The Regulation and Quality Improvement Authority

Inspection Report

8 August 2024

Hollylane Supported Living Accommodation

Type of service: Domiciliary Care Agency
Address: Gransha Park, Clooney Road,
Londonderry, BT47 6TF
Telephone number: 028 7161 0754

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: Western Health and Social Care Trust (WHSCT) **Responsible Individual:** Mr Neil Guckian	**Registered Manager:** Mr Ashley John Burnside **Date registered:** 29/04/2024
Person in charge at the time of inspection: Mr Ashley John Burnside	
Brief description of the accommodation/how the service operates: Hollylane Supported Living Accommodation is a domiciliary care agency, supported living type service based in Gransha Park, Londonderry. The agency provides single person accommodation for up to sixteen service users with mental health needs. The WHSCT is the main provider of care and support.	

2.0 Inspection summary

An unannounced inspection took place on 8 August 2024 between 9.50 a.m. and 4.45 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 were also reviewed.

Areas for improvement identified related to staffing levels, medicines competency assessments, mandatory training, accident/incident audits, annual quality review report, staff induction and staff competency when in charge of the agency. At the conclusion of this inspection, detailed feedback was provided to the manager.

Good practice was identified in relation to service user involvement and good communication with multidisciplinary healthcare professionals.

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

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 staff survey.

4.0 What did people tell us about the service?

During the inspection we spoke with a service user and staff members.

The information provided identified some concerns in relation to staffing levels.

Comments received included:

Service user's comments:

- "I am very happy here. I feel safe here and staff are always available at night. Staff always ask permission to come into my house and they are respectful and kind. I have choice how I spend my day. Sometimes they are short staffed but the staff work really hard to ensure that everything is done."

Staff comments:

- "I feel very supported by senior staff. I enjoy my job. Very good training provided. I feel we are short staffed over the last few months and we use a lot of bank staff. We do our best to meet the service users' needs with the staff we have. Sometimes it's hard to deliver activities."

- "We maintain care records on an up to date basis. We have good working relationships with multidisciplinary professionals and they are informed of any changes in the service users mental health. At times we are under pressure due to being short staffed."

Review of returned service users' questionnaires outlined varied views in relation to the care and support provided. The questionnaire responses were shared with the manager following the inspection for further consideration and action, as appropriate.

Written comments included:

- "Due to a lack of staff I feel all my needs are not met."
- "We do need more staff but my care is satisfactory."

No staff responded 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 30 May 2023 by a care inspector. A Quality Improvement Plan (QIP) was issued. This was approved by the care inspector and was validated during this inspection.

Areas for improvement from the last inspection on 30 May 2023		
Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 12 (a)(b)(i)(ii) **Stated:** First time	The registered person shall ensure that the procedure referred to in paragraph (6)(a) shall in particular provide for— (a) written records to be kept of any allegation of abuse, neglect or other harm and of the action taken in response; and (b) the Regulation and Improvement Authority to be notified of any incident reported to the police, not later than 24 hours after the registered person— (i) has reported the matter to the police; or (ii) is informed that the matter has been reported to the police.	**Met**

	Action taken as confirmed during the inspection: The returned quality improvement plan and discussion with the manager confirmed that this area for improvement had been addressed. Review of incident records evidenced that this area for improvement was addressed.	

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. The organisation's policy and procedures reflected information contained within the Department of Health's (DoH) regional policy 'Adult Safeguarding Prevention and Protection in Partnership' July 2015 and clearly outlined the procedure for staff in reporting concerns. The organisation had an identified Adult Safeguarding Champion (ASC). The safeguarding champion was known to the staff team.

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 safeguarding training during induction and every two years thereafter. Review of the mandatory training matrix identified a small number of staff had not completed safeguarding training. An area for improvement has been identified in this regard.

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.

The agency retained records of any referrals made to the relevant Health and Social Care (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's governance arrangements for the management of accidents/incidents were reviewed. Review confirmed that an incident/accident reporting policy and system was in place. Staff are required to record any incidents and accidents in a centralised electronic record, which is then reviewed and audited by the manager and the WHSCT governance department.

A sample of accident/incident records were reviewed by the inspector. Discussion with the manager revealed that monthly audits of accidents and incidents were not undertaken to determine if there were patterns or trends. An area for improvement has been identified in this regard.

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

Review of the mandatory training matrix identified that a small number of staff had not been provided with moving and handling training appropriate to the requirements of their role. An area for improvement has been identified in this regard.

Care reviews had been undertaken in keeping with the agency's policies and procedures. There was also evidence of regular contact with service users and their representatives, in line with the commissioning Trust's requirements.

All staff had been provided with training in relation to medicines management. However, a medicines competency assessment had not been completed. An area for improvement has been identified in this regard.

The manager advised that no service users required liquid medicine to be administered orally with a syringe. The manager was aware that should this be required; a competency assessment would be undertaken before staff undertook this task.

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 MCA.

Review of the mandatory training matrix identified that a small number of staff had not had completed DoLS training appropriate to their job roles. An area for improvement has been identified in this regard.

The manager reported that none of the service users were subject to DoLS.

There was a system in place for notifying RQIA if the agency was managing individual service users' monies in accordance with the guidance.

5.2.2 What are the arrangements for promoting service user involvement?

From reviewing service users' care records and through discussions with a service user, it was positive to note that service users had been supported to have 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 service users and /or their relatives participate, where appropriate, in the review of the care provided on an annual basis, or when changes occur.

It was also positive to note that the agency had facilitated regular service users' meetings. This supported service users to discuss the provisions of their care and support. Some matters discussed included activities, outings, staffing levels and complaints and compliments procedures.

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

The manager reported that none of the service users had SALT recommendations in place. A review of training records confirmed that a small number of staff had not completed training in Dysphagia. An area for improvement has been identified in this regard.

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

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); there was a system in place for professional registrations, including bank staff, to be monitored by the manager and a record of checks retained. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

The manager stated that there were no volunteers supporting the agency.

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

Induction records were not available for all staff working in the agency. All newly appointed, including bank staff, must complete a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care, to ensure they are competent to carry out the duties of their job in line with the agency's policies and procedures. An area for improvement has been identified in this regard.

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.

Discussion with the manager identified that the Annual Quality Review Report had not been completed. An area for improvement has been made in this regard.

The agency's registration certificate was up to date and displayed appropriately.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Where complaints were received since the last inspection, these were appropriately managed and were reviewed as part of the agency's quality monitoring process. Discussion with staff confirmed that they knew how to receive and respond to complaints sensitively and were aware of their responsibility to report all complaints to the manager or the person in charge.

Our discussion with staff revealed they had a clear view about their role and responsibility to meet service user's individual needs and promote their rights, choices, independence and future outcomes. They identified staff training, policies and procedures, staff support mechanisms and the management team supported them to provide safe, effective and compassionate care in this setting.

It was noted that none of the staff who were left in charge of the agency in the absence of the manager had been assessed as competent and capable to do so. An area for improvement has been identified.

Discussions with service users, the manager and staff identified concerns in relation to staffing levels. A review of a sample of staffing rosters evidenced that the planned staffing levels were not always adhered to. However, a number of staff stated that when staffing levels were affected by short notice leave, this can impact on their ability to deliver planned care and support arrangements. Staff stated that it was difficult to obtain cover for short notice absenteeism however acknowledged that management offered support and assistance to the best of their ability. It was noted that a significant number of bank staff were utilised to endeavour to maintain staffing levels.

The identified needs of service users should be assessed, specifically for the purpose of ensuring that staffing levels are appropriate for the assessed needs of service users, the number of service users accommodated and the statement of purpose. An area for improvement has been identified.

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	3	3

Areas for improvement and details of the QIP were discussed with Mr Ashley Burnside, Manager, as part of the inspection process. Details of the QIP were also discussed with the Service Manager and Head of Service for Recovery and Supported Living post inspection. 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 (7) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of the inspection	The registered person shall ensure that a medicines competency is completed for all staff delegated the task of medicine administration. Ref: 5.2.1
	Response by registered person detailing the actions taken: All medication competency assessments are now complete for permanent staff both senior support workers and support workers and regular bank staff. one new member of staff is still going through induction and her medication competency assessment will be completed in due course and prior to completing medications independently. Evidence of completed medication competency assessment supplied on attachement of email. A yearly schedule is being developed across Supported Living in the WHSCT to ensure such assessment are completed timely going forward.
Area for improvement 2 **Ref:** Regulation 16 (2)(a) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of the inspection	The registered person shall ensure that each employee of the agency receives training and appraisal which are appropriate to the work he is to perform. This specifically relates to the following training: • DoLS • Dyspahgia • Safeguarding • Moving and Handling Ref: 5.2.1& 5.2.3
	Response by registered person detailing the actions taken: All appraisals for permanent staff have been completed. Staff have now completed or have enrolled onto the training identifed above. Evidence of training matrix provided on attachment. Holly Lane registered manager has developed a recording sheet for regular bank staff regarding training, registration and their access NI check. Gaps have been highlighted to the bank staff to ensure their training is up to date. This recording sheet is attached as evidence.

Area for improvement 3 **Ref:** Regulation 16 (1)(a)(d) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of the inspection	The registered person shall ensure that: • Suitably qualified and competent persons are available to be consulted during any period of the day in which a person is working for the purposes of the agency. • There is at all times an appropriate number of suitably skilled and experienced persons working in the agency in such numbers as are appropriate for the care and support of service users. Ref: 5.2.6
	Response by registered person detailing the actions taken: Band 5 competency assessments have been completed for all permanent and regular band 5 bank staff that work within Holly Lane. The band 5 competency assessment will be added to the yearly schedule for all Supported Living registered managers to complete timely going forward. Evidence of the competency assessments are attached in email. The staffing model within Holly Lane has been reviewed and there is an increased number of staff on the rota per day (day shift). The staffing model is now 5 staff per day shift with 2 staff remaining at night. This staffing model meets the assessed care and support needs of the residents within Holly Lane.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 8.16 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of the inspection	The registered person shall ensure that regular accident/incident audits are undertaken in order to identify any trends or patterns and take appropriate action to minimise recurrence. Ref: 5.2.1
	Response by registered person detailing the actions taken: New datix incident form has been developed to be completed following each incident. This form aims to collect data to identify if themes are reoccuring to faciliate an appropriate action plan to be developed. Additonal to this, registered managers will commence a monthly governance report which will outline number of datixs per month, themes and if there are trend. New datix incident form and monthly governance report attached as evidence.

Area for improvement 2 **Ref:** Standard 8.12 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of the inspection	The registered person must make arrangements for the completion of the Annual Quality Review Report for this service. This should be submitted to RQIA with the returned QIP. Ref: 5.2.6
	Response by registered person detailing the actions taken: The Annual Quality Review Report has been completed and attached for evidence. This will also be added to the yearly schedule to ensure timely completion going forward.
Area for improvement 3 **Ref:** Standard 12.1 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of the inspection	The registered person shall ensure that all newly appointed staff, including bank staff, complete a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care, to ensure they are competent to carry out the duties of their job in line with the agency's policies and procedures. Ref: 5.2.5
	Response by registered person detailing the actions taken: All bank staff have had a bank induction completed. These have been attached as evidence. A trust wide task and finish group for Supported Living registered managers has been established to review permanent staff induction process which will include the completion of the NISCC Induction Standards for new workers in social care booklet. This will standardise the induction process across Adult Mental Health Supported Living faciliaties. The task and finish group will establish links with NISCC with the view that they will attend the first task and finish group to discuss the induction process and module booklet with the aim of having a standarised agreed timeframe.

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

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