The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Mullaghcarton Supported Living**

Provider: **Autism Initiatives NI**

Date of Inspection: **10 September 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:	Autism Initiatives NI
Responsible Person:	Adele Leighton
Registered Manager:	Miss Orlagh Dillon
Service Profile – Mullaghcarton Road Supported Living is a supported living type domiciliary care agency which provides personal care and social support to service users. The service is operated by Autism Initiatives NI. Services are commissioned by the South Eastern Health and Social Care Trust (SEHSCT) and the Southern Health and Social Care Trust (SHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 10 September 2025 between 10.04 am and 3.34 pm by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards, and to assess progress with the areas for improvement identified during the last care inspection on 13 August 2024.

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 and Dysphagia management were also examined.

As a result of this inspection two areas of improvement previously identified relating to staff induction and COSHH practices were assessed as having been addressed by the provider. This is discussed in more detail in sections 4.1 & 4.7.

This 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 a result of this inspection, one area for improvement was identified relating to the medication policy. This is discussed in more detail in section 4.7. Further details of the findings of this inspection are outlined in the main body of the report.

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.

To prepare for this inspection we reviewed information held by RQIA about this agency. This included the previous area for improvement issued, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning Trust.

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 for staff.

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.

We approached service users, relatives, staff and a HSC professional to seek their views of living, visiting and working within the Mullaghcarton Supported Living.

Service users were observed to be relaxed and content with a good rapport noted between service users and staff.

A relative who spoke with the inspector indicated that communication with the staff was good and that staff did their best to support their loved one.

Staff who spoke with the inspector spoke positively about the care provided to service users, that there was good teamwork and that manager was supportive.

One HSC professional contacted for feedback said that the care delivery and management support in the agency was good.

Written feedback on a questionnaire indicated that staff felt very satisfied that the care provided by the service was safe, effective and compassionate and that the service was well led.

4.0 Inspection findings

4.1 Staff Recruitment, Induction and Training Arrangements

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.

An area for improvement identified during the previous inspection related to the induction of newly appointed staff. Review of a sample of the most recently appointed staff, evidenced that staff had completed a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care. There was a robust, structured, induction programme which included shadowing of a more experienced staff member. This was reviewed periodically and signed off to ensure competence in carrying out the duties of their job in line with the agency's policies and procedures. On this basis the area for improvement was deemed to have been met by the provider.

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

The agency maintained an electronic record of all staff training; however a review of this record, evidenced a number of staff's training in Fire Safety and Manual Handling had expired. This was discussed with the manager who provided confirmation following the inspection that staff have since completed these training modules or are booked on to the next available date. This will be followed up at a future inspection. Staff confirmed that they were provided with opportunities to complete training commensurate with their role.

All staff had been provided with training in relation to medicines management. Competency assessments were undertaken with staff to ensure that they were proficient in administration of medications and this is reviewed annually. Where medication errors occurred, appropriate action was taken which required staff to undertake refresher training and a renewed competency assessment to ensure staff are competent in assisting with this task.

It was evident that staff received regular supervision and that there were procedures in place to appraise staff performance.

4.2 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).

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.

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. The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. A review of safeguarding records evidenced that these were managed appropriately. Advice was given to the manager with regards creating a log of all safeguarding concerns raised for tracking purposes to include consideration of any protection plans that may be implemented for the prevention and protection of harm of service users.

The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

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

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

An area for improvement identified in the previous inspection related to COSHH practices with in the agency. A review of same identified that all chemicals were safely stored in a locked cabinet. On this basis the area for improvement was deemed to have been met by the provider.

4.3 Mental Capacity Act / Deprivation of Liberty Safeguards (DoLS) and Restrictive Practice

The Mental Capacity Act (Northern Ireland) 2016 (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 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. It was positive to note that the service maintained a register of all service users subject to DoLS and reviewed this on a regular basis to ensure that any deprivations of liberty were proportionate, necessary and applied for no longer than is necessary in line with the MCA legislation. A review of service user records where DoLS were in place, evidenced that care records contained details of assessments completed and agreed outcomes as developed in conjunction with the relevant HSC Trust representative. The manager advised that there was one service user who had recently had a review of their DoLS but awaited their updated documentation. Assurances were provided that this would be followed up to ensure that all documentation pertaining to DoLS remains up to date.

There was a policy in place for the use of restrictive interventions and any restrictive practices applied such as locked safes for finances and medication were reviewed regularly alongside the support plan, care review and included multidisciplinary input for the safety and well-being of the individual.

4.4 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. The service users' care plans contained details about their likes and dislikes and the level of support they may require. 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.

Staff recorded regular evaluations about the care and support provided. A review of a sample of these records evidenced that they were legible, up to date and signed by the person making the entry. There was a system in place for recording the management of individual service users' monies in accordance with the guidance.

4.5 Management of Dysphagia and Recommendations for Eating, Drinking and Swallowing Documents (REDS)

A number of service users were assessed by Speech and Language Therapist (SALT) with recommendations provided and some required their food and fluids to be of a specific consistency. A review of training records confirmed that staff had completed training in Dysphagia and in relation to how to respond to choking incidents.

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. There was evidence that staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate. Staff implemented the specific recommendations of the SALT which were recorded within care plans along with associated SALT dietary requirements. Staff were familiar with how food and fluids should be modified to ensure that the care received in the setting was safe and effective and demonstrated a good knowledge of service users' wishes, preferences and assessed needs.

4.6 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. Regular

staff meetings were held and minutes maintained of the meetings for staff, unable to attend, to read for information sharing.

There was evidence of a range of activities for service users to avail of as noted within the annual survey report including shopping, swimming, visits to the zoo, drives in the car and day centre attendance. It was noted however, that there was no visual timetable on display for service users or staff to easily refer to. This was discussed with the manager and it was noted that staff were aware of the different activities which service users participated in on a daily basis however, for any newer staff, the activities arranged were contained within support plans and daily notes only. It was therefore recommended that staff devise a visual activities timetable which meets the needs of the service users so they are aware what activities are available each day/week/month. This will be reviewed at a future inspection.

Staff interactions with service users were observed to be friendly and supportive and prompt in recognising service users' needs including those service users who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with service users; they were respectful, understanding and sensitive to service users' needs and in responding to any signs that required their assistance. At mealtime, staff were observed to be working well together to ensure that service users are provided with a nutritious meal in accordance with their SALT and dietary requirements.

4.7 Managerial oversight and Governance

There has been no change in the management of the service since the last inspection. Staff commented positively about the manager and described them as supportive, approachable and able to provide guidance.

There were monitoring arrangements in place and 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/day care setting. The reports of these visits were completed in detail and carried forward actions for the service to focus on between visits. Progress on actions identified was highlighted on subsequent reports.

There was a range of policies available to direct staff in care delivery and support planning based on individual risk assessments. Staff confirmed they had access to policies and it was positive to note that the manager requested staff to sign and date when they had read a policy that had been reviewed or amended. On review of the recently reviewed medication policy, it was noted that it omitted guidance around training and administration of liquid medication. As it was evident that some service users required medication in liquid form, a further review of this policy is required. An area for improvement has been identified.

Staff confirmed they had opportunity to attend staff meetings where they are provided with updates on policies and additional training requirements. Staff told us that they would have no issue in raising any concerns regarding service users' safety or care practices and that they were confident that the manager or person in charge would address their concerns.

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

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. No complaints were received since the last inspection.

5.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	0	1

The area for improvement and details of the Quality Improvement Plan were discussed with Miss Orlagh Dillon, 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 Minimum Standards 2021	
Area for improvement 1 **Ref:** Standard 7.5 **Stated:** First time **To be completed by:** Immediately	The Registered Person shall ensure that the medication policy and procedure cover each of the activities concerned with the management of medicines This refers to the need to incorporate the administration of liquid medications within the policy to include the associated training needs for all staff Ref: 4.7
	Response by registered person detailing the actions taken: The organisations Medication Policy has been updated to include the following: Liquid Medications (including suspensions) Staff may administer liquid medication if trained and authorised to do so. All liquid medication must be: • Clearly labelled, with the person supported full name, dose, and expiry date. • Stored correctly (in fridge if required). • Shaken well before use, if instructed on the label. Doses must be measured accurately using the appropriate measuring device. Household teaspoons should NOT be used. Staff must follow Autism Initiatives medication administration procedures, double checking the medicine, dosage, timings, and the person to whom the medication is applicable for, before administration.

	Medication records must be completed and details recorded as per Autism Initiatives medication Kardex records. If a person supported refuses or spits out medication, or if an error or spillage occurs, follow the standard reporting procedure. Opened bottles should be dated and any unused or expired bottles of medicine, returned to the pharmacy for safe disposal, as per Autism Initiatives disposal procedure.

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

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