The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Supported Living Services**

Provider: **SHSCT**

Date of Inspection: **2 December 2024**

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 & Social Care Trust
Responsible Individual	Colm McCafferty, Acting Chief Executive
Registered Manager:	Mrs Sarah McCartney, acting since 1 July 2023
Service Profile Supported Living Services, known locally as Bowens Close, is a domiciliary care agency supported living type, providing care and support to eight individuals who live in the Lurgan area. The agency's registered office is located in one of the homes of the service users. Service users have a range of needs including mental health issues, learning disabilities and autism.	

2.0 Inspection summary

An unannounced inspection was undertaken on 02 December 2024 between 10.00 a.m. and 4.30 p.m. 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 examined.

Five areas for improvement were identified. These related to adult safeguarding records, protection planning and implementation, staff training, records of restrictive practice, and staffing arrangements.

Good practice was identified in respect to service user involvement.

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, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about the service. This included any previous areas 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 easy read questionnaires and an electronic survey.

3.2 What people told us about the service and their quality of life

Throughout the inspection process inspectors will seek the views of those living, working and visiting the home and review a sample of records to evidence how the home is performing in relation to the regulations and standards.

We spoke to a service user and a relative to seek their views of living within and visiting the agency. The information provided indicated that the staff were very attentive to some service user's needs but one service user did not feel that staff knew how to respond to their particular interests. This was shared with the person in charge after the inspection.

Service Users' comments:

- "I would like to live on my own and I hope to find somewhere soon. The staff are alright here but they don't understand my interests. I don't want to live with other people I don't get along with."

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 showed mixed responses, for example, one service user indicated they felt unsure if their care was safe and if the support received was effective and well managed. Another service user felt unsure if they received the right support. This feedback was shared with the person in charge after the inspection and it was agreed that all service users would be spoken to individually to ascertain how they felt about the care they received to

identify any aspects of their care which could be improved. Written comments regarding the care received included:

- "ok."
- "They always look after me."

Relative's comments:

● "I think the service is very good. My relative is very well cared for and always has been. There is a mix of staff and I can go to any of them with any concerns – I have no complaints at all. Over the years I can only speak highly of them."

No staff responded to the electronic survey.

3.3 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 12 June 2023 by a care inspector. No areas for improvement were identified.

3.4 Inspection findings

3.4.1 Adult Safeguarding

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 person in charge 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. The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. A review of adult safeguarding records, however, identified that these records were retained along with other records. This made it difficult to identify potential trends and to effectively track progress of concerns raised. There was discussion with the person in charge about the need to develop a separate system for tracking the progress of all adult safeguarding referrals. This has been identified as an area for improvement.

A review of adult protection processes identified that protection plans had not always been completed in a timely manner for service users who might be at risk of harm or in need of protection. At the time of inspection, assurances were given that this would be rectified immediately. Evidence was provided by the agency to confirm that safeguarding referrals had been reviewed and, where appropriate, protection plans devised and implemented to ensure the safety and well-being of all service users. This has been identified as an area for improvement.

Staff were required to complete adult safeguarding training during induction and every two years thereafter. A review of training records identified that four staff members did not have updated adult safeguarding training. This has been included in an area for improvement described in section 3.4.3 below.

3.4.2 Incident Reporting

RQIA had been notified appropriately of any incidents that had been reported to the Police Service of Northern Ireland (PSNI) in keeping with the regulations. Incidents had been managed appropriately.

3.4.3 Staff Induction and Training

There was evidence that all newly appointed staff were provided with training appropriate to the requirements of their role. A review of training records of newly appointed staff concluded staff had received mandatory and other training relevant to their roles and responsibilities to ensure they were competent to carry out the duties of their job in line with the agency's policies and procedures. This included shadowing of a more experienced staff member. There were no volunteers deployed within the agency.

The service had maintained a record for each member of staff of all training, including induction and professional development activities undertaken; this included staff that were supplied by recruitment agencies.

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.

A review of training records identified that training had lapsed for several staff in respect of DoLS, dysphagia, adult safeguarding, medication management and personal safety/ intervention training. During inspection there was reference to how the service had achieved and relied on having high training compliance rates. Following on from this, there was discussion with the person in charge about the need to monitor the training records regularly to ensure that all staff with outstanding training needs were identified in a timely manner and suitable training provided. This has been identified as an area for improvement.

The person in charge advised that no service users required their medicine to be administered with an oral syringe. The person in charge was aware that should this be required, a competency assessment would be completed before staff undertook this task.

3.4.4 Mental Capacity and Restrictive Practice

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.

Whilst staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles, several staff required refresher training. Advice was given in relation to updating the training records to highlight the frequency of DoLs training and the need to develop a resource folder containing DoLS information which would be available for staff to reference.

Discussion with the person in charge established that the DoLS status of one service user required to be clarified with the community Social Work team. This has since been addressed by the agency and no service users are currently subject to DoLS within the agency.

A review of service user records identified that where service users were subject to restrictions, these were not clearly documented and therefore could not be kept under regular review. This has been identified as an area for improvement.

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

3.4.5 Care Records and Service User Input

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. 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.

It was also 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. Some matters discussed included: choosing the menu, tidying the house and agreeing chores, buying groceries and planning activities of service users' choice. There was discussion about the need to revisit some of the agreed actions to ensure these are appropriately carried out.

A number of service users were assessed by the Speech and Language Therapist (SALT) with recommendations provided and some required their food and fluids to be of a specific consistency. Staff implemented the specific recommendations of the SALT to ensure the care received was safe and effective.

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.

Care records identified that moving and handling risk assessments and care plans were up to date.

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.

3.4.6 Governance and Managerial Oversight

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 had identified occasions when there had been low staffing levels and the need to obtain additional support from senior care staff. On the day of the inspection, due to unforeseen circumstances, the service was short staffed, however a senior staff member agreed to provide cover at short notice.

On reviewing the staff rota and through discussion with the person in charge, it was also noted that the registered manager was not included in the rota for the service. An area for improvement is stated in regard to staffing arrangements and the staff rota.

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

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 and compliments were documented, however no complaints had been received. Advice was given to the person in charge in respect of ensuring service users are aware of how to make a complaint and of the need to collate information about any complaints and compliments received on a monthly basis. This will be reviewed at a future inspection.

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	5	0

Areas for improvement were discussed with Mrs. Marian McGuigan, Assistant Manager, Abbey Gourley, Head of Service, and Craig Cromie, Governance Lead, 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 ensure safeguarding records are retained separately for the purposes of tracking progress and identifying patterns and trends. Ref: 3.4.1
	Response by registered person detailing the actions taken: The service has developed and implemented a safeguarding database and tracker that will enable effective tracking of all safeguarding referrals. This database will enable the Registered Manager to identify and review any adult safeguarding patterns and trends. The Registered Manger is responsible for reviewing this database monthly. In addition the Registered Manager will review the database with the Supported Living Co-ordinator monthly, and with the Supported Living Head of Service quarterly, to ensure that it is being fully maintained and actions taken as required. The process for record keeping in relation to safeguarding reports and minutes has been reviewed to ensure clarity on what records are to be kept and where they can be accessed.
Area for improvement 2 **Ref:** Regulation 14(a) & (b) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that the agency and the prescribed services arranged are provided to as to ensure the safety and well-being of service users and to safeguard service users against abuse or neglect. This is specific to protection plans being devised and implemented in a timely manner. Ref: 3.4.1.
	Response by registered person detailing the actions taken: All current protection plans have been transcribed and are reflected in tenant support plans. The requirement for this has been discussed with all Senior Support Workers to ensure compliance going forward. Regular audits of support plans are in place within the service. Audits will include a cross checking with the safeguarding database to ensure protection plans are detailed in the support plans as required. The Registered Manager will spot check

	completed audits to ensure compliance and address any issues.
Area for improvement 3 **Ref:** Regulation 16 (2) (a) **Stated:** First time **To be completed by:** Immediate and ongoing from date of inspection	The registered person shall ensure each employee of the agency receives training and appraisal which are appropriate to the work he is to perform. This relates to the need to ensure staff training is kept up to date and under regular review. Ref: 3.4.3
	Response by registered person detailing the actions taken: A new training matrix is in place which is formulated with the training frequency requirments. The matrix clearly identifies individual staff training which is due to expire or has expired (RAG rated). This enables the management team to identify any training due early to ensure completion / complaince. Training frequency dates will be reviewed anually by the Registered Manager in conjunction with the Head of Service to ensure accuracy. All staff have completed mandatory Adult Safeguarding Level 2 E-learning training. Where Adult Safeguarding Enhanced level 2 face to face training has expired or is due to expire staff are booked to complete. The Registered Manager going forward will review the training matrix monthly to identify any actions required to ensure complaince to corporate mandatory and role specific training.
Area for Improvement 4 **Ref:** Regulation 15 (4)	The Registered Person shall ensure that any restrictive practices used by the agency in the delivery of care and support to services users are clearly documented within the care plan and kept under regular review. Ref 3.4.4
	Response by registered person detailing the actions taken: All tenants with restictive interventions in place agreed by the multi-disciplinary team (MDT) as part of their management plan have had their support plans reviewed to ensure any restrictive interventions are clearly documented.

	The Registered Manager will ensure restrictive interventions are reviewed at least anually by the MDT to ensure they remain necessary and proportionate. Restrictive practice will be added to the staff meeting agenda to provide management and staff with the opportunity to disucss the issue of restrictive intervention and to ensure it is only used where prescribed, as a last resort and its use is proportoniate.
Area for improvement 5 **Ref:** Regulation 16 (1) (a) **Stated:** First time **To be completed by:** Immediate and ongoing from date of inspection	The registered person shall ensure that there is at all times suitably skilled and experienced persons employed for the purposes of the agency This relates to the need to ensure appropriate staffing levels across the service, and the inclusion of the manager's presence within the agency on the staff rota. Ref: 3.4.6
	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. Staffing levels within the services are based on the needs of the tenants. In the event of staffing shortages there is an agreed process in place to ensure safe staffing levels e.g. use of bank staff, seek support from other supported living services. Staff shortages are not a frequent occurrence in this service. The rota has been reviewed to ensure that the staff on duty have the necessary skills and experience to meet the needs of the tenants. There is a senior management on-call rota outside of normal office hours which staff have access to and can seek support from as necessary.

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