The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Inspire Moylena Court**

Provider: **Inspire Wellbeing**

Date of Inspection: **7 March 2025**

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:	Inspire Wellbeing
Responsible Individual/Responsible Person:	Ms Kerry Anthony
Registered Manager:	Mrs Sarah Taggart
Service Profile: Inspire Moylena Court is a supported living type domiciliary care agency based in Antrim. The agency provides support to up to 20 service users with enduring mental health; the service users live on two separate sites. Service users have their care and support commissioned by the Northern Health and Social Care Trust (NHSCT) and Supporting People.	

2.0 Inspection summary

An unannounced inspection took place on 7 March 2025, between 9.15 am and 3 pm by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care on 15 January 2024; and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that care delivery was safe and that effective and compassionate care was delivered to service users. However, improvements were required to ensure the effectiveness and oversight of certain aspects of the agency, such as recruitment practices, the care records and complaints records. Improvements were also required in relation to staff having an escalation protocol in place to support their decision making in the event of a suspected overdose.

Service users said that the care and support provided by Inspire Moylena Court was good. Refer to Section 3.2 for more details.

As a result of this inspection one area for improvement, previously identified at the last care inspection, was assessed as having been addressed by the provider. Another area for improvement has been carried forward for review at the next inspection. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

Inspire Moylena Court uses the term 'residents' 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 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, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this agency. This included the previous Quality Improvement Plan 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 seek the views of those living, working and visiting the agency; and review/examine a sample of records to evidence how the agency is performing in relation to the regulations and standards.

3.2 What people told us about the service

Through active listening, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

Service users told us that they were very satisfied that the care was safe, effective and compassionate; and the service was well led; they described the staff as being 'very good' and that they had 'no criticisms'. Staff told us they were very happy in their roles and they felt well supported. HSC' Trust representatives told us that the staff were very good and gave examples of how the staff have gone above and beyond in their roles, to support the service users.

3.3 Inspection findings

3.3.1 Staffing Arrangements

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 of robust systems in place to manage staffing.

It was noted that there was enough staff in the agency to respond to the needs of the service users in a timely way.

Review of the agency's staff recruitment records confirmed that pre-employment checks, including criminal record checks (AccessNI), were generally completed and verified before staff members commenced employment and had direct engagement with service users. However, review of recruitment records identified that the reasons staff left previous employments were no ascertained as part of the recruitment process. An area for improvement has been identified.

Additionally, advice was given regarding the need for the agency to revert to the previously used reference request forms, used by the organisation. Whilst RQIA acknowledges that some organisations provide 'factual' references, which only confirm start and end dates of employment, it remains good practice for agencies to ask more detailed questions as part of the reference-checking process. An area for improvement has been identified.

Newly appointed staff, including those supplied by recruitment agencies, had completed a structured orientation and induction, to ensure they were competent to carry out the duties of their job.

Records of all staff training were retained and were noted to be up to date. Staff confirmed that got sufficient training for their roles. Service user specific training had also been provided to staff, as identified in the last care inspection.

Competency assessments were undertaken on all staff to ensure that they were competent in their roles and responsibilities. Medicines Competency assessments were completed for any staff who administered medicines. It was good to note that the assessment included a section on Clozapine, as this is a medicine which requires staff to pay particular attention to possible side effects. It is also important that any refusals in taking Clozapine are reported promptly to the Community Mental Health Team; the manager confirmed to RQIA that this is included within the face to face medicines training.

Discussion took place with the manager regarding previous findings of serious adverse incidents. It was identified that there is a need for a written protocol to be developed to support staff of what actions to take where there is a suspected overdose of prescription or non-prescription medication. An area for improvement has been identified.

All staff received regular supervision and appraisals.

3.3.2 Care Delivery

There was a daily handover at the beginning of each shift, which included information about any changes to the service users' care, that the staff needed to assist them in their roles. Regular staff meetings were held and minutes maintained of the meetings for staff, unable to attend, to read for information sharing.

There was a system in place to ensure that the activities offered to service users were varied and geared towards their individual needs and preferences. Service users' needs were met through a range of individual and group activities such as creative writing, quizzes, movie nights, table tennis and pool. There was also a gardening club which the service users were encouraged to attend. Staff used a white board in the dining room to alert service users to any upcoming activities they may be interested in attending.

Staff supported service users with pursuing volunteering opportunities. Advice was given in relation to developing resources that would support staff and service users in this regard, to ensure that they were aware of all the volunteering opportunities that are available in the area.

It was observed that staff respected service users' privacy by their actions such as knocking on doors before entering and discussing service users' care in a confidential manner. Where service users required support with domestic tasks, the level of support required was included in their support plan.

Service users' meetings were held on a regular basis. It was good to note that the matters discussed included supporting service users to learn new skills and how to keep themselves safe. Advice was given in relation to keeping safety around rechargeable Vapes as a standing item on the agenda, to reduce the risk of a fire occurring.

3.3.3 Management of Care Records

Service users' needs were assessed when they were first referred to the agency and before care delivery commenced. Following this initial assessment support plans were developed to direct staff on how to meet service users' needs and included any advice or recommendations made by other healthcare professionals.

Whilst each of the service users had a number of support plans in place, improvements were required in relation to the Medicines care plan, to ensure that it reflected the information in the NHSCT Clozapine care pathway. An area for improvement has been identified.

In addition, service users should have a service user agreement in place, to ensure that they are aware of the number of care and support hours they are entitled to. An area for improvement has been identified.

Some service users may decline to attend their scheduled Out Patient Appointments. Whilst there may be a number of valid reasons for this, the manager was advised to develop and implement a system for tracking the occurrence of same, given that repeated cancellations may be indicative of deteriorating mental health. The manager welcomed this advice.

Sometimes service users had items, such as medicines or monies, removed from them for their safety/protection. These would be considered to be restrictive practices. Whilst there was evidence that any restrictive practices were included with the service users' support plans, advice was given in relation to developing a restrictive practice register to assist in demonstrating manager oversight of this area.

Records pertaining to consent were available, however given that the agency had recently introduced a new electronic records management system, these documents had yet to be completed and uploaded to the new system. This will be followed up at future inspection.

Service users care records were held confidentially.

3.3.4 Quality of Management Systems

There has been no change in the management of the agency since the last inspection. Mrs Sarah Taggart has been the manager in this agency since 14 November 2019. Those consulted with commented positively about the manager and described her as supportive and approachable.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place. The agency was visited each month by a representative of the registered provider to consult with service users, their relatives and staff and to examine all areas of the running of the agency. The reports of these visits were completed in detail; however, advice was given in relation to ensuring that any areas for improvement included in the RQIA QIP are more explicitly detailed every month up to the next inspection. For example, an area for improvement had previously been identified regarding the need for care plans relating to any high risk behaviours to be comprehensively completed where enhanced observations may be required by staff. The area for improvement also included the need for records of such checks to be retained to enable auditing of same. Review of the records identified that a proforma had not been developed for staff to record the frequency of the checks. In addition, through discussion with the manager, it was evident that HSCT input was required regarding the frequency of observations. Given that the service user this area for improvement related to was not residing in Moylena Court on the day of the inspection, this area for improvement has been carried forward for review at the next inspection.

The manager was advised that all records pertaining to the agency must be retained within the registered premises, regardless of whether or not the complaint was sent to Inspire's Head Office. An area for improvement has been identified.

Agencies are required to have a person known as the Adult Safeguarding Champion (ASC), who has responsibility for implementing the regional protocol and the agency's adult safeguarding policy. There was an individual within the organisation's senior management team who was identified as the appointed ASC for the agency. Advice was again given regarding the need for the Annual Position Report to have service specific data appended to the organisational report.

There were good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm. However, it was identified that there were no records of when an agency cleaner was present within the building. This was discussed with the manager who agreed to implement a sign in/out book with immediate effect.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Regulations and the Standards.

	Regulations	Standards
Total number of Areas for Improvement	4*	3

* the total number of areas for improvement includes one that has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Sarah Taggart, 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 15 (a)(b) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that care plans are comprehensively completed; this relates to any high risk behaviour that necessitates escalated observations by staff; and records of such checks must be retained enabling regular audit of same. Ref: 3.3.4
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref:** Regulation 13 (d) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that the reasons for leaving previous employments are sought as part of the recruitment process. Ref: 3.3.1
	Response by registered person detailing the actions taken: The registered person has reviewed the organisations application form. Reasons for leaving are captured on this document. The organisations specific dates of employment form used to capture gaps of employment or request clarity, will be updated to include reasons for leaving. It will be implemented no later than the 30/04/25.
Area for improvement 3 **Ref:** Regulation 15 (2)(a) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the Medicines care plan is further developed to ensure that it is reflective of the NHSCT Clozapine care pathway. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Registered Manager liased with the person's CPN who confirmed that the care pathway for Clozapine is held on their Trust records and not shared with the service currently. However, the Register Manager has reviewed and updated the service's care plan to ensure it relfects the required care and support

	required for a person taking clozapine. The Care Plans for all people receiving Clozapine will be reviewed no later than the 30/04/25.

Area for improvement 4 **Ref:** Regulation 22 (8) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that all records pertaining to complaints are retained within the registered office and retained centrally; this includes any complaints about the service that have been received by Inspire's Head Office. Ref: 3.3.4
	Response by registered person detailing the actions taken: The Registered Manager has updated their local complaint records.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 11 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that the reference request proforma is further developed, in keeping with good practice. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Responsible Person will ensure that Inspire's Policy on Recruitment is reviewed to ensure compliance with relevant social care regulation and standards alongside employment legislation no later than 30/04/25.
Area for improvement 2 **Ref:** Standard 8 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that a written protocol is developed to support staff of what actions to take where there is a suspected overdose of prescription or non-prescription medication. Ref: 3.3.1
	Response by registered person detailing the actions taken: Inspire's medication competency assessment was updated on the 04/04/25 to include the actions and protocols to take where there is a suspected ovedose of prescription or non-prescrition medication.
Area for improvement 3 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that the service user agreement includes a breakdown of the numbers of care and support hours the service users receive. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Registered person has now updated the records for the identified person supported on the day of the inspeciton to include the supporting people documentation.

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

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