

Inspection Report

15 January 2024



Inspire – Moylena Court

Type of service Domiciliary Care
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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

<p>Organisation/Registered Provider: Inspire Wellbeing</p> <p>Responsible Individual: Ms Kerry Anthony</p>	<p>Registered Manager: Mrs Sarah Taggart</p> <p>Date registered: 14/11/2019</p>
<p>Person in charge at the time of inspection: Mrs Sarah Taggart</p>	
<p>Brief description of the accommodation/how the service operates: Inspire Moylena Court is a supported living type domiciliary care agency based in Antrim. The agency provides support to 19 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.</p>	

2.0 Inspection summary

An unannounced inspection took place on 15 January 2024 between 11.30 a.m. and 3.30 p.m. The inspection 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 was also reviewed.

Areas for improvement identified related to the care planning process and in relation to staff training.

Good practice was identified in relation to service user involvement. Feedback from service users reflected their positive experience of the care and support provided.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were 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.

In preparation for this inspection, a range of information about the service was reviewed. This included any previous areas for improvement identified, registration information, and any other written or verbal information received from service users, relatives, staff or the Commissioning Trust.

As a public-sector body, RQIA has a duty to respect, protect and fulfil the rights that people have under the Human Rights Act 1998 when carrying out our functions. In our inspections of domiciliary care agencies, we are committed to ensuring that the rights of people who receive services are protected. This means we will seek assurances from providers that they take all reasonable steps to promote people's rights. Users of domiciliary care services have the right to expect their dignity and privacy to be respected and to have their independence and autonomy promoted. They should also experience the individual choices and freedoms associated with any person living in their own home.

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.

4.0 What did people tell us about the service?

During the inspection we spoke with a number of service users who described the care and support in positive terms. We spoke with staff who indicated that they had no concerns to raise. Consultation with a NHSCT visiting professional was also positive, noting that the staff are always good in keeping them informed of any issues.

Returned questionnaires indicated that the respondents were satisfied with the care and support provided. Written comments included:

- "I find it hard to come out of my room at times due to Obsessive Compulsive Disorder (OCD). This means I can't do art therapy."
- "The staff are so helpful. You get a say in what happens."

Positive comments were also noted within the monthly quality monitoring reports. A number of reflected that the service users felt safe and that the staff were 'very supportive'.

No responses were received to the electronic survey.

5.0 The inspection

5.1 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 7 February 2023 by a care inspector. No areas for improvement were identified.

5.2 Inspection findings

5.2.1 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. Review of incident records and care records identified a high risk behaviour pertaining to an identified service user. Whilst there was evidence of known antecedents to the behaviour and action for staff to take in response, this was displayed on the noticeboard in the staff office, rather than being included within the service user's care plan. Whilst the behaviour was for reason of distraction, enhanced observations/supervision and support were required at times. The care plan was not sufficiently robust in terms of mitigating against this risk. In addition, the agency did not have a system in place for recording the required checks until the behaviour deescalated. An area for improvement has been identified.

Review of training records identified that whilst the majority of training requirements were met, a number of staff had yet to undertake training in relation to suicide awareness, self-harm and ligature management. An area for improvement has been identified.

All other training elements had generally been undertaken. It was good to note that staff were working towards completing training in relation to Diabetes awareness and Autism awareness. The manager was advised to add training in respect of the administration of Buccal Midazolam to the training matrix.

The organisation's adult safeguarding 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 was satisfactory. Advice was given in relation to page 4 of the report being presented in relation to incidents which occurred in Inspire Moylena Court, as opposed to the whole organisation; this can be retained as an addendum to the report.

Discussions with the manager 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.

The manager advised that no concerns had been raised under the whistleblowing procedures.

There was a system in place to record any referrals made to the HSC Trust in relation to adult safeguarding. Any referrals made had been managed appropriately.

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

5.2.2 What are the arrangements for promoting service user involvement?

From reviewing care records, it was evident that service users had an input into devising their own plan of care.

Service users' meetings were held on a regular basis which enabled the service users to discuss the provisions of their care and support. Items discussed included:

- Menu choices
- Christmas lunch planning
- Activities
- Fire safety
- Cooking

It was good to note the service users were involved in planning various activities, which included:

- Movie night
- Creative writing
- Breakfast club
- Film night
- Hair and Nail treatments
- Diamond painting
- Craft nights
- Bingo/Quizzes
- Cinema

Service users' consent was sought in relation to whether or not they wanted:

- Their photograph to be used in various organisational documents
- Information pertaining to sharing information with other professionals.

5.2.3 What are the systems in place for identifying service users' Dysphagia needs in partnership with the Speech and Language Therapist (SALT)?

A review of training records confirmed that staff had completed training in Dysphagia and in relation to how to respond to choking incidents. The manager advised that there were no service users requiring a modified diet.

5.2.4 What systems are in place for staff recruitment and are they robust?

Review of records confirmed that Appropriate checks were undertaken with AccessNI before the staff had direct engagement with service users. However, review of records identified that the manager had not signed a declaration of physical and mental fitness in keeping with the regulations. When raised with the manager, immediate action was taken to update the recruitment checklist with the required information.

5.2.5 What are the arrangements for staff induction and are they in accordance with NISCC Induction Standards for social care staff?

There was a system in place to ensure 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.

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

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 Annual Quality Report was reviewed and was satisfactory.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedures.

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

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Review of records identified that any complaints had been managed appropriately

There was a system in place which enables staff to access service users' accommodation in the event of an emergency.

6.0 Quality Improvement Plan (QIP)/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 (revised) 2021

	Regulations	Standards
Total number of Areas for Improvement	1	1

The areas for improvement and details of the QIP were discussed with Mrs Sarah Taggart, Registered 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	
<p>Area for improvement 1</p> <p>Ref: Regulation 15 (a)(b)</p> <p>Stated: First time</p> <p>To be completed by: Immediate from the date of the inspection</p>	<p>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.</p> <p>Ref: 5.2.1</p>
	<p>Response by registered person detailing the actions taken:</p> <p>The Registered Manager has undertaken a review of support plans and safety management plans. Where risk and associated support needs, including requirements for observations, has not been clearly identified a service improvement plans in consultation with individuals statutory workers has been devised. Service improvement plans will be completed by 19th July 2024. The Registered manager has further implemented a regular file audit to ensure future compliance with accuracy and review.</p>
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
<p>Area for improvement 1</p> <p>Ref: Standard 12.4</p> <p>Stated: First time</p> <p>To be completed by: Immediate from the date of the inspection</p>	<p>The registered person shall ensure that staff receive training in relation to suicide awareness, self-harm and ligature management.</p> <p>Ref: 5.2.1</p>
	<p>Response by registered person detailing the actions taken:</p> <p>The Registered Provider has sourced this training with delivery having commenced. The full team will have completed this training no later than October 25th 2024.</p>

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