The Regulation and Quality Improvement Authority

# Inspection Report

## 15 September 2022

# Larne Supported Living Service

Type of service: Domiciliary Care Agency
Address: 43 Gardenmore Place, Larne, BT40 1SE
Telephone number: 02828279746

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:**<br>Praxis Care Group<br><br>**Responsible Individual:**<br>Mrs Alyson Dunn | **Registered Manager:**<br>Mrs Norah Christie<br><br>**Date registered:**<br>20 July 2020 |
|---|---|
| **Person in charge at the time of inspection:**<br>Mrs Lorrie Rees, Team Leader from 10:00 a.m. – noon<br>Miss Natasha Shaw, Team Leader noon – 3.30 p.m. | |
| **Brief description of the accommodation/how the service operates:**<br><br>Larne supported living service is a registered domiciliary care agency, supported living type. The agency provides care and support to service users who have a range of enduring mental health needs. The service users reside in a combination of shared accommodation, self-contained flats and houses situated in the Larne and Carrickfergus areas. | |

## 2.0 Inspection summary

An unannounced inspection took place on 15 September 2022 between 10.00 a.m. and 3.30 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, Dysphagia management and Covid-19 guidance was also reviewed.

Areas for improvement identified related to notifications of incidents to RQIA involving the PSNI and to ensure that in the absence of the manager, complaints records are made available for inspection purposes.

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

For the purposes of the inspection report, the term 'service user' is used to describe the people to whom the agency provide care and support. This is in keeping with the relevant regulations.

## 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 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'.

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 some 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. There were no relatives visiting the service during the inspection.

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

Comments received included:

**Service users' comments:**

- "I'm very happy living here because I feel safe. It's reassuring to know that staff are there to support me whenever I need it and they are contactable by the buzzer."

- "I need staff to support me to manage my medication."

- "I'm happy with the level of support from staff, though at the beginning I felt staff called me too often. Sometimes it can be noisy here. It can be noisy re. doors closing… I feel safe here and staff are approachable and kind."

Returned questionnaires indicated that the respondent/s were very satisfied with the care and support provided. There were no written comments included in the questionnaire.

**Staff comments:**

- "I really enjoy my work here, the staff team are excellent and we support each other. Our manager is approachable and open, there's good communication between the staff team."

- "I love my job here and have built up good working relationships with the service users and all of the staff team. If I was concerned about anything, I'd talk to one of the team leaders or the manager. The training opportunities are good."

- "It's a great place to work, I enjoy it a lot, every day is different. We all work very well together and support each other. Our manager's door is always open and we can talk easily with her if we've any concerns or suggestions."

All of the staff stated they felt the care provided was safe, effective and compassionate and that the service was well led.

None of the staff or visiting professionals responded to the electronic survey.

## 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 18 May 2021 by a care inspector. A Quality Improvement Plan (QIP) was issued. This was approved by the care inspector and was validated during this inspection.

| Areas for improvement from the last inspection on 18 May 2021 | | |
|---|---|---|
| **Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007** | | **Validation of compliance** |
| **Area for Improvement 1**<br><br>**Ref:** Regulation 14(e)<br><br>**Stated:** First time | The registered person shall make suitable arrangements that the agency is conducted, and the prescribed services arranged by the agency, are provided-<br>(e) in a manner which respected the privacy, dignity and wishes of service users, and the confidentiality of information relating to them.<br><br>This relates specifically to the storage and administration of medication. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The inspector reviewed records and documentation pertaining to the storage and administration of medication. This provided evidence of compliance with this specific regulation. | |
| **Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021** | | **Validation of compliance** |
| **Area for Improvement 1**<br><br>**Ref:** Standard 3.3<br><br>**Stated:** First time | The registered person shall ensure that individual service users care plans include information of the care and services to be provided and the management of identified risks. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The inspector randomly sampled and reviewed four service users care plans during this inspection. These provided evidence that care plans detailed the care and services provided to each individual service user. | |

## 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). The agency's annual Adult Safeguarding Position report was reviewed and found to be satisfactory

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.

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.

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.

RQIA had not been notified appropriately of several incidents that had been reported to the Police Service of Northern Ireland (PSNI), this is not in keeping with the identified regulations. This is an identified area for improvement. However, review of these incidents evidenced they had been managed appropriately by the agency and referred to the relevant organisation/s. These notifications were retrospectively received by RQIA after this inspection.

Staff were provided with training appropriate to the requirements of their role. Where service users required the use of specialised equipment to assist them with moving, this was included within the agency's mandatory training programme.

The person in charge 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. A review of care records identified that moving and handling risk assessments and care plans were up to date. Moving and Handling policy: A review of the policy pertaining to moving and handling training and incident reporting identified that there was a clear procedure for staff to follow in the event of deterioration in a service user's ability to weight bear.

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. The person in charge advised that no service users required their medicine to be administered with a syringe. The person in charge was aware that should this be required, a competency assessment would be undertaken before staff undertook this task. The person in charge agreed to liaise with the manager to ascertain if the agency's current medicines policy and procedure included staff guidance if service users required their medicine to be administered with a syringe.

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 who spoke with the inspector demonstrated their understanding that service users who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the Mental Capacity Act (MCA).

Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The person in charge reported that none of the service users were subject to DoLS. A resource folder was available for staff to reference. There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had had their capacity considered and, where appropriate, assessed. Where a service user was experiencing a deprivation of liberty, the care records contained details of assessments completed and agreed outcomes developed in conjunction with the HSC Trust representative.

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. Where appropriate 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:

- Outings
- Activities
- Summer trips / holidays

### 5.2.3 What are the systems in place for identifying service users' Dysphagia needs in partnership with the Speech and Language Therapist (SALT)?

New standards for thickening food and fluids were introduced in August 2018. This was called the International Dysphagia Diet Standardisation Initiative (IDDSI). Whilst none of the service users had swallowing difficulties, the person in charge was aware that training in Dysphagia could be accessed, if required in the future.

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. The person in charge is aware of the relevance of making timely and appropriate referrals to the multi-disciplinary team. Any specific recommendations made by the SALT would then be incorporated into the service user's care plan to ensure the care received in the setting was safe and effective.

Staff demonstrated a good knowledge of service users' wishes, preferences and assessed needs. These were recorded within care plans.

### 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.

A review of the records relating to staff that were provided from recruitment agencies also identified that they had been recruited, inducted and trained in line with the regulations.

The agency has 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.

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 person in charge said staff are aware of their post registration training requirements and are compliant with these.

### 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 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.

The Annual Quality Report was reviewed and was satisfactory.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAIs) or Significant Event Audits (SEAs) procedures.

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

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Complaints are reviewed as part of the agency's quality monitoring process. The person in charge said she was unable to access the online complaints records and written records were not made available during this inspection. This is an identified area for improvement. After the inspection, the person in charge liaised with agency's Head Office and subsequently forwarded information to RQIA regarding complaints. The information was reviewed and no concerns were raised.

There is a system in place that services should have 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. In addition to written direction, it is essential that all staff (including management) are fully trained and competent in this area.

## 6.0 Conclusion

Based on the inspection findings, two areas for improvement were identified. Despite this, RQIA was satisfied that this agency was providing services in a safe, effective, caring and compassionate manner and the service was well led by the manager / management team.

## 7.0 Quality Improvement Plan (QIP)/Areas for Improvement

Two areas for improvement has/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 |
|---|---|---|
| **Total number of Areas for Improvement** | 1 | 1 |

Areas for improvement and details of the QIP were discussed with Miss Natasha Shaw, person in charge 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**<br><br>**Ref:** Regulation 15(12)(b)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>From 16 September 2022 and ongoing | The registered person shall notify RQIA of all incidents involving PSNI.<br><br>Ref: 5.2.1 |
| | **Response by registered person detailing the actions taken:**<br>This action will be taken by the manager (or buddy manager in the event of the manager's absence) at any incident where the police have been involved. |
| **Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021** | |
| **Area for improvement 1**<br><br>**Ref:** Standard15.15<br><br>**Stated:** First time<br><br>**To be completed by:**<br>From 16 September and ongoing | The registered person shall ensure all complaints records should be made available for inspection purposes.<br><br>Ref: 5.2.6 |
| | **Response by registered person detailing the actions taken:**<br>All complaints will be held in hard copy form in the service for the access of any inspectors. File number 49 is set up in the manager's office at present and at time of inspection we had no active complaints to store here from our last RQIA visit in May 2021. |

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

The Regulation and Quality Improvement Authority

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