The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Central Promenade**

Provider: **Autism Initiatives NI**

Date of Inspection: **27 May 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:	Autism Initiatives NI
Responsible Person:	Adele Leighton
Registered Manager:	Mrs Leanne Binks
Service Profile – Central Promenade is a supported living type domiciliary care agency for adults with autistic spectrum conditions and/or learning disability. The care and support service provided by Autism Initiatives NI are commissioned by the South Eastern Health and Social Care Trust (SEHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 27 May 2025, between 10.00am and 2.00pm. This inspection was conducted 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 inspection on 29 July 2024; and to determine if the agency is delivering safe, effective and compassionate care and if the service 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 were also reviewed.

Good practice was identified in relation to service user involvement. There were good governance and management arrangements in place.

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 recording of staff and service user/relative signatures on review documentation.

Central Promenade uses the term 'people who we support' 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 home; and review/examine a sample of records to evidence how the home 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 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 facility.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

We spoke to a range of service users, relatives and staff to seek their views of living within, visiting and working within Central Promenade.

A number of service users spoke in positive terms about the care workers. Comments included that the staff treat service users respectfully and that staff were "brilliant" Relatives spoke about the care being good and staff keeping them informed.
Staff were very complimentary about the supportive management team describing a "close" team who work together and "genuinely care"

3.3 Inspection findings

3.3.1 What are the systems in place for identifying and managing risk?

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 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. A review of records confirmed that these had been managed appropriately and actions had been taken to prevent reoccurrence.

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 service had provided service users with information about 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).

3.3.2 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 the Northern Ireland Social Care Council's (NISCC) 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, 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 NISCC 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 and the manager maintained oversight of the training matrix to ensure compliance. It was noted that some staff had not completed some elements of their mandatory training specifically dysphagia training. Since the inspection the manager has confirmed that all staff working at present have now completed this training.

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 sensitive manner and helping prepare nutritious food.

There were no volunteers deployed within the agency.

3.3.3 Care delivery and care records.

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.
Staff were knowledgeable of individual service users' needs, their daily routine wishes and preferences. 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 a sample of care records evidenced that service users, where possible, were involved in planning their own care and efforts had been made to ascertain service users' preferences and choices around how their support was provided. The details of care plans were shared and signed by service users and/or their representatives as appropriate.

There was evidence that staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate. Staff also implemented the specific recommendations of the SALT to ensure the care received in the setting was safe and effective. The inspector noted a recording sheet to demonstrate that all staff had read specific SALT guidelines had not been signed by all staff. The manager agreed to ensure this action was completed.

An area for improvement identified previously regarding records and signatures will be restated; while some signatures have been added within support plans and consent forms some reviews were not signed. The inspector also discussed that some review forms did not have a signature box and the addition of this section may aid compliance in this matter.

It was observed that staff respected service users' privacy by their actions such as knocking on doors before entering, discussing service users' care in a confidential manner, and by offering personal care to service users discreetly. Staff were also observed offering service users choice in how and where they spent their day or how they wanted to engage socially with others.

On the day of inspection, the inspector observed a member of staff from the organisation's Health and Wellbeing department demonstrating and encouraging a service user to develop cookery skills.

The service users availed of a variety of activities which included visiting family, going shopping, cinema, visiting peers and travel opportunities. Some service users had access to their own cars which helped foster independence and choice.

There was a selection of policies available to direct staff in care delivery and support planning based on individual risk assessments. Staff confirmed they had access to policies and that those relevant to individual service users would be reflected in their care plans.

3.4.4 Governance and managerial oversight.

There were processes in place to review the quality of the service on an annual basis. The Annual Quality Report was reviewed and was satisfactory.

Staff had managed incidents appropriately and reported to RQIA, the commissioning trust and NISCC 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 was included in the statement of purpose and service users guide. There was evidence of a system to ensure oversight of complaints, this included a review of complaints during the monthly quality monitoring visits. 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.

One matter recorded as a complaint was discussed with the manager who agreed to engage with the Adult Safeguarding Champion for review.

There was evidence to demonstrate that a robust system was in place to ensure that staff undergo regular supervisions and appraisals in keeping with Regulation and the Agency's own policies.

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

There is a system in place that ensures that the service has an operational policy, procedure or protocol that clearly directs staff from the Agency as to what actions they should take to manage and report such situations in a timely manner.

4.0 Quality Improvement Plan/Areas for Improvement

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	1*	0

* the total number of areas for improvement includes one that has been stated for a second time and which is carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Leanne Binks, 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 21 (1) schedule 4 **Stated:** Second time **To be completed by:** Immediate and ongoing	The registered person shall ensure that the records are kept up to date, in good order and in a secure manner, this relates specifically to signatures within care reviews. Ref:3.3.3
	Response by registered person detailing the actions taken: There is a review sheet which is signed and dated by the person undertaking the review and also a designated area for signatures in care reviews. All records are kept up to date, in good order and in a secure manner.

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

The Regulation and Quality Improvement Authority

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