The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: MENCAP Riversley Project

Provider: MENCAP Limited

Date of Inspection: 19 November 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:	MENCAP Limited
Responsible Individual/Responsible Person:	Mr Barry Joseph McMenamin
Registered Manager:	Mrs Anita Shannon

Service Profile –

Mencap Riversley Project is a supported living type domiciliary care agency, located close to the town centre of Banbridge. The agency provides domiciliary care and housing support to adults with a learning disability in Banbridge and Keady.

2.0 Inspection summary

An unannounced inspection was conducted on 19 November 2024, from 9.30 a.m. to 3.45p.m. by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards. The inspection also sought to determine if the agency is delivering safe, effective and compassionate care and if the agency is well led.

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 was also examined.

There were no new areas for improvement (AfIs) identified. Two AfIs from the previous inspection, which related to the Annual Quality Report and feedback from service users and their representatives, have been carried forward to allow the service time to complete in line with their quality audit and reporting cycle.

Good practice was identified in relation to service user involvement. There were good governance and management arrangements in place. Service users were observed to be relaxed and comfortable in their interactions with staff and spoke positively about the care and support they receive.

Mencap Riversley Project uses the term 'tenants' to describe the people to whom they provide care and support. For the purposes of the inspection report, the term 'service user' is used, in keeping with the relevant regulations.

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 service. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors will seek the views of those living, working and visiting the service and examine a sample of records to evidence how the service is performing in relation to the regulations and standards.

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

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

Throughout the inspection the RQIA inspector will seek to speak with service users, their relatives or visitors and staff for their opinions on the quality of the care and support, their experiences of living, visiting or working in this agency to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

Staff spoke very positively in regard to the care delivery in the agency. They confirmed they enjoyed working in the service and everyone worked together as a team.

Service users spoke positively about their experience of the support they received from staff, and staff said they received good support from their manager and were very happy working at Mencap Riversley Project.

Returned questionnaires indicated that the respondents were very satisfied with the care and support provided. No responses were received to the electronic survey.

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

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 26 February 2024 by a care inspector. A Quality Improvement Plan (QIP) was issued. This was approved by the care inspector and was validated during this inspection.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 26 February 2024</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Regulation 13 (d)

Stated: First time</td><td>The responsible person shall ensure that no domiciliary care worker is supplied by the agency unless full and satisfactory information is available in relation to him, this specifically refers to exploring and recording the reasons for leaving previous posts and gaps in employment and references from current / most recent employer.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A sample of staff recruitment records was reviewed and were found to contain evidence that the reasons for leaving previous posts and gaps in employment and references from current / most recent employer were explored and recorded. This AFI has been assessed as met.</td></tr>
<tr><td rowspan="2">Area for Improvement 2

Ref: Regulation 23 (1)

Stated: First time</td><td>The registered person shall establish and maintain a system for evaluating the quality of the services, this relates specifically to Quality Improvement Plan not accurately referenced within the monthly monitoring reports and action plans being inaccurate.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The three most recent monthly monitoring reports were reviewed and each contained a section relating to the Quality Improvement Plan. This AfI has been assessed as met.

It was noted this section could be further strengthened to contain progress updated on the areas of improvement identified. The manager agreed to consider how best to incorporated this detail.</td></tr>
</table>

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021		Validation of compliance
Area for Improvement 1 **Ref:** Standard 9.1 **Stated:** Second time	The registered person shall develop a policy and procedure in relation to access to service users' accommodation including in the event of an emergency.	**Met**
	Action taken as confirmed during the inspection: There was a policy and procedure to guide staff in relation to access to service users' accommodation including in the event of an emergency. This AfI has therefore been assessed as met.	
Area for Improvement 2 **Ref:** Standard 8.12 **Stated:** First time	The registered person shall ensure that views and opinions of service users and their carers / representatives are sought formally at least once a year, and a report prepared that identifies the method used to obtain the views, comments made, issues raised and actions to be taken for improvement. This full report should be available in request .	**Carried forward to the next inspection**
	Action taken as confirmed during the inspection: There was evidence the service completed service user surveys in order to actively seek the views and opinions of service users. There were also plans to hold an event during which the staff would seek the views of service users' representatives. The manager stated that following this event, the information would be assessed and a report completed which would include a summary of the issues raised and an action plan to address these. This AfI will be assessed fully at the next inspection to allow time for the gathering of information and the report to be produced.	

Area for improvement 3 **Ref:** Standard 8.12 **Stated:** First time	The registered person shall ensure that the quality of the service is evaluated on at least an annual basis and follow-up action taken.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection as the Annual report was not due for completion until March 2025. This is carried forward to the next inspection.	

3.4 Inspection findings

3.4.1 Governance and Managerial Oversight

The agency's registration certificate was up to date and displayed appropriately along with current certificates of public and employers' liability insurance.

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, 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.

The new Annual Quality Report has yet to be completed and will therefore be reviewed as part of the next inspection. Additional information can be found in section 3.3.

Incidents had been managed appropriately and reported to RQIA within appropriate timeframes in keeping with the regulations.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Staff demonstrated a good awareness of both the complaints procedure and whistleblowing policy. A register of complaints was retained by the service. Details relating to the complaints process were included in the statement of purpose and service users guide. There was evidence of a system to ensure oversight of complaints which included a review of complaints during the monthly quality monitoring visits.

Service user meetings were held on a regular basis which enabled the service users to discuss any activities they would like to become involved in and also any other matters relating to their home. Activities service users availed of included attending college, work placements, attending the gym, going for walks, shopping and travel opportunities. A contemporaneous record was available to review.

Staff confirmed they had opportunity to attend staff meetings where they are provided with updates on policies and additional training requirements. They stated they could add to the meeting agenda if there were items they wished to discuss. Staff told us that they would have no issue in raising any concerns regarding service users' safety or care practices and that they were confident that the manager or person in charge would address their concerns.

3.4.2 Staffing (recruitment and selection, induction and training).

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of 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, three-day 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.

A review of the agency's staff recruitment records confirmed that all pre-employment checks, including criminal record checks (AccessNI), were completed and verified before staff members commenced employment and had 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) or any other relevant regulatory body; 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.

All registrants must maintain their registration for as long as they are in practice. This includes renewing their registration and completing Post Registration Training and Learning. Staff said they get an opportunity to discuss the post registration training requirements during supervision and appraisal meetings.

Records of all staff training were retained. Staff confirmed that they were provided with opportunities to complete training commensurate with their role.

There were good systems in place to manage staffing. There were enough staff on duty to help the service users. Staff said there was good teamwork and that they felt well supported in their role and that they were satisfied with the staffing levels. Staff were seen assisting service users in a caring and compassionate manner.

There were no volunteers deployed within the agency.

3.4.3 Care Records

From reviewing service users' care records and through discussions with service users, 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. 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.

The person in charge reported that one service user currently required the use of specialised equipment. There was evidence staff had competed manual handling training and received competency assessments in relation to the use of this equipment.

The person in charge also advised that no service users required their oral medicine to be administered with a syringe. The person in charge was aware that should this be required, a competency assessment should be completed before staff would undertake this task.

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.

3.4.4 Safeguarding

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). The agency's annual Adult Safeguarding Position report was reviewed and found to be satisfactory.

Discussions with the person in charge 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 manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

3.4.5 Deprivation of Liberty Safeguards (DoLs)

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 Mental Capacity Act (MCA).

Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The person in charge reported that none of the service users were subject to DoLS, but some restrictive practises were in place.

4.0 Quality Improvement Plan/Areas for Improvement

No new 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	0	2*

* the total number of areas for improvement includes two which are carried forward for review at the next inspection.

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Anita Shannon, Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021

Area for improvement 1 **Ref:** Standard 8.12 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The registered person shall ensure that views and opinions of service users and their carers / representatives are sought formally at least once a year, and a report prepared that identifies the method used to obtain the views, comments made, issues raised and actions to be taken for improvement. This full report should be available in request Ref: 3.3
	Response by registered person detailing the actions taken: Mencap have changed the survey for the people we support to an online survey coordinated by our national Quality team. It was launched in January 2024 and a report was sent to each Area Operations Manager with findings. 32 out of 47 people we support completed the survey and the AOM is supporting the service managers to action areas for improvement. A new survey will be sent to the people we support early 2025 by the Quality team.
Area for improvement 2 **Ref:** Standard 8.12 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The registered person shall ensure that the quality of the service is evaluated on at least an annual basis and follow-up action taken. Ref: 3.3
	Response by registered person detailing the actions taken: Each month, the service managers and assistant service managers undertake monitoring visits to services they do not have responsibility for. Mencap have been devising a new online version of the monitoring reports which will allow an annual report to be run which will show areas of the service that need improved and an action plan will be put in place to address. The first report will be available on 1st April 2025 and annually thereafter.

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

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