The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **The Lodge**

Provider: **Northern HSC Trust**

Date of Inspection: **9 July 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:	Northern HSC Trust
Responsible Individual:	Ms Jennifer Welsh
Registered Manager:	Mr Norman Doole
Service Profile: The Lodge is a supported living type domiciliary care agency which provides 24 hour support with accommodation for six tenants with enduring mental health needs.	

2.0 Inspection summary

An unannounced inspection took place on 9 July 2025 between 8.35 am to 2.10 pm, this was conducted by a care inspector.

The last care inspection of the agency was undertaken on 7 November 2023 by a care inspector. No areas for improvement were identified. This inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; and to determine if the service 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 incident notification, training, medication audits and monthly monitoring reports.

The Lodge uses the term ‘tenants’ to describe the people to whom they provide care and support. For the purposes of the inspection report, the term ‘service user’ is used, in keeping with the relevant regulations.

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 the service users/relatives who are in receipt of care and support; workers for the agency; and review/examine 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 and their quality of life

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

Service users told us that they had no complaints and they enjoyed living here, that they received support that enabled them to spend time away to visit family. They reported that the "staff were great".

Staff told us they loved their job, that the manager was approachable, with no concerns expressed about the delivery of care. One staff member remarked that "The lodge is very friendly and homely unit the care is excellent, the manager and staff are very professional in the care provided "and another shared that "The Lodge can be commended on their level of care and empathy for service users. Tenants have commented that they enjoy living in the Lodge and pass on positive remarks regarding the staff and level of care they receive. The Lodge provides a welcoming environment and the staff are very dedicated to their role and providing an effective service for all tenants".

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. There was evidence of robust systems in place to manage staffing.

The Person in charge confirmed that no new staff had been recruited since the last inspection.

Checks were made to ensure that staff were appropriately registered with NISCC. 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.

Staff training was recorded on a training matrix, this matrix was reviewed and found to have incorrect training review dates. An area for improvement has been identified.

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place.

3.3.2 Care Delivery

Staff were knowledgeable of individual service users' needs, their daily routine wishes and preferences. There was a system in place to ensure that the activities offered to service users were geared towards their individual needs and preferences. Service users' needs were met through a range of individual activities.

Records reviewed evidenced that staff were prompt in recognising service users' needs and any early signs of distress or illness.

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.

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. Following this initial assessment care plans were developed to direct staff on how to meet service users' needs and included any advice or recommendations made by other healthcare professionals.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the service users' needs. Staff recorded regular evaluations about the care and support provided. Service users, were involved in planning their own care.

The restrictive practice register has recently been reviewed and restrictive practices were reviewed alongside the support plan review and the multidisciplinary review.

3.3.4 Quality of Management Systems

Mr Norman Doole has been the manager in this agency since 7 April 2025. Those staff consulted commented positively about the manager and described him as approachable.

The agency was visited each month by a representative of the registered provider to consult with service users, their relatives and staff. The action plan progress in the reports viewed, were not found to be in keeping with actions identified in the previous month. The reports contained incorrect manager details and omitted details of an incident which had occurred.
An area for improvement has been identified.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. No complaints were received since the last inspection. Discussion took place during inspection in relation to improvements the current complaints log. This will be reviewed at future inspections.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure. A review of incident records identified an incident that had required onward reporting to RQIA. An area for improvement has been identified.

Medication audits were found to lack evidence of a systematic review of policy and procedure. There was no evidence of actions taken in relation to the findings from the most recent medication audit. An area for improvement has been identified.

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

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 safeguarding policy. A specific individual was identified as the agency's ASC. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm.

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	2	2

Areas for improvement and details of the Quality Improvement Plan were discussed with the Senior Support Worker, 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 16 (2) (a) **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure that the training matrix is maintained with accurate information Ref: 3.3.1
	Response by registered person detailing the actions taken: The registered person will ensure that the training matrix is updated and monitored on a monthly basis. Due dates have been removed from the Matrix and only the initial date of attending training will be implemented to reduce confusion.
Area for improvement 2 **Ref:** Regulation 23 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure that the quality monitoring report contain appropriate information to enable this tool to be used to drive improvement Ref: 3.3.4
	Response by registered person detailing the actions taken: Quality monitoring visits are undertaken on a monthly basis across all schemes. The Quality monitoring template used to facilitate these visits was originally agreed with RQIA. This information is used to consider the necessity for a change in practice, areas for improvement etc. The registered manager will ensure that the information collected as part of these quality monitoring visits is adequately recorded.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 7.14 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall establish and maintain a system for the regular review of medication practices with documented actions taken Ref: 3.3.4
	Response by registered person detailing the actions taken: Medication has consistently been reviewed across all schemes on a monthly basis, utilising the MAR sheet shared with schemes by pharmacy. In addition to this, pharmacy colleagues undertake an annual audit. In response to this report, a new medication audit form has been developed in collaboration with RQIA and implemented across all Mental Health Supported Living schemes. This will be held on file at the respective scheme and can be reviewed as and when required by RQIA.

Area for improvement 2 **Ref:** Standard 14.5 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure that all notifiable incidents are reported to RQIA Ref: 3.3.4
	Response by registered person detailing the actions taken: The registered person will ensure that any incident that meets the threshold for a reportable incident is shared with RQIA.

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