The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Rigby Close Supported Living Service**

Provider: **Belfast HSC Trust**

Date of Inspection: **30 December 2024**

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:	Belfast HSC Trust
Responsible Individual/Responsible Person:	Mrs Maureen Edwards
Registered Manager:	Mrs Arlene Kerr
Service Profile – Rigby Close Supported Living Service is a domiciliary care agency, supported living type service operated by the Belfast Health and Social Care Trust (BHSCT) which currently provides care and support to adults with a learning disability. Service users receive care and support in their own individual apartments and staff are available to the needs of service users 24 hours per day.	

2.0 Inspection summary

An unannounced inspection took place on 30 December 2024, between 8.50 a.m. and 2:30 p.m. This 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 and Dysphagia management were also reviewed.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards, and to assess progress with the area for improvement identified during the last care inspection on 29 December 2023.

Five new areas for improvement were identified, these were related to notification of incidents, medication auditing, complaints management, service user meetings and service user feedback.

As a result of this inspection, the area for improvement previously identified was assessed as having been addressed by the provider.

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 agency 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.

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 number of staff to seek their views of the agency.

Staff spoke very positively in regard to the care delivery and management support in the agency. One told us that they feel supported in their role and the service users are given lots of choices.

There were no responses to the questionnaires or the 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 29 December 2023 by a care inspector. A Quality Improvement Plan (QIP) was issued. This was reviewed by the care inspector during this inspection.

3.4 Inspection findings

3.4.1 Staffing Arrangements

A review of the agency's staff recruitment records confirmed that criminal record checks (AccessNI) were completed and verified before staff members commenced employment and had direct engagement with service users.

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.

A review of the records relating to staff that were provided from recruitment agencies also identified that they had been recruited, inducted and trained in line with the regulations.

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

3.4.2 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).

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 one of the safeguarding incidences met the requirement of notification to RQIA but this had not been reported. An area for improvement has been identified.

Staff were provided with training appropriate to the requirements of their role. Where service users required the use of specialised equipment to assist them with moving, this was included within the agency's mandatory training programme.

All staff had been provided with training in relation to medicines management. A review of medication errors found that appropriate action was taken. The monthly medication audit had not been undertaken for several months. An area for improvement has been identified. The person in charge advised that no service users required their oral medicine to be administered with a syringe.

The Mental Capacity Act (Northern Ireland) 2016 (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 had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles, but a number of staff require refresher training. The manager has provided assurances that this has been prioritised, this will be reviewed at future inspections. There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had had their capacity considered and, where appropriate, assessed. Where a service user was experiencing a deprivation of liberty, the care records contained details of assessments completed and agreed outcomes developed in conjunction with the HSC Trust representative.

Care and support plans are kept under regular review.

A review of training records confirmed that staff had completed training in Dysphagia and in relation to how to respond to choking incidents.

3.4.3 What are the arrangements for promoting service user involvement?

From reviewing service users' care records, it was good 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. Person centred support plans were reviewed and found to involve the service user.

Since the last inspection, the agency had not undertaken an evaluation of the service to include feedback from service users. An area for improvement has been identified.

The monthly service user meetings had only taken place on one occasion since the last inspection. An area for improvement has been identified.

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

There were monitoring arrangements in place. A review of the reports of the agency's quality monitoring established that there was engagement with service users, staff and HSC Trust representatives. The reports included details of a review of accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

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 lack of evidence that a robust system was in place to ensure that complaints were managed in accordance with the agency's policy and procedure. An area for improvement has been made.

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	2	3

Areas for improvement and details of the Quality Improvement Plan were discussed with the Person in charge and the Operational 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 Domiciliary Care Agencies Regulations (Northern Ireland) 2007	
Area for improvement 1 **Ref:** Regulation 22 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall establish and maintain a complaints procedure Ref: 3.4.4
	Response by registered person detailing the actions taken: The registered person has established a complaints procedure which is now in place.
Area for improvement 2 **Ref:** Regulation 23 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided. This relates specifically to service user meetings Ref: 3.4.3
	Response by registered person detailing the actions taken: The registered person has established a system of 'House Meetings' which provides the service user a forum to discuss the quality of the service they receive. House Meetings now take monthly.
Action required to ensure compliance with ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 1.8, 1.9 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure that a report is prepared and available of the formal seeking of views of service users and their carers / representatives Ref: 3.4.3
	Response by registered person detailing the actions taken: The Registered Person has prepared a Survey to seek the views of service user's and their carers/representatives. The service user's and their carers/representatives have been provided with these surveys and the registered person will compile a report when all surveys are returned.

Area for improvement 2 **Ref:** Standard 7.4 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure that practices for the management of medicines are systematically audited to ensure they are consistent with the agency's policy and procedures and action is taken when necessary. Ref: 3.4.2
	Response by registered person detailing the actions taken: The registered person has prepared an audit tool which will be completed monthly by a member of the management team. This audit has taken place monthly since the inspection.
Area for improvement 3 **Ref:** Standard 14.5 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure that all suspected, alleged or actual incidents of abuse are reported to the relevant persons and agencies in accordance with the procedures. Ref: 3.4.2
	Response by registered person detailing the actions taken: The registered person has ensured that all suspected, alleged or actual incident are reported to RQIA and other relevant persons.

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

The Regulation and Quality Improvement Authority

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