The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Triangle Housing Association

Provider: Triangle Housing Association

Date of Inspection: 19 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:	Triangle Housing Association
Responsible Individual:	Mr Christopher Harold Alexander
Registered Manager:	Miss Sarah Brown
Service Profile: Triangle Housing Association is a domiciliary care agency supported living type which provides 24 hour care and housing support to eight service users. The office is located in the same building as the homes of the service users and accessed from a shared entrance. The care is commissioned by the Northern Health and Social Care (NHSC) Trust.	

2.0 Inspection summary

An unannounced inspection took place on 19 June 2025 between 10.00 am and 5.30 pm. This inspection was conducted by a care inspector who was accompanied by another who was observing practice.

The last care inspection of the agency was undertaken on 14 August 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 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, as staffing arrangements, care records and records relating to staff training.

Service users said that the care and support provided by the agency was a good experience. Refer to Section 3.2 for more details.

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 and being supported by the agency; and review/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 and their quality of life

As part of the inspection process, we spoke to service users and staff members to seek their views of the care and support provided by the agency.

Service users spoke positively about the staff who support them. Comments included: “I’m happy here, sure you couldn’t fault them.”

Staff spoke positively in regard to the care delivered and management support in the agency. Comments included: “The manager is organised, supportive and has an open door policy.”; ‘Service users are very well supported with their individual needs.’

A professional representative provided varied feedback. This was shared with management for appropriate action.

A number of staff responded to the electronic survey. The respondents indicated that they were ‘satisfied/very satisfied’ that care provided was safe, effective and compassionate and that the agency was well led. Written comments included: ‘Service users are very well supported with their individual needs.’.

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 systems in place to manage staffing. However, it was noted that no staff member had been identified to cover in the absence of the registered manager. An area for improvement has been identified.

There was a process in place to ensure that recruitment was managed appropriately; this ensured that all pre-employment checks, including criminal record checks (AccessNI), are completed and verified before staff members commenced employment and have direct engagement with service users.

The person in charge confirmed that a process was in place that newly appointed staff are required to 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 day care setting's policies and procedure.

Review of records and discussion with the person in charge confirmed that there is a system in place to ensure all staff receive appropriate training to fulfil the duties of their role on an ongoing basis; this includes a programme of refresher training for staff. However, a review of the training matrix evidenced that it had not been kept up to date. An area for improvement has been identified.

Observation of the delivery of care evidenced that service users' needs were met by the number and skills of the staff on duty.

Procedures were in place for supervision and appraisal of staff.

3.3.2 Care Delivery

There was a daily handover at the beginning of each shift, which included information about any changes to the service users care, that the staff needed to assist them in their roles.

Staff were observed to be prompt in recognising service users' needs. Staff were skilled in communicating with service users; they were respectful, understanding and sensitive.

Staff were observed offering service users choice in how and where they spent their day or how they wanted to engage socially with others.

Good nutrition and a positive dining experience are important to the health and social wellbeing of service users. Service users may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified. Review of records and discussion with the person in charge evidenced that there were systems in place to manage service users' nutrition.

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, regularly reviewed and updated to ensure they continued to meet the service users' needs. However, it was identified in two service user's care record that the care plan had not been updated to reflect the current assessed need. An area for improvement has been identified.

It was also noted that the service users' care record indicated they were transported regularly by staff in their wheelchair accessible vehicle. RQIA noted the absence of written guidance for staff in the use of appropriate wheelchair tie down and occupant restraint system. An area for improvement has been identified.

A review of a sample of care records evidenced that service users, where possible, were involved in planning their own care and efforts had been made to ascertain service user's preferences and choices around how their support was provided. The details of care plans were shared and signed by service users and/or their representatives as appropriate.

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.

There was a policy in place for the use of restrictive interventions and a register was in place which was reviewed and updated regularly.

It was 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 activities and outings.

Service users care records were stored securely and accessible to authorised personnel in accordance with data protection regulations.

3.3.4 Quality of Management Systems

There has been a change in the management of the agency since the last inspection. Miss Sarah Brown has been the Registered Manager in this agency since 12 December 2024.

Staff consulted with commented positively about the manager and described her as supportive.

Review of a sample of records evidenced that a system for reviewing the quality of care and staff practices was in place.

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.

Staff had been provided with training in relation to medicines management. However, a review of the management of medication errors indicated that follow up actions had not been completed. An area for improvement has been identified.

The Annual Quality Report was reviewed and was satisfactory.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Where complaints were received since the last inspection, these were appropriately managed and were reviewed as part of the agency's monthly quality monitoring process. Advice was given in relation to updating the complaints policy to include contact details for the Patient Client Council and RQIA.

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.

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. Discussions with the person in charge established that they were knowledgeable in matters relating to the role of the ASC and the process for reporting and managing adult safeguarding concerns.

The annual safeguarding position report had been completed and found to be satisfactory.

Staff were required to complete adult safeguarding training during induction and every two years thereafter.

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

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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	3	2

Areas for improvement and details of the Quality Improvement Plan were discussed with 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 **Ref:** Regulation 16 (1)(d) **Stated:** First time **To be completed by:** Immediately from the date of inspection	The registered person shall ensure that suitably qualified and competent persons are available to be consulted during any period of the day in which a person is working for the purposes of the agency. Ref: 3.3.1
	Response by registered person detailing the actions taken: In the absence of the registered manager and team leader a keyholder will be identified for the shift on the staff rota. The Keyholder will take the lead in the event of an emergency. The Keyholder has access to alternative registered managers in the local area as per rota. The Keyholder has access to a Regional Manager 24 hours per day as per rota A memo will be issued to all staff to confirm these arragements
Area for improvement 2 **Ref: Ref:** Regulation 15 (1)(2)(a)(b)(c) **Stated:** First time **To be completed by:** Immediately from the date of inspection	The registered person shall ensure that the care plans are kept up to date and reflect the service users' assessed needs. Ref: 3.3.3
	Response by registered person detailing the actions taken: The registered manager had requested updated care plans / risk assessments from the named workers in NHSCT. The last request was the 22/05/25. At the date of inspection they had not had a response. These plans have subsequently been obtained

Area for improvement 3 **Ref:** Regulation 15 (8) **Stated:** First time **To be completed by:** Immediately from the date of inspection	The registered person shall make suitable arrangement, including training, to ensure domiciliary care workers operate a safe system of working. This includes the operation of any specialist equipment. This relates specifically to the safe use of wheelchair tie down and occupant restraint systems (WTOPS) Ref: 3.3.3
	Response by registered person detailing the actions taken: Two service users have wheelchair accessible vehicles. On 22/07/25 Mobility services provided wheelchair accessible vehicle adaptation training and demonstration for both vehicles. This included, tie downs to secure points,stowing of tie downs,use of seat belt and use of ramp. Certificates were provided for the staff attending. Staff members unavailable on the 22/07/25 will have a demonstration from a team leader who attended. Records maintained

Action required to ensure compliance with the Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 10.4 **Stated:** First time **To be completed by:** Immediate from the date of inspection	The registered person shall ensure that the information held on record is accurate, up to date and necessary and that staff receive appropriate training. This relates specifically to the agency's staff training information. Ref: 3.3.1
	Response by registered person detailing the actions taken: Staff are nominated for all required mandatory training in advance of due date.In the case of safeguarding training, Triangle exceeds the mandatory requirement by aiming to train all staff on an annual basis The registered manager updates the training matrix spreadsheet when they have been informed by the Learning and development department that the staff member attended. On a monthly basis the regional manager receives a report of any non attendance to monitor compliance.

Area for improvement 2 **Ref:** Standard 7.5 **Stated:** First time **To be completed by:** Immediate from the date of inspection	The registered person shall ensure that actions identified in regard to medication errors are completed. Ref: 3.3.4
	Response by registered person detailing the actions taken: The action identified in regards to medication errors is completed, support offered and discussion recorded

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