The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Slievegrane**

Provider: **SEHSCT**

Date of Inspection: **18 February 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:	South Eastern Health & Social Care Trust
Responsible Individual/Responsible Person:	Ms Roisin Coulter
Registered Manager:	Mr Christopher Lowry

Service Profile –

Slievegrane, is a domiciliary care agency, supported living type located in Downpatrick. The agency's staff provide care and support to service users living in shared accommodation and in houses situated within the local community. The service users have a range of enduring mental health needs.

The agency provides care and support to service users; this includes assisting service users with personal care needs, meals, medication, housing support and assistance to access community services with the overall goal of promoting independence and maximising the quality of life.

This organisation also provides floating support to service users who live in the community. RQIA does not regulate these elements of support.

2.0 Inspection summary

An unannounced inspection took place on 18 February 2025, between 8.40 am and 3.30 pm This 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.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards, and to assess progress with the area for improvement identified during the last care inspection on 4 December 2023.

Four new areas for improvement were identified, these were related to the updating of risk assessments, pre-employment checks, the Annual Quality Report and annual feedback from service users.

As a result of this inspection, the area for improvement previously identified was assessed as having been addressed by the provider.

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.

To prepare for this inspection we reviewed information held by RQIA about this agency. This included the previous area for improvement issued, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning Trust.

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

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

Service users told us that they loved living there, they felt safe and that the staff were great.

Staff spoke very positively in regard to the care delivery and management support in the agency. One told us that they have no concerns about the care of the service users, that the manager is brilliant, approachable and always very measured. He is calm and inspires calmness, while another remarked that the management structure has now been stable for a year and they are all benefiting from this.

The information provided indicated that there were no concerns in relation to the service.

3.3 Inspection findings

3.3.1 Staffing Arrangements

A review of the agency's staff recruitment records confirmed that criminal record checks (AccessNI) were not consistently completed and verified before a staff member commenced employment and had direct engagement with service users. It was explained that this because of the Trust's policy and procedure in relation to the internal transfer of staff. This was discussed with the manager who provided assurance that corrective action has been undertaken. An area for improvement has been identified.

The agency has maintained a record for each member of staff of all training, including induction and professional development activities undertaken.

3.3.2 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).

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.

The Mental Capacity Act (Northern Ireland) 2016 (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. The manager reported that none of the service users were subject to DoLS.

Following the inspection the manager shared the Restrictive Practice register, which was reviewed and found to be acceptable.

The manager shared their plans to reinstate the care file auditing process, this will be reviewed at future inspections. While support plans were found to be kept under regular review, updated risk assessments were not available. An area for improvement has been identified.

3.3.3 What are the arrangements for promoting service user involvement?

From reviewing service users' care records, it was good to note that service users had an input into devising their own plan of care. Person centred support plans were reviewed and found to involve the service user.

Since the last inspection, the agency had not undertaken an evaluation of the service to include feedback from service users. An area for improvement has been identified.

It was good to note that the agency had service users' meetings on a regular basis which enabled the service users to discuss the provisions of their care.

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

There were monitoring arrangements in place. A review of the reports of the agency's quality monitoring, established that there was engagement with service users, staff and HSC Trust representatives. The reports included details of a review of accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements. The manager shared plans for future monitoring to include care file review.

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.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. No complaints were received since the last inspection.

The Annual Quality Report was not available. An area for improvement has been identified.

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	2	2

Areas for improvement and details of the Quality Improvement Plan were discussed with the 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 Domiciliary Care Agencies Regulations (Northern Ireland) 2007	
Area for improvement 1 **Ref:** Regulation 13 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The registered person shall ensure that no worker is supplied by the agency unless full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 3. This relates specifically to Access NI checks for one individual. Ref: 3.3.1
	Response by registered person detailing the actions taken: Whilst awaiting an update as to the outcome of engagement between Executive Directors of Social Work/Directors of HR to arrive at a regionally agreed position in relation to the above, the Trust will carry out an Access NI check for any new staff taking up post in Slievegrane Support Living.
Area for improvement 2 **Ref:** Regulation 15 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure that care records are kept updated, this refers specially to the review of risk assessments Ref: 3.3.2
	Response by registered person detailing the actions taken: The Risk assessments of 5 individual Tenants did not migrate over from maxims to the new Encompass system. There is a process now in place with this work now commenced. Records will be updated a minimum of 6 monthly or more often as risks are identified.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 3 **Ref:** Standard 1.8, 1.9 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure that a report is prepared and available of the formal seeking of views of service users and their carers / representatives Ref: 3.3.3
	Response by registered person detailing the actions taken: Service users and Carers questionnaires are being developed by a sub-group, to include Registered Managers and tenants, with agreement being sought on the format and questions asked. This will be collated annually at a minimum. Views are also sought and recorded at house/ tenant meetings and through the Monthly Monitoring contact by the Senior Manager.

Area for improvement 4 **Ref:** Standard 8.12 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure that the quality of services provided is evaluated on at least an annual basis and follow-up action taken. Key stakeholders are involved in this process. This relates specifically to the Annual Quality Report not being available at inspection Ref: 3.3.4
	Response by registered person detailing the actions taken: Slievegrane Registered Managers, in conjunction with the managers from our other two Supported Living schemes, are developing a 'You Said, We Did,' Annual Quality Report, based on the findings of the Tenant and Carer's annual questionnaire. We aim for this to commence in April 2025, and annually subsequently.

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

The Regulation and Quality Improvement Authority

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