidents; safeguarding matters; complaints; staff recruitment and training, and staffing arrangements. In addition, there was evidence of audits having been completed with regards to medication and finance. It was noted that an action plan was generated to address any identified areas for improvement and these were followed up on subsequent months, to ensure that identified matters had been addressed.

There is a process for recording complaints in accordance with the agency's policy and procedures. From records viewed and discussions with the person in charge it was noted that complaints received since the last inspection had been managed in accordance with the policy and procedures. Complaints are reviewed as part of the agency's monthly quality monitoring process.

There was a system in place to ensure that staff received supervision and appraisal in accordance with the agency's policies and procedures.

It was established during discussions with the person in charge that the agency had not been involved in any Serious Adverse Incidents (SAIs) Significant Event Analyses (SEAs) or Early Alerts (EAs) since the last inspection.

The discussions with staff and review of service user care records reflected the multi-disciplinary input and the collaborative working undertaken to ensure service users' health and social care needs were met within their home environment. There was evidence that staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate. It was identified from records viewed and discussions with the person in charge and the manager that there is ongoing engagement with the Health and Social Care Trust (HSCT) keyworker with regards to one service user due to a change in their care and support needs.

It was identified that staff have completed training with regard to Dysphagia and Speech and Language Therapist (SALT) swallow assessments and recommendations. There is currently one service user who has been assessed by the SALT team in relation to Dysphagia needs and specific recommendations made. Staff demonstrated a clear understanding of the needs of the service user.

The review of staff rota information highlighted that sticky labels had been used to make changes to the documentation. An area for improvement was identified.

6.0 Conclusion

As a result of this inspection two areas for improvement were identified in with regard to safe and effective care. Details can be found in the Quality Improvement Plan included.

7.0 Quality Improvement Plan/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, 2011.

	Regulations	Standards
Total number of Areas for Improvement	1	1

Areas for improvement and details of the Quality Improvement Plan were discussed with the person in charge, 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)(a) **Stated:** First time	The registered person shall ensure that the records specified in Schedule 4 are maintained, and that they are- (a) kept up to date, in good order and in a secure manner. Ref: 5.2.4
To be completed by: Immediate and ongoing from the date of the inspection	**Response by registered person detailing the actions taken:** The Registered Manager has audited the records as specified in Schedule 4 and the use of sticky labels. The use of sticky labels on these records has been discontinued. All staff have been made aware of this at a team meeting.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards 2011	
Area for improvement 1 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure that staff are trained for their roles and responsibilities. This relates specifically to DoLS training. Ref: 5.2.1
To be completed by: Immediate and ongoing from the date of the inspection	**Response by registered person detailing the actions taken:** The Registered Manager will ensure that all staff receive training at a level appropriate to their role. Training on DOLS has been arranged for the staff as required in line with Trust policy.

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

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