# Inspection Report

## 11 June 2024

# Lisburn Supported Living Service

Type of service: Domiciliary Care Agency
Address: Thompson House Hospital, 19-21 Magheralave Road
Lisburn, BT28 3BP
Telephone number: 028 9263 3181

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

## 1.0 Service information

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| **Organisation/Registered Provider:**<br>South Eastern Health and Social Care Trust<br><br>**Responsible Individual:**<br>Ms Roisin Coulter | **Registered Manager:**<br>Mrs Lynette Marshall - Acting |
| **Person in charge at the time of inspection:**<br>Mrs Lynette Marshall | |
| **Brief description of the accommodation/how the service operates:**<br><br>Lisburn Supported Living Service is a supported living type domiciliary care agency which provides personal care and housing support to 13 service users to live as independently as possible within the local community. Services are provided at a number of addresses in the greater Lisburn area. The agency works in partnership with the Northern Ireland Housing Executive's Supporting People programme, the South Eastern Health and Social Care Trust (SEHSCT) and with a number of housing associations. | |

## 2.0 Inspection summary

An unannounced inspection took place on 11 June 2024 between 9.45 a.m. and 3.45 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 was also reviewed.

Areas for improvement identified related to the annual update of care plans; the inclusion of accurate Speech and Language Therapist (SALT) recommendations and Deprivation of Liberty Safeguards (DoLS) records within care plans. Other deficits noted were the absence of records of induction, supervision and appraisal and the staffing levels within the service.

RQIA convened an Enforcement Decision Making meeting on 20 June 2024 to decide if enforcement action was required. It was agreed that due to the regulatory history and the assurances provided by the manager and senior manager during and following the inspection, no further enforcement action would be progressed, however, an Enhanced Feedback Meeting was scheduled for 1 July 2024 with RQIA. At this meeting the manager and senior SEHSCT staff outlined actions planned to address the deficits found on inspection and their plans to

become compliant with the Regulations and Standards. RQIA will continue to monitor this service.

## 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.

Having the model "We Matter" Adult Learning Disability Model for NI 2020, the Vision states, 'We want individuals with a learning disability to be respected and empowered to lead a full and healthy life in their community'.

RQIA shares this vision and want to review the support individuals are offered to make choices and decisions in their life that enable them to develop and to live a safe, active and valued life. RQIA will review how service users who have a learning disability are respected and empowered to lead a full and healthy life in the community and are supported to make choices and decisions that enables them to develop and live safe, active and valued lives.

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

## 4.0 What did people tell us about the service?

During and following the inspection we spoke with a number of service users, relatives and staff members.

Comments received included:

**Service users' comments:**

- "Yes, I am happy here."

- “They are good to me.”
- “I can say what I want to eat.”

**Service user’s relative’s comments:**

- “It is not as good as it was.”
- “My opinion is divided.”
- “There is inconsistency with staffing.”

The feedback provided from staff, both during the inspection and from the electronic survey, indicated that they were ‘dissatisfied’ that the care provided was safe, effective and compassionate and that the service was well-led. The concerns raised related to staffing levels, the implementation of one to one supervision for those who require this level of support and the management of the rota at the agency. These were discussed with the manager and senior management during the Enhanced Feedback Meeting and assurances were provided that the issues raised were being progressed and an action plan was in place.

## 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 13 November 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. 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).

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. 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.

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).

The manager reported that none of the service users currently required the use of specialised equipment. They were aware of how to source such training should it be required in the future.

Care reviews had not been undertaken in keeping with the agency's policies and procedures. An area for improvement has been identified. There was 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. The manager advised that no service users require their medicine to be administered with a syringe. The manager was aware that should this be required a competency assessment would be undertaken before staff undertook this task. The inspector discussed recent medicine errors and was satisfied that plans to urgently investigate practices and procedures in respect of administration of medicines should improve safety in this area.

At the time of inspection, the manager confirmed that staffing levels were difficult to maintain and that there were issues with the rota. Staff and relatives spoken with also voiced concerns about recent rota changes. These matters were discussed at the Enhanced Feedback Meeting and strategies to address staffing deficits were outlined; an area for improvement has been identified.

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 had completed appropriate DoLS training appropriate to their job roles. The arrangements to ensure that service users who required high levels of supervision or monitoring and restriction had had their capacity considered and, where appropriate, assessed were not available on inspection. The manager who was recently appointed had difficulty locating the details of assessments completed and agreed outcomes developed in conjunction with the SEHSCT representative. These matters were discussed at the Enhanced Feedback meeting, assurances were given that reviews were being arranged and records sourced; an area for improvement has been identified.

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 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 but were not kept under regular review which has been identified as an area for improvement as stated in section 5.2.1.

On the day of inspection, it was apparent that service user meetings had not been held regularly, this matter will be reviewed at future inspections.

### 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 number of service users were assessed by SALT with recommendations provided and some required their food and fluids to be of a specific consistency. A review of training records confirmed that staff had completed training in Dysphagia and in relation to how to respond to choking incidents.

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. A review of some service user records evidenced that SALT recommendations were not included in either office files or electronic records. An area for improvement has been identified.

There was evidence of the specific recommendations of the SALT in the file held in the service users' home. Staff demonstrated a good knowledge of service users' wishes, preferences and assessed needs. Staff were familiar with how food and fluids should be modified.

### 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); 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.

There were no volunteers working in 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?

There was no 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. An area for improvement has been identified.

The agency has maintained a record for each member of staff of all training and professional development activities undertaken. This record revealed gaps in training; following the inspection the manager emailed the inspector to confirm that most staff were compliant with mandatory training and those who required updates were booked to attend. These matters will be reviewed at a future inspection.

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. The manager was advised to discuss the post registration training requirement with staff to ensure that all staff are compliant with the requirements.

### 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 SEHCT representatives. The reports included details of a review of service user care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

Discussions during the Enhanced Feedback meeting centred on the robustness of the process of the monitoring arrangements in view of the deficits highlighted on inspection. Assurances were provided that these matters were being reviewed and RQIA will also monitor these arrangements at future inspections.

The records of supervision and appraisal were not up to date and did not reflect compliance with policy; an area for improvement has been identified.

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.

We also discussed the acting management arrangements which have been ongoing since June 2024; RQIA will keep this matter under review.

## 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 |
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| **Total number of Areas for Improvement** | 3 | 3 |

Areas for improvement and details of the QIP were discussed with Lynette Marshall, manager and Diana McIntyre-Patel, Senior Manager as part of the inspection process. The timescales for completion commence from the date of inspection.

| Quality Improvement Plan | |
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| **Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007** | |
| **Area for improvement 1**<br><br>**Ref:** Regulation 15 (3) (b)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate and ongoing. | The registered person shall ensure that every service user's care plan is kept under review. This should be completed on an annual basis or if the service users' needs change.<br><br>Ref: 5.2.1 and 5.2.2 |
| | **Response by registered person detailing the actions taken:**<br>I have made a matrix of Annual view of service users care/support plan, this is kept in Lisburn suported Livings shared folder. The B5 seniors have access to this. I have liased with the Social workers and gained information of the last reviews held to create the matrix. I have organised outstanding reviews to those who are outstanding<br>During B5 supervisons which are 4 weekly I ask them to bring a service users All about me file along with them so i can audit it myself and give an action plan to B5 during supervison. B5 supervise B3 staff 6-8 weekly and it's the role of the band 3 to keep the folder itself in good condition. It is the responsibility of all staff to update information as it changes to ensure smooth communiation of the care /support of our service users. This is to be handwritten on, dated and signed if staff cannot at that time get access to the computer to change the information. Any changes should be communicated via email and on shift handover. I also do spot checkson the units to call in to offer support and monitor the service. |
| **Area for improvement 2**<br><br>**Ref:** Regulation 15 (2) (a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate and ongoing | The registered person shall ensure that the risk assessments and care plans are reflective of the International Dysphagia Diet Standardisation Initiative and contain records associated with Deprivation of Liberty Safeguards (DoLS) decisions consistent with any plan prepared by any Health and Social Services Trust professionals.<br><br>Ref: 5.2.2 and 5.2.3 |
| | **Response by registered person detailing the actions taken**:<br>I have liased with SALT and all guideance is in service users files that require them. |

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| | All Service users that have SALT guidelines have information to hand within their kitchen also as an extra measure of reducing risk.<br>Encompass also holds the REDS information from SALT for each service user.<br><br>There is a matrix for MCA/DOLS which 2 of our service users are on and the renewal dates available to see.<br><br>Within the service plans the risk assesements are held. As a new manager in this service I have arranged to meet the social worker of both Service Users to review risk assessments. |
| **Area for improvement 3**<br><br>**Ref:** Regulation 16 (1) (a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate and ongoing | The registered person shall ensure that there is at all times an appropriate number of suitably skilled and experienced persons employed for the purposes of the agency<br><br>Ref: 5.2.1 |
| | **Response by registered person detailing the actions taken**:<br><br>I have liased with Finance and have approval for 5x30 B3 contracts, 1x18.5 B3 contract Adult Services plan to have a recruitment Fair in September to fill these voids. By employing Trust Staff and going through the rigorus safeguarding checks at the employment stage this will give the team qualified staff to be inducted correctly into our service brining stability and the consistancey that our service requires. I am curerntly giving induction to the staff that were employeed late 2023. Again by having the sttructure put in place for supervisions the staff team will feel supported and know what direction they are working towards. Supervisions highlight training required.<br>I have access to the full staff teams engagement with the LMS trianing system. I do a monthly audit and publish to the whole team. B5 bring this to B3 attenstion as previosly mentioned.<br><br>Number of agency staff members are currently helping service. Those staff are inducted into the service. |
| **Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021** | |
| **Area for improvement 1**<br><br>**Ref:** Standard 12.1<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate and ongoing | The registered person shall ensure appointed staff complete 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.<br><br>Ref: 5.2.5 |
| | **Response by registered person detailing the actions taken:** |

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| | All staff, Trust Permanent, Bank, Agency are NISCC registered to come to work in Lisburn Supported Living.<br>I have a matrix that is audited monthly and our admin will email and remind staff close to renewal.<br><br>When organising agency, I hold a folder of current staff their profiles and their NISCC. Through the inspection it became apparent through evidence wriiten and verbal that many staff only had 3 day corporate induction. I have gave those staff induction documentation to complete, this is being updated and reviewed currently. They are being supported by their peers and supervisors. |
| **Area for improvement 2**<br><br>**Ref:** Standard 13.3<br><br>**Stated:** First time<br><br>**To be completed by:**<br>11 September 2024 | The registered person shall ensure that staff have recorded supervision to promote the delivery of quality care and services.<br><br>Ref: 5.2.6 |
| | **Response by registered person detailing the actions taken:**<br>I have made a structure of whom supervises whom for accountability and order.<br>I have made a superviosn folder on shared folder in which i have A training link to supervison skills for the B5 staff,<br>A folder with up to date documentation, supervision agreements, supervison records<br>I have made a supervison schedule which are live documents that B5 access and update so meetings held and planned are visable and can be monitored.<br>I have scheduled 4 Team meetings and this has been circulated.<br>All Band 5 supervisions are schedualed and dates are now in the matrix. |
| **Area for improvement 3**<br><br>**Ref:** Standard 13.5<br><br>**Stated:** First time<br><br>**To be completed by:**<br>11 September 2024 | The registered person shall ensure that staff have their performance appraised to promote the delivery of quality care and services.<br><br>Ref: 5.2.6 |
| | **Response by registered person detailing the actions taken:**<br>I have made an apprasail conversations folder.<br><br>All B5 staff have training within their LMS system for apprasail conversations, this has been highlighted to them for their confidence knowledge and skills.<br><br>I have a guide to apprasail conversations for all staffs information within the folder. |

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| | I have the paperwork for the core demsinsions fro both B5 and B3 staff and the guideance on it.<br><br>I have planned dates within the schedule for the team to be appraised to make the team feel valued and goals to work towards. |

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