Inspection Report

21 October 2024 & 20 November 2024

5 Lilburn Hall

Type of service: Domiciliary Care Agency
Address: Avenue Road, Lurgan, BT66 7TL
Telephone number: 028 3832 8374

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: Southern Health and Social Care Trust (SHSCT) **Responsible Individual:** Dr. Maria O'Kane	**Registered Manager:** Mrs. Sarah McCartney **Date registered:** Acting since 1 July 2023
Person in charge at the time of inspection: Manager	
Brief description of the accommodation/how the service operates: 5 Lilburn Hall is a supported living type domiciliary care agency which provides care and support to six service users living with a learning disability. The service users live in two houses in close proximity to each other on the outskirts of Lurgan. SHSCT provide the staff that deliver the care and support to service users. The service users have individual rooms, a range of shared facilities and are supported to be involved in decisions associated with their care and support.	

2.0 Inspection summary

An unannounced inspection was undertaken on 21 October 2024 between 10 a.m. and 4 p.m. by two care inspectors and on 20 November 2024 from 10.45 a.m. to 3.15 p.m. by a finance 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.

Good practice was identified in relation to staff training and service user involvement.

Five areas for improvement were identified; these related to adult safeguarding procedures, management of medication, monthly monitoring reports, updating service users' written agreements and recording of the manager's presence within the agency.

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 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. We are committed to ensuring that the rights of people who receive services are protected. This means we will be seeking assurances from providers that they take all reasonable steps to promote people's rights. Users of domiciliary care agencies have the right to expect their dignity and privacy to be respected and to have their independence and autonomy promoted.

Having reviewed 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.

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 survey.

4.0 What did people tell us about the service?

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

The information provided indicated that they had no concerns in relation to the agency.

Service users' comments:

- "Staff help me with my money."
- "It's easy to get in touch with the manager."
- "I do my own cooking. I can go up the road for a walk and see places I like."

Staff comments:

- "I'm loving working here. My training has all been organised. All the staff are supportive. No question is considered stupid. I know how to raise a concern."
- "I'm happy working here. I've just picked up an extra shift."
- "I enjoy this work and taking the service users out and about – every day is different and we get to go to different places which is good for the service users."
- "I have been working here a long time – its good work and I enjoy the service users."

During the inspection we provided a number of easy read questionnaires for those supported to comment on the following areas of service quality and their lived experiences:

- Do you feel your care is safe?
- Is the care and support you get effective?
- Do you feel staff treat you with compassion?
- How do you feel your care is managed?

Returned questionnaires show that those supported thought care and support was either excellent or good. No written comments were received.

A number of staff responded to the electronic survey. The respondents indicated that they were 'very satisfied' that care provided was safe, effective and compassionate and that the service was well led.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last care inspection of the agency was undertaken on 14 July 2023 by a care inspector. No areas for improvement were identified.

5.2 Inspection findings

5.2.1 Are there 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).

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.

On the day of the inspection the manager reported a number of ongoing safeguarding investigations. As there was no centralised record of referrals and investigations, the manager was unable to effectively track progress of these matters within the agency. This also meant that they had no mechanism to critically analyse and review any potential trends around adult safeguarding matters. This has been identified as an area for improvement.

The manager advised that no concerns had been raised under the whistleblowing policy since the last inspection.

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

Staff were provided with training appropriate to the requirements of their role. Review of a sample of staff training records concluded staff had received mandatory and other training relevant to their roles and responsibilities since the previous care inspection; this included first aid, information governance and dysphagia.

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

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. A review of medication records identified that errors which had occurred since the previous inspection had not been managed in line with the agency's Medication Policy. This has been identified as an area for improvement.

Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The manager reported that none of the service users were subject to DoLS. A resource folder was available for staff to reference.

5.2.2 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. Service users were provided with easy read reports which supported them to fully participate in all aspects of their 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 services users and /or their relatives participate, where appropriate, in the review of the care provided on an annual basis, or when changes occur.

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. There was evidence that staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate.

It was also positive to note that the agency had service user meetings on a regular basis which enabled the service users to discuss what they wanted from attending the day centre and any activities they would like to become involved in. Some matters discussed included trips and outings, and house painting.

5.2.3 Is there a system 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.

Staff demonstrated a good knowledge of service users' wishes, preferences and assessed needs. These were recorded within care plans along with associated SALT dietary requirements. 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) or the Nursing and Midwifery Council (NMC) 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.

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 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.

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.

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

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

There were monthly monitoring arrangements in place in compliance with Regulation 23 of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007. A review of the reports of the agency's monthly quality monitoring established that there was engagement with service users and staff. The reports included details of a review of service user care records; staff recruitment and training, and staffing arrangements.

These reports did not contain a review of the open safeguarding investigations within the agency. Two of the reports identified problems accessing information regarding medication audits but this was not carried over into the reports' Action Plans. Overall engagement with service users' relatives and HSC Trust representatives was limited. RQIA is therefore not fully assured that robust quality monitoring arrangements are in place so as to identify deficits and drive necessary improvements in an effective and sustained manner. This has been identified as an area for improvement.

The Annual Quality Report was reviewed and was satisfactory.

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.

The manager is also the manager of several other supported living services. Review of staffing roster identified that their presence within the agency was not always recorded on the staffing roster. An area for improvement stated in this regard.

The manager had submitted an application to RQIA for registration as manager; this will be reviewed in due course.

5.2.7 Finance inspection

A safe place was provided within the agency for the retention of service users' monies and valuables. There were satisfactory controls around the physical location of the safe place and the members of staff with access to it. A review of a sample of records of service users' monies held at the agency showed that the records were up to date on 20 November 2024.

Agreed weekly budget plans for service users were retained at the agency. The plans included details of the charges for support provided by the agency's staff and utility charges, such as oil and electric. Other communal costs were also included in the plans.

A review of records confirmed that service users paid a weekly contribution into a bank account for the “house budget” in line with their weekly budget plan. Discussion with staff confirmed that the house budget was not used to purchase food. Service users paid for their own food separately.

Records confirmed that reconciliations (checks) between the monies held on behalf of service users and the records of monies held were undertaken daily. Reconciliations of the bank account holding the monies for the house budget were undertaken on a monthly basis. The records of the reconciliations were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.

There was evidence of additional controls in place, as a senior member of staff carried out spot checks on service users’ financial records on a monthly basis.

Discussion with staff confirmed that a patient’s property account (PPP account) was managed by the Southern Health and Social Care Trust (SHSCT) on behalf of a service user. The service user also had a bank account, in their own name, for which the agency provided support, such as helping the service user to make withdrawals.

A review of a sample of records of bank withdrawals undertaken on behalf of the service user showed that receipts were retained from the withdrawals. The amounts on the receipts reflected the amounts recorded as lodged at the agency.

There was no evidence within either the service user’s financial support plan or written agreement of the arrangements for staff involved in providing support to the service user regarding their bank account. An area for improvement was identified.

Discussion with the manager and a review of records, confirmed that members of staff returned service users’ bank cards on the same day that they were withdrawn from the agency. There was no evidence of a policy in place regarding this procedure.

The manager provided assurances that they will liaise with the SHSCT following the inspection, to ensure that the policies are updated, where necessary, in order to reflect all operational areas relating to service users’ finances. The policies will be reviewed at the next RQIA inspection.

A review of training material issued by the SHSCT showed that although guidance was provided to staff regarding the bank cards for the house budget, there was no evidence of guidance being provided for staff supporting service users with their own bank accounts. The manager provided further assurances that the discussions with the SHSCT will include the updating of the training material. This will be reviewed at the next RQIA finance inspection.

A review of records and discussion with staff confirmed that individual transaction sheets were maintained for each service user. The sheets were used to record the details of transactions undertaken on behalf of service users, such as the purchase of items and the recording of monies deposited at the agency on behalf of service users.

A review of a sample of records of purchases undertaken on behalf of two service users showed that the records were up to date. Two signatures were recorded against each entry in the service users’ records and receipts from the purchases were retained for inspection.

Good practice was observed, in relation to aiding the audit process, as a number was recorded on the receipts with the corresponding number recorded against the purchases in the service users' transaction sheets.

It was noticed that a few entries in the service users' transaction sheets had been written over obscuring the original amount recorded for the purchase and the original balance recorded following the purchase. The manager provided assurances, on 20 November 2024, that the policy for recording transactions, which includes the procedure for dealing with errors, will be strengthened with staff. This procedure will be reviewed at the next RQIA finance inspection.

Discussion with staff confirmed that a vehicle, owned by the SHSCT, was available for service users to undertake journeys. The miles undertaken for the journeys were recorded and subsequently invoiced to the service users at an agreed rate per mile. The total cost of the journey was divided evenly among the service users undertaking the journey. A sample of transport invoices raised for two service users was reviewed; the miles invoiced to the service users reflected the information recorded within the agency's records.

6.0 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	4	1

Areas for improvement and details of the QIP were discussed with Mrs. Sarah McCartney, 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 Agency Regulations (Northern Ireland) 2007

Area for improvement 1 **Ref:** Regulation 15(6)(a) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall specify the procedure to be followed after an allegation of abuse, neglect or other harm has been made. This is specific to Safeguarding records. Ref: 5.2.1
	Response by registered person detailing the actions taken: This recommendation is in relation to how the service records and tracks Adult Safeguarding Referrals which have been made in relation to tenants living in the service. An adult safeguarding database and tracker has been introduced within the service. This will support the service to record and track progress on all adult safeguarding referrals made. This database will enable management to have better oversight of all adult safeguarding referrals / investigations and this will support in identifying any trends, patterns and learning from referrlas / investigations. The Registered Manger is responsible for reviewing the database monthly, identifying trends and patterns and sharing any learning with others as appropriate. The Registered Manager will review with the Supported Living Coordinator monthly and with the Head of Service quarterly to ensure it is being maintained, reviewed and actions taken as necessary. The process for record keeping in relation to safeguarding reports and minutes has been reviewed to ensure clarity across the service as to what records are to be kept and where they can be accessed.
Area for improvement 2 **Ref:** Regulation 14(a) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall make suitable arrangements to ensure that the agency is conducted, and the prescribed services arranged by the agency, are provided so as to ensure the safety and well-being of service users. This is specific to the management of medication errors. Ref: 5.2.1

	Response by registered person detailing the actions taken: Following the inspection, support has been provided to the service by the Learning Disability Professional Lead Nurse and Nurse Development Lead. They have provided intensive support within the service to ensure all staff are aware of their responsibilities in relation to medication processes, error management and reporting. This support included training in relation to the medication policy; reflection and learning from recent medication errors; reporting and recording and reinforcing the importance of documenting any actions taken. Going forward medication action plans are to be completed for all staff involved in medication errors and these will be maintained in staff personnel files. The Registered Manager and Assistant Managers will review all medication incidents within the service monthly to identify any trends, patterns and learning and agree any actions necessary to reduce incident / prevent reoccurances. In addition the Head of Service for Supported Living will be reviewing all medication incidents on a monthly basis with all supported living Registered Managers. This will facilitate learning across services. The Trust medication policy is currently being updated to provide clearer guidance for all staff in relation to medicines management. Once finalised work will be undertaken across services to ensure staff are trainined to ensure they are familiar with and knowledgelable of the revised policy.
Area for improvement 3 **Ref:** Regulation 23(2)(a)(b)(4) **Stated:** First time	The registered person shall ensure the monthly monitoring reports review all open safeguarding investigations and audit activity within the agency. They should also reflect the views of service user representatives. Ref: 5.2.6
To be completed by: Immediate and ongoing from date of inspection	**Response by registered person detailing the actions taken**: The monthly monitoring reporting template has been updated to give greater focus on adult safeguarding. The new safeguarding database and tracker (outlined in area for improvement 1 above) is in place and will be viewed by the Monitoring Officers during each monitoring visit. The Registered Manager will continue to monitor audit activity within the service and put relevant action plans in place where

	concerns are noted following audit. The Monitoring Officers will add the audit action plans to the monthly monitoring report and review these as part of their monitoring to ensure they are being actioned. Monthly monitoring reports will be reviewed by the Registered Manager, Co-ordinator and Head of Service to ensure all actions identified are followed up. An escalation process is in place so Monitoring Offciers can escalate where actions are not being following up within service. It can be difficult for Monitoring Officers to obtain service user representative views as part of their monthly visit however, this is sought as part of the monitoring visit. Where feedback is not obtained Monitoring Officers will record their efforts to obtain feedback in the report. Annual feedback is gained via the carer survey. Feedback also continues to sought on a monthly basis by Monitoiring Officers from community keyworkers and other relevant professionals. Going forward the Monitoring Officer will detail on the report who they have contacted for feedback, dates of contact and whether feedback was received or not.

Area for improvement 4 **Ref:** Regulation 16(1)(d) **Stated:** First time **To be completed by:** Immediate and ongoing from date of 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. This relates to the manager's presence within the agency being recorded on the staff roster. Ref: 5.2.6
	Response by registered person detailing the actions taken: The Registered Manager has been added to each service rota and will record the days and times they are in each facility. The electronic rota system will also be updated by the Registered Manager with a note to reflect the location of where the manager is based each day. The Supported Living Co-ordinator will audit this on a regular basis when completing scheme visits and during manager supervision sessions. The Head of Service will also audit this as a minimum quarterly. The Registered Managers mobile phone contact number is on display in each office should they need to be contacted and are not on site. An Assistant Manager is also in place at each facility with an on-call Assistant Manager rota across a 7-day period for staff support and consultation as necessary. A MHD senior manager on-call rota is in place outside of normal office hours. Details of the on-call manager is circulated across all facilities weekly and is available on Rota Watch via Share Point.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 4.2 **Stated:** First time **To be completed by:** 15 January 2025	The registered person shall ensure that service users' written agreements are updated to include the agreed arrangements for any financial transactions undertaken on behalf of service users by the agency's staff. This includes the arrangements for the support provided to service users regarding their own bank accounts. Ref: 5.2.7

	Response by registered person detailing the actions taken: Specific support needs for each tenant in relation to their finances is detailed in their Support Plan and Financial Support Agreement. The Financial Policy for Supported Living has been updated (December 2024) and training is being developed to ensure all staff are familiar with and knowledgable in the new policy.

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

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