The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: West Tyrone Domiciliary Care Services and Supported Living

Provider: Trinity Support & Care Services Limited

Date of Inspection: 10 June 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:	Trinity Support & Care Services Limited
Responsible Person:	Mr Cormac Coyle
Registered Manager:	Mr Colm McDaid (Acting)
Service Profile – West Tyrone Domiciliary Care and Supported Living Service provides a service to one service user with very complex needs. The objective of the service is to promote independence and to maximise quality of life through interventions and supports which are underpinned by Positive Behaviour Support in line with their model of Person-Centred Care and Support. Services are provided in a home-like environment.	

2.0 Inspection summary

An unannounced inspection was undertaken on 10 June 2025 between 9.50 am and 5.40 pm by care Inspectors.

The last care inspection of the agency was undertaken on 7 May 2024 by a care Inspector. No areas for improvement were identified.

RQIA received information on 20 May 2025 which raised concerns in relation to a number of areas which included care and support, record keeping, staffing, management and the care environment. As some aspects of this information related to potential adult safeguarding issues, RQIA shared the information with the local HSC Trust. Other information provided related to issues which do not fall within the remit of RQIA; these were shared with the Responsible Individual who provided written commentary on the issues raised.

In response to this information RQIA completed an unannounced inspection which focused on the concerns raised as well as examining how the agency is performing in relation to the regulations and standards.

RQIA received immediate assurances by the HSC Trust that there were no concerns in relation to care and support. The inspection established that care delivery was safe and that effective and compassionate care was delivered to the service user and that the service is well led. There were no areas for improvement identified during this inspection. Full details can be found in the main body of this report.

Good practice was identified in relation to care records and there were good governance and management arrangements in place.

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 this agency. This included 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 working for or being supported by the agency and review a sample of records to evidence how the agency is performing in relation to the regulations and standards. Information was provided to service users, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included questionnaires and an electronic survey.

3.2 What people told us about the service

Through active listening, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

The service user was observed to be relaxed and comfortable in their interactions with staff and appeared to be happy and content with the care and support they received. We contacted a relative for feedback on the service. The information provided indicated satisfaction with the care and support provided by the agency and that the staff were caring and understanding of service user's needs. Staff who spoke with the inspectors said that they were very happy working in the agency and that they had no concerns regarding the care and support provided. Trust representatives consulted with advised that they were very satisfied with the quality of care and support provided, that communication with the agency was good and that staff engaged positively with the service user and were proactive in implementing any suggestions or advice given.

3.3 Inspection findings

3.3.1 Staffing Arrangements (recruitment and selection, induction and training)

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.

There was evidence of effective systems to manage staffing and the manager advised that whilst there was some difficulty in recruiting, there were imminent plans for a recruitment event which aimed to attract new staff to the service.

An examination of the staff duty rota and discussions with staff confirmed that there was sufficient staff on duty to support the service user. There was no evidence of any dissatisfaction in relation to the staffing levels voiced from staff who said that there were enough staff to meet the needs of the service user. Staff said that they felt well supported in their role by the manager and that there was good team work. It was evident that staff had a good understanding of the needs, likes and dislikes of the service user.

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 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 deployed within the agency.

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. One induction record reviewed had been completed but was not signed off by management. Advice was given to the manager around ensuring that all induction records are signed off by the person assessing competency. The manager confirmed this has since been rectified.

Staff training was recorded electronically and highlighted when refresher training was due. On review of training records, it was noted that all staff except one had completed their mandatory training including Adult Safeguarding, Health & Safety, Basic Life Support, Dysphagia, Mental Capacity Awareness, Medication Practice, Moving and Handling Awareness and COSHH. The manager confirmed that dates for the identified staff member had been recorded in error and the records have since been rectified to record the correct date which rendered all staff training up to date at the time of inspection.

All staff had been provided with training in relation to medicines management. The manager advised that the service user did not require their liquid medicine to be administered orally with a syringe but confirmed competency assessments were completed before staff undertook medication administration tasks.

There were procedures in place for appraising staff performance and records confirmed staff received regular supervision in addition to yearly appraisal.

3.3.2 Adult Safeguarding and Incident Reporting

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 policy required an update in respect of a change in the organisation's identified Adult Safeguarding Champion (ASC). The manager has since provided an amended copy of the Adult Safeguarding policy which, along with the agency's annual Adult Safeguarding Position report, was reviewed and found to be satisfactory.

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. 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.

The agency's governance arrangements for the management of accidents/incidents were reviewed. The review confirmed that an effective incident/accident reporting policy and system was in place. A review of a sample of accident/incident records evidenced that these were managed appropriately.

3.3.3 Mental Capacity and Restrictive Practice

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 had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. 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.

On examination of the care records relating to the implementation of DoLS, it was identified that an updated care plan with respect to DoLS had not been provided after extension of DoLS was authorised. This was highlighted to the manager who arranged to obtain this immediately and has since provided evidence that this is now held within the service users' care records.

There was a policy in place for the use of restrictive interventions and a register was in place which was reviewed and updated regularly. Any restrictive practices were reviewed alongside the support plan, care review and subject to multidisciplinary review.

On examination of the planning and recording of the use of restrictive practices such a door locks, locked medication boxes and environmental restrictions, it was identified that the use of all restrictive practices were risk assessed with multi-disciplinary input, documented within service user's records and recorded on a restrictive practice register. Whist the use of restrictive interventions was subject to informal regular review by management and staff of the service, best practice advice was given to the manager in respect of ensuring regular communication, input and ratification from multi-disciplinary professionals, thereby evidencing a robust multi-disciplinary approach and confirmation that the restrictive practice is proportionate to the aim sought and used for no longer than is necessary for service user's safety. The manager agreed to ensure that restrictive practice forms an integral part of the service user's annual review.

3.3.4 Care Delivery and Care Records

Service users' needs were assessed as part of planned transitional arrangements involving outreach work, as part of both initial and ongoing assessment, to develop care plans to direct staff on how to best meet service users' needs. It was positive to note that in-depth assessment of need was conducted alongside the advice and recommendations made by other healthcare professionals prior to the service commencing with any service user.

Care records were person-centred, well maintained and regularly reviewed and updated to ensure they continued to meet the service user's needs. It was good to note that the service user was involved, as far as possible, in planning their own care; relatives of the service user also had an input into care planning. The service user's care plan contained details about their likes and dislikes, the level of support they may require and activities in which the service user enjoys participating. Care and support plans are kept under regular review and services users and /or their relatives participated, where appropriate, in the review of the care provided on an annual basis, or when changes occurred. The details of care plans were shared and signed by service users and/or their representatives as appropriate. Advice was given to the manager around archiving old care records to avoid and confusion for staff and this was actioned immediately. The records of the service user were held confidentially.

It was good to note that the agency had meetings with the relative of the service user on a regular basis which enabled the provisions of their relative's care to be discussed. Staff provided updates of activities undertaken with the service user and observations which were recorded within a communication book. There was a daily handover at the beginning of each shift with management and care staff which included information about any changes to the service user's care, that the staff needed to assist them in their roles. The daily handover was also used to assist staff in relation to planned activities for the day. Activities on offer included visits to a leisure facility, outdoor play area and bus trips to a local park. It was positive to note the agency was also exploring other leisure activities and that planning was done in close consultation with relatives. Progress with respect to offering a wider range of activities to engage in will be reviewed at a future inspection.

3.3.5 Quality and Management of the Environment

A review of the service user's living environment found that substantial works were ongoing to ensure a safe and tidy living area that was conducive to the service user's needs. There was evidence of ongoing works both indoors and outdoors to improve the living and outdoor space for the service user. Records confirmed that the manager had a refurbishment plan in place to address safety aspects and wear and tear of floors and doors and to provide a safe outdoor play area. Details were discussed with the manager who has since provided evidence of progress with respect to works ongoing to the outdoor space. This will be kept under review to ensure that these issues continue to progress as planned in a timely way, to ensure that the living environment of the service user is being maintained to an appropriate standard for the service user's dignity. This will be examined during a future inspection.

There was evidence that fire safety checks had been completed as required. Staff had completed training in regard to fire safety and had participated in a fire evacuation drill. Throughout the inspection fire doors were observed to be unobstructed.

3.3.5 Quality of Management Systems

Acting management arrangements have been in place since 18 June 2024. The manager advised of their intention to submit an application to RQIA for registration as manager; this will be reviewed in due course

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. The reports of these visits were completed in detail.

Complaints and incidents were managed appropriately.

The annual quality report was reviewed and noted to include stakeholder feedback.

The Statement of Purpose was reviewed and found to be satisfactory.

There was evidence that the agency responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the agency.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Colm McDaid (Acting Manager), as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority

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