Announced Care Inspection Report
20 February 2018

Church Lane Mews Supported Living Service

Type of Service: Domiciliary Care Agency
Address: 1-16 Church Lane Mews, Churchwell Avenue, Magherafelt,
Tel No: 028 7936 6819
Inspectors: Marie McCann and Jim McBride

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a supported living type domiciliary care agency which provides 24 hour supported living and rehabilitation service with accommodation for 14 tenants either male or female. The service provides 14 individual bungalows situated in Churchwell Lane, Magherafelt. The service aims to provide a complete integrated package of support and housing that is flexible, responsive and innovative.

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

3.0 Service details

Organisation/Registered Provider: Northern HSC Trust **Responsible Individual(s):** Dr Anthony Baxter Stevens	**Registered Manager:** Mrs Heather Mabel Lynch
Person in charge at the time of inspection: Mrs Heather Mabel Lynch	**Date manager registered:** 02 October 2014

4.0 Inspection summary

An announced inspection took place on 20 February 2018 from 09.20 to 13.20.

This inspection was underpinned by the Domiciliary Care Agencies Regulations (Northern Ireland) 2007 and the Domiciliary Care Agencies Minimum Standards, 2011.

The inspection assessed progress with any areas for improvement identified during and since the last care inspection and to determine if the agency was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staff supervision and appraisal, adult safeguarding, risk management, care records and reviews, communication between service users, agency staff and other key stakeholders and the provision of compassionate care.

Areas requiring improvement were identified in relation to improving the governance arrangements for the ongoing management of staff training.

Service users said “we are free to come and go as we want”; “I’m proud of my home and love being here.”

The findings of this report will provide the agency with the necessary information to assist them to fulfil their responsibilities, enhance practice and service users’ experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Heather Lynch, registered manager and the locality manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection dated 04 July 2016.

No further actions were required to be taken following the most recent inspection on 04 July 2016.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- Unannounced care inspection report 04 July 2016.
- Incident notifications which revealed three incidents had been notified to RQIA since the last care inspection in July 2016.
- Information and correspondence received from the registered manager and the Northern Health and Social Care Trust (NHSCT).
- Record of complaints notified by the agency.

During the inspection the inspectors met with:

- two service users
- the registered manager
- the locality manager
- two staff

The inspectors also observed the interactions of the staff with service users.

The following records were examined during the inspection:

- Service users care files
- Staff files
- A sample of service users progress records
- The complaints/issue of dissatisfaction record from April 2016 to January 2018
- A sample of incidents and accidents records
- The staff rota arrangements from 01 January 2018 to 31 January 2018
- The service user meetings
- Monthly monitoring reports
- Staff training and record of NISCC/NMC registration
- Adult Safeguarding Policy (2017)
- Whistleblowing Policy (2016)
- General Procedures for the Processing of Personal Information Policy (2017)
- Human Rights and Deprivation of Liberty Policy (2017)
- Statement of Purpose (June 2017)
- Service Users Guide (May 2017)
- Annual review of the quality of care

During the inspection the inspectors met with the registered manager, the locality manager and two staff. At the request of the inspectors, the registered manager was asked to display a poster within the setting. The poster invited staff to provide their views by an electronic means to RQIA regarding the quality of service provision; six responses were received.

A number of service user and relatives' questionnaires were also given for distribution; nine questionnaires were returned to RQIA post inspection.

The findings of the inspection were provided to the registered manager and locality manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 04 July 2016

The most recent inspection of the agency was an unannounced care inspection.

6.2 Review of areas for improvement from the last care inspection dated 04 July 2016

There were no areas for improvement made as a result of the last care inspection.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to service users from the care, treatment and support that is intended to help them.

The agency has a dedicated human resources department (HR dept) which oversees the recruitment process. An inspector visited the agency's HR dept. on the 12 December 2017 to review a number of recruitment records, which verified that the pre-employment information and documents had been obtained as required for each of the care workers. The documents reviewed were satisfactory. The registered manager could describe the procedure for ensuring that staff are not provided for work until all necessary checks have been completed, the outcome of the checks completed is retained by the HR dept.

The registered manager takes responsibility for the induction process, discussions with staff supported an induction process lasting more than three days which included corporate induction, areas of mandatory training, shadowing other staff members, meeting service users and becoming familiar with their needs before staff are included on the staff rota. Staff gave feedback that the induction period prepares staff for their roles and responsibilities within the setting.

Discussions with the registered manager and staff indicated that there are sufficient numbers of staff in various roles to meet the needs of the service users. They explained that additional staff are rostered at times depending on the specific needs of the service users for outings etc. A review of the agency's staff rota information reflected staffing levels as described. It was agreed with the registered manager that she would amend the duty rota to specify the hour's staff are on duty and make clearer the designation of staff.

The registered manager outlined the timescales and processes for supervision and appraisal, the supervision schedules maintained were examined. Discussions with staff and review of staff files confirmed that regular individual formal supervision and annual appraisals are undertaken. The supervision record has a focus on supporting service users, service development, training, continuous professional development and safeguarding. The records in place were satisfactory.

Discussions with staff on duty at the time of inspection revealed that they felt the staff team were sufficiently trained, competent and experienced to meet the assessed needs of the service users present, taking into account the size and layout of the premises and the statement of purpose.

A review of staff training records showed staff received mandatory training and other training relevant to their roles and responsibilities; such as, WRAP (Wellness Recovery Action Plan), Autism Awareness, Human Rights and Quality 2020. Staff confirmed that mandatory training was ongoing and they had training opportunities over and above mandatory requirements. However the inspectors noted that the training matrix held by the registered manager indicated that some mandatory training was out of date and the training file did not have full records as outlined in the Domiciliary Care Agencies Minimum Standards, 2011. Standard 12.17 requires that a record of training is kept in the agency. This record should include the names and signatures of those attending training event or evidence of completion of online training; the date(s) of the training; the name and qualification of the trainer or the training agency and the content of the training programme. Two areas for improvement are made in this regard.

The inspectors reviewed the settings management of any adult safeguarding concerns. The registered manager reported that there were no current suspected, alleged or actual incidents of abuse. A recent adult safeguarding referral had been screened out. The registered manager spoke confidently about the agency's role in working with the Health and Social Care Trust in relation to the referral, despite the referral being screened out of the adult safeguarding process. Effective person centred support plans were put in place to contribute to safer outcomes for the service user, with the aim of reducing risk of a reoccurrence.

It was identified that the agency has reviewed and updated their policy and procedures to reflect information contained within the DHSSPS regional policy 'Adult Safeguarding Prevention to Protection in Partnership' issued in July 2015 and the Operational Procedures. There is a clear pathway of referral for safeguarding concerns to the appropriate professionals and the organisation has an identified Adult Safeguarding Champion (ASC).

Records show that staff have read the Adult Safeguarding Prevention to Protection in Partnership Policy and Operational Procedures and that they receive two yearly updates on adult safeguarding training. The registered manager and staff spoke confidently about their role and responsibility to act preventatively and proactively to safeguard the service users, and about their obligation to report concerns.

The registered manager and staff described the systems in place to ensure that unnecessary risks to the health, welfare or safety of service users are identified, managed and where possible eliminated. These include completion of validated risk assessments as part of the admission process, which are reviewed as required and inform the support planning process; weekly scheduled meetings with the multi-disciplinary team; individual service user's monthly reviews; formal and informal discussions with staff and sharing of information at service users meetings. Staff and service users spoke of how service users are encouraged and supported to be involved in the development of risk assessments, support plans and review processes.

As noted in the Statement of Purpose some service users may be under Guardianship, declaratory orders or other restrictive practices and an individual's human rights are acknowledged by ensuring that restrictive practices are monitored and reviewed regularly. The inspectors noted that appropriate documentation was obtained in the service users file reflecting assessment and review involving specialist multi-professional trust personnel for those service users where restrictive practice was assessed as appropriate to meet their needs.

The agency' registered premises includes a range of offices, staff facilities and communal areas within a building adjacent to the service user's individual bungalows, which are suitable for the operation of the agency as set out in the statement of purpose.

Service User comments:

- "I feel safe here and close to everything in town."
- "You have privacy in your own bungalow but if you want company you can come and sit in the communal areas, no bother, and talk to staff."
- "I'm very happy to live here."
- "I'm proud of my home and love being here."

Staff comments:

- "We provide care and support to a very high level."
- "Staffing levels are good and care is sustainable."

Nine service users and relatives returned questionnaires to RQIA post inspection. The responses indicated a high level of satisfaction regarding the question "is care safe" in this setting. The six responses from staff questionnaires indicated that they were very satisfied regarding the question "is care safe". By safe care, RQIA means there was enough staff to help them, they felt protected and free from harm, they could talk to staff if they had concerns and the environment is safe and clean.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff supervision and appraisal, adult safeguarding and risk management.

Areas for improvement

Two areas of improvement were identified during the inspection in relation to improving the governance arrangements for the management of staff training.

	Regulations	Standards
Total number of areas for improvement	0	2

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The agency's arrangements for appropriately responding to and meeting the assessed needs of service users were reviewed during the inspection. The full nature and range of service provision is laid out in the agency's Statement of Purpose (June 2017) and the Service User Guide (May 2017).

Discussion with staff and service users confirmed that service users were involved in the assessment, support planning and review process.

Five service user individual records were reviewed; these were kept in individual files, well organised and held securely. They contained evidence of assessment; support planning documentation; daily progress records; risk assessment; review documentation and minutes for monthly review with support worker and the HSC trust annual review. Records showed participation of the service user and where appropriate their representative. Service users confirmed that they are given encouragement and support to be involved in their support planning. There was evidence of multi professional collaboration in planned care, risk assessment and review. It was noted that support plans were comprehensive, person centred and were reviewed. The review of these files did not identify any improvements required.

The arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to service users at regular intervals were inspected. Service users are given multiple opportunities to comment on the quality of the service both informally and formally through the service user meetings, monthly quality monitoring visits and the annual review of quality of care report. In discussion with service users they confirmed they were aware of how to raise any concerns they had regarding the service. The agency's complaints procedure is clearly set out in the statement of purpose and service user guide. It was good to note that one service user referred to regular visits to the service of an independent advocate.

The monthly quality monitoring visits demonstrated engagement with service users, staff, relatives and HSC trust staff regarding the quality of care and support provided by the agency. Relatives provided positive feedback, commenting "I'm happy my xxxx is doing very well", "the level of support is good" and "the support and care is at a high standard". A HSC trust professional also commented "I'm pleased with the care and support in the scheme". The monthly quality monitoring reports also identified areas for action and these were followed up monthly.

The agency facilitates regular service user meetings typically every three months, the service users who met with the inspectors indicated that they are able to contribute to the agenda and express their views and wishes. Minutes of the meetings were available for inspection, there is a clear and wide ranging agenda and a record of what was discussed and actions required. It was noted that new service users were welcomed and outside agencies were also invited on occasions to share information and provide advice, e.g. PSNI provided advice on home and personal safety.

Staff meetings are facilitated bi-monthly; and records maintained of who attended, the agenda and discussions. There was no evidence of a system in place to ensure that staff not in attendance were updated on the issues discussed at the team meeting. It was agreed in discussions with the registered manager and locality manager that minutes of staff meetings will be emailed to all staff and it will be responsibility of individual staff to ensure they are updated with issues discussed.

Nine service users and relatives returned questionnaires to RQIA post inspection. The responses indicated a high level of satisfaction regarding the question "is care effective" in this setting. The six responses from staff questionnaires indicated that they were very satisfied regarding the question "is care effective".

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records and reviews, communication between service users and agency staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Service users are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The inspection sought to assess the agency's ability to treat service users with dignity and respect, and to fully involve service users or their representatives in decisions affecting their care and support and life choices.

Discussions with service users and staff; and observations made during the inspection indicated there is a culture and ethos that supports the values of dignity, respect and independence. Staff engaged with service users in an easy, friendly and respectful manner. Service users could describe ways in which staff support them in making decisions regarding the care and support they receive and that the care was provided in an individualised manner with service user consent being sought. The service users were able to identify their keyworker and said they felt comfortable approaching staff if worried about anything and that they could speak to staff at any time.

Service users described how they have been supported to access services available to them in the local community which enable them to live full and active lives.

Staff provided feedback about the person centred nature of the service. They discussed how they maintained a focus on service user's health and wellbeing while ensuring service users had the information to make informed decisions and choices. Staff described how flexibility and review of support and support planning occurred to take into account the changing needs of

service users. This would occur as needed or with the service user and keyworker during the monthly review of their support plan; and as necessary collaboration with service user relatives/ representatives and HSC trust professionals would be required.

Discussions with staff and the agency records confirmed there are policies and procedures in place to ensure service users confidentiality with the most recent General Procedures for the processing of Personal Information Policy becoming operational in July 2017.

The inspectors noted that the views of service users and their representatives were recorded throughout a range of the agency's records. This was done effectively with a transparent complaints process, tenant meetings, quality monitoring reports and ongoing support plan reviews.

Service user comments:

- "We are free to come and go as we want."
- "When I get upset staff comfort me."
- "I have got qualifications since coming here….now thinking about going on to do something else next year."

Nine service users and relatives returned questionnaires to RQIA post inspection. The responses indicated a high level of satisfaction regarding the question "is care compassionate" in this setting. The six responses from staff questionnaires indicated that they were very satisfied regarding the question "is care compassionate".

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the provision of compassionate care and the involvement of service users.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The inspectors reviewed management and governance systems in place to meet the needs of service users. It was found that the agency has a range of policies and procedures some of which were accessible in a hard copy contained within an identified file and with access to a full range electronically. Staff confirmed that they were aware of how to access policy and procedures as needed to enable them to fulfil their roles and responsibilities.

The inspectors found that the agency has governance arrangements in place to highlight and promote the identification of and management of risk. Accidents and incidents were noted to be effectively recorded within the corporate electronic system. Details of accident/incidents were recorded with actions taken, with focus on preventing recurrence and learning from outcomes. The information entered into the system is passed electronically to the registered manager, locality manager and the NHSCT governance team who monitor and audit.

The registered manager demonstrated knowledge of the procedure to follow regarding reporting accidents and incidents to RQIA. Notifications received since the previous inspections were discussed with the registered manager, these had been recorded satisfactorily. The registered manager was able to describe actions taken following the incidents which included discussions with the service user and relevant HSC trust staff to reduce potential for reoccurrence and to support better outcomes for the service user.

The registered manager discussed how the agency manages and reports complaints. The inspectors reviewed the arrangements for recording complaints. Complaints from service users resolved locally are detailed in the service user progress notes. A record is maintained on a complaints log, which includes: the date and nature of complaint and action/outcome. It was discussed and agreed with the registered manager and locality manager that the complaints log would be reviewed to ensure that additional detail of the complaint is recorded to provide a more comprehensive auditing tool to monitor and review.

There was evidence that the agency operates in accordance with the regulatory framework. The registration certificate was up to date and displayed appropriately.
There was a clear organisational structure and staff spoken to demonstrated awareness of their roles, responsibility and accountability. This information was outlined in the statement of purpose and service user guide which are reviewed and updated as required. Discussion with the registered manager identified that she had good understanding of her role and responsibilities under the legislation.

Staff were able to describe how arrangements for collaborative working with services users, their families and or representatives and HSC trust professionals was for the benefit of the service users and contributed to care planning and risk management. Weekly meetings held with HSC trust professionals provided opportunity for staff to review and reflect on support provided to service users to ensure it was effective, timely and provided the best outcomes. Staff described good team working and positive working relationships between the team which ensures that there is sufficient staffing levels and continuity of care for the service users. The inspectors saw evidence of effective planning of staff resources to enable service users to engage in activities in the local community and develop skills in healthy meal preparation. Staff confirmed that as well as formal mechanisms for support through supervision and appraisal processes, they can also meet with the registered manager informally as needed and there is an “open door policy” in place. Staff indicated that they are confident that managers would listen to and respond to their concerns. They said “I feel very supported in my role” and “we are very lucky with the manager that we have”. Staff were able to demonstrate awareness and knowledge of the agency’s whistleblowing policy.

The registered manager has a system in place to monitor the Northern Ireland Social Care Council (NISCC) and the Nursing and Midwifery Council (NMC) registration of staff and renewal dates, which is reviewed at set intervals. It is also a running agenda item on the bi monthly staff meetings.

Nine service users and relatives returned questionnaires to RQIA post inspection. They identified they were “very satisfied” regarding the question “is care well led” in this setting. The six responses from staff questionnaires indicated that they were very satisfied regarding the question “is the service well led”.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Heather Lynch, registered manager and the locality manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the agency. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with the Domiciliary Care Agencies Minimum Standards, 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007

Area for improvement 1 **Ref**: Standard 12.3 **Stated**: First time **To be completed by**: 20 March 2018	The registered person shall ensure that a robust governance process is implemented and monitored to ensure that staff are trained for their roles and responsibilities through the completion of mandatory training at required intervals. This area for improvement relates to the registered manager ensuring that governance records regarding mandatory training is completed in an accurate, consistent manner and available for inspection. Ref: 6.4
	Response by registered person detailing the actions taken: a training matrix has been implemented to ensure governance records regarding mandatory training are accurate. This will be monitored and maintained by the manager and available for inspection.
Area for improvement 2 **Ref:** Standard 12.7 **Stated**: First time **To be completed by**: 20 March 2018	The registered person shall ensure that a robust governance system is in place in relation to monitoring the completion of mandatory training. The following should be evidenced in the records maintained: • the names and signatures of those attending the training event or evidence of completion of online training • the date(s) of the training • the name and qualification of the trainer or training agency; and • content of the training programme This area of improvement relates to the registered manager ensuring these records are maintained and available for inspection. Ref: 6.4
	Response by registered person detailing the actions taken: The manager will ensure staff provide a copy of certificates as evidence of training copmpleted. A training matrix has been implementated to record staff training and the date of the training. The Training department has provided manager with the qualifications of the trainer or training agency. A copy of handouts outlining training content will be filed by manager. All of the above will be maintained by the manager and available for inspection.

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

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