The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: North Down & Ards Supported Living Service

Provider: South Eastern HSC Trust

Date of Inspection: 2 October 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 HSC Trust
Responsible Individual/Responsible Person:	Ms Roisin Coulter
Registered Manager:	Mrs Sarah Lee Miley (*Acting*)
Service Profile: This is a supported living type domiciliary care agency that provides care and support to adults with learning disabilities who live at a number of properties located in the North Down and Ards area. Staff support service users to live as independently as possible and encourage them to be part of the community they live in.	

2.0 Inspection summary

An unannounced inspection was undertaken 2 October 2025, between 10.10 a.m. and 6.10 p.m. by a care Inspector.

RQIA received information on 10 September 2025, which raised concerns in relation to North Down & Ards Supported Living Service acting outside the parameters of the agency's statement of purpose. In response to this information, RQIA decided to undertake an unannounced inspection which focused on the concerns raised.

In addition, the inspection sought 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 10 July 2024; and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

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 quality monitoring reports, the agency's annual quality report and service user plans.

It was evident that staff promoted the dignity and well-being of service users and that staff were knowledgeable and well trained to deliver safe and effective care.

Service users said that the care and support provided by North Down & Ards Supported Living Service was a good experience. Service users who were unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As a result of this inspection, the four areas for improvement previously identified were assessed as having been addressed by the provider. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

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 North Down & Ards Supported Living Service. This included the previous Quality Improvement Plan 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 seek the views of those being supported by, working in, and visiting the agency; and examine a sample of records to evidence how the agency is performing in relation to the regulations and standards.

3.2 What people told us about the service

Service users provided a warm welcome upon arriving at the agency. They advised upon names of staff on duty and when asked stated that the staff were "good". Communal areas were decorated to a high standard and felt homely. Some service users showed off their own bedrooms, proudly highlighting items important to them such as photographs, posters, themed bedding, musical instruments or recently purchased décor. The spaces reflected each individuals own personality, preferences and interests. It was also positive to note, individual needs of service users had been considered with respects to use of the environment, with a space within one home containing sensory equipment. Service users told us that they were happy with their accommodation.

Observation of interactions between service users and staff were positive. It was great to see service users feel empowered to direct their own care, indicating to staff the support they wanted on the day. Service users spoke positively about staff, said that they were "good" and did not have any concerns regarding the support they received. For those service users with limited verbal communication, their affection for staff was evident through body language observed.

All staff consulted advised how much they liked their job. Staff told us that the Manager was an excellent leader, who was organised and service user focused. They advised that they felt supported by the Manager both within a professional and personal capacity with staff advising her empathy has led to them feeling valued. Staff spoke positively about the admission procedures, with additional training required identified and provided in advance of service users transitioning to the service. They confirmed that they received regular supervision and felt able to request additional support when and as required.

Staff spoke knowledgably about the needs of the people they support. They explained how they would respond to incidents and/or accidents that may arise and understood their responsibilities associated with safeguarding. Staff spoke positively about service users and appeared to take pleasure in seeing the people they support achieve personal goals, from smaller objectives such as purchasing new homeware items to going on holidays. One staff member told us that North Down & Ards Supported Living Service "is a wonderful friendly homely service to work in and seeing the service users happy on a daily basis warms my heart."

3.3 Inspection findings

3.3.1 Staffing Arrangements

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.

Recruitment was ongoing in an effort to appoint to current vacancies. North Down & Ards Supported Living Service were found to be utilising recruitment agency staff in order to maintain safe staffing levels. Documents reviewed evidence that all appropriate checks had been conducted for each agency staff member and assurances were obtained that relevant mandatory training had been completed.

In discussion with the Manager, they advised where possible they block booked agency staff in an effort to ensure continuity of care for the people they support. There was evidence of robust systems in place to manage staffing with the agency's rota found to be prepared in advance. It was also positive to note that where possible, for those service users requiring higher levels of staffing North Down & Ards Supported Living Service contracted staff were scheduled alongside agency staff.

Following discussion, review of the agency's rota and other documentation we were assured that staffing arrangements in place were appropriately aligned with the remit of North Down & Ards Supported Living Service's statement of purpose and was in keeping with the registration of the agency.

Staff said there was good teamwork and that they felt well supported in their role by both their colleagues and the Manager. Staff were observed assisting service users in a caring and compassionate manner, for example, when one service user complained about experiencing physical pain and discomfort staff patiently took time to aid the service user in communicating this and enquired if they wanted to avail of PRN pain relief.

On review of recruitment records it was identified that one staff member currently employed within the agency had done so without an enhanced AccessNI check having been completed. There was discussion with the Manager following the inspection about the need for the provider organisation to be fully assured they have a robust system for criminal checks to be completed for staff. RQIA is aware of ongoing discussion between the Department of Health and HSC Trusts in respect of this, and will keep this matter under review.

Newly appointed staff, including those supplied by recruitment agencies, had completed a structured orientation and induction, to ensure they were competent to carry out the duties of their job. The agency had also devised service specific aids to support all new staff in becoming familiar with processes and procedures, which was highlighted as an area of good practice during feedback.

Records of all staff training were retained and the manager maintained oversight of the training matrix to ensure compliance. This training included Deprivation of Liberties Safeguards (DoLS), adult safeguarding, and dysphagia, at a level appropriate to their job roles. It was however identified that some staff training had lapsed, such as fire safety. Following the inspection, it was confirmed to RQIA that plans were in place to assess these training needs. This will be examined again during a future inspection.

Staff consulted confirmed they were provided with opportunities to complete training commensurate with their role and are actively encouraged by the manager to develop new skills and knowledge. They stated they were satisfied with training provided.

Competency assessments were undertaken on all staff to ensure that they were competent in their roles and responsibilities.

Policy and procedure relating to administration of medications had been updated to include the requirement for training in specific administration techniques. Medicines Competency assessments utilised by the agency were also found to have been amended to include administration of liquid medications orally via syringe. As such, both previous areas for improvements were satisfactorily met.

Review of records identified that supervisions had been undertaken with staff, in addition to one to one supervision sessions group supervisions were also regularly facilitated to aid effective communication amongst the team and promote shared learning. Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place.

3.3.2 Care Delivery

With North Down & Ards Supported Living Service being dispersed in nature makes the importance of effective communication all the more significant. It was positive to note that the agency had very robust handovers in place to ensure the timely sharing of information relevant to the care and support of service users.

Activities were personalised and bespoke including such things as bowling, pamper nights, baking and cooking. Observations illustrated that service users directed the support they wanted in respects to activities and that their preferences were validated by staff who showed flexibility in their approach.

As well as outings within the local community to cafes, restaurants, discos etc. staff had also supported service users in organising holidays to locations of their choice.

It was positive to observe that staff understood the localities that they work to be the homes of the people that they support. They were found to be respectful of service users' homes, aiding them to complete domestic tasks and maintain their living environment to a high standard. Service users' right to privacy was acknowledged by staff, evident by staff seeking consent and permission to enter service users bedrooms.

Management of food stock was assisted by staff who undertook daily food checks to ensure that the food was always in date and that the fridge was maintaining the optimum temperature to keep the food safe for eating. In properties where more than one individual lived, it was positive to note that separate food storage arrangements were in place. Such arrangements ensured independence was promoted.

3.3.3 Management of Care Records

Service users' needs were assessed when they were first referred to the agency and before care delivery commenced. As advised by staff this had permitted advance planning for provision of additional training when needed. Following this initial assessment, care plans were developed to direct staff on how to meet service users' needs.

Service users care records were held confidentially in line with data protection regulations.

Consent forms were in place, with different formats available dependent on the needs of individuals. Templates reviewed evidenced consultation had occurred with service users regarding photography, sharing of information, transportation and elements of support such as finances and personal care.

An area for improvement identified as part of the previous inspection relating to guidance for staff if unable to gain access to a service user's home had been addressed. A step-by-step procedure had been developed, shared with staff and is being kept under review.

Whilst care plans were in place to direct staff on how to meet service users' needs, it was found that these did not always contain sufficient information. Care to be delivered to promote skin integrity for example was not included within a service users plans. One service user's plans did not reference use of visual aids relating to communication needs as recommended within their Speech and Language Therapy (SALT) Care Plan. Several sections of service user care plans were found to be blank.

Furthermore, in the risk assessments reviewed it was identified that a number of known risks were not recorded, whilst other risks had no associated management plan in place. Identified risks relating to behaviours that challenged, failed to include directions relating to use of PRN for agitation. It also did not outline when physical restraint would be deemed necessary and proportionate in order to reduce presenting risks to the service users, others and staff or action to be taken subsequent to physical intervention being deployed.

As a result of the findings relating to service user plans an area for improvement had been identified were action is needed to ensure compliance with the Regulations.

There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction 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 also evidence that the agency sought change of address for one service user's DoLs care plan who had been admitted under emergency procedures.

Any service user subject to authorised Deprivation of Liberty Safeguards (DoLS) had their care plan reviewed by an HSC professional annually to ensure that they were not used disproportionately or for longer than is necessary. The agency had a central register that enable tracking of any DoLS due for review.

3.3.4 Quality of Management Systems

There has been a change in the management of the agency since the last inspection. Mrs Sarah-Lee Miley has been the Acting manager in this agency since 6 April 2025

Those consulted with described Mrs Sarah-Lee Miley as an effective and proficient leader, whose empathetic approach ensured service users were well cared for and staff were supported in their roles.

Review of incident records identified that they were managed appropriately. There was evidence that incidents were audited on a regular basis, to establish any patterns/trends.

Agencies are required to have a person known as the Adult Safeguarding Champion (ASC), who has responsibility for implementing the regional protocol and the agency's adult safeguarding policy. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm.

There was a process in place to manage any complaints received in line with the agency's policies and procedures.

The area for improvement identified during the previous inspection to ensure quality monitoring reports had been reviewed and verified was found to have been met with a sign off section added to the report template. The agency was visited each month by a representative of the registered provider to consult with service users, their relatives and staff and to examine all areas of the running of the agency. Although feedback was evident, no identifiable reference was included making it unclear if consultation was undertaken with the same or different service users and staff each month.

The reports failed to identify the total number of service users being supported by the agency at the time of the visit, nor did it reference leavers, current voids or new admissions. On review of the reports it was recognised that a generic statement had been entered in relation to DoLs and restrictive practice; there was no specific information detailed such as upcoming expiry dates. Entries made relating to the review of training, service user and staff folders were found to lack meaning. Due to this we were not assured that current arrangements would sufficiently drive service improvement, as such, an area for improvement has been identified were action is required to ensure compliance with the Regulations.

The agency had completed an annual service user survey to acquire feedback on the quality of care and gain insight as to the performance of the agency from the prospective of the people in receipt of the service. Results of this survey was shared with the service users in an appealing and an accessible format making findings easy to follow for the reader. This was highlighted as an area of good practice during feedback.

The agency had not produced an annual quality report and as such an area for improvement was identified were action is required to ensure compliance with the Standards.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Regulations and the Standards.

	Regulations	Standards
Total number of Areas for Improvement	2	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Sarah-Lee Miley, Acting 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 15(2) (a) (b) (c), (4) **Stated:** First time **To be completed by:** 25 December 2025	The Registered Person shall ensure service user plans contain accurate and all necessary information to adequately and safely respond to identified needs and presenting risks. Ref: 3.3.3
	Response by registered person detailing the actions taken: Comprehensive review of all service user support plans scheduled with senior support workers for November 2025.Schedule provided to inspector. Review outcomes and action plan will be provided to all senior support workers following review. Documentation provided to all staff responsible for developing and maintaining plans to outline details required. Quarterly audit tool updated and will be completed for each service user to monitor the quality of information held in each individuals records.
Area for improvement 2 **Ref:** Regulation 23(1), (2)(a) **Stated:** First time **To be completed by:** 25 December 2025	The Registered Person shall ensure quality monitoring reports contain sufficient detail and promote meaningful and ongoing service improvement. Ref: 3.3.4
	Response by registered person detailing the actions taken: Raised with monitoring officer and governance lead. Improvements and recommendations to be included in reports from November 2025. This will include a tracker to monitor actions taken on recommendations for service improvement.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 8.12 **Stated:** First time **To be completed by:** 13 November 2025	The Registered Person shall ensure 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. Ref: 3.3.4
	Response by registered person detailing the actions taken: Forms of feedback/data collection and review of such evidenced at inspection. This will now be collated and summarised for the period April-March in an annual evaluation report in April 2026. This will include an action plan based on outcomes. Proposed format shared with inspector.

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

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