The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Ballymacoss Supported Living Service**

Provider: **South Eastern Health and Social Care Trust**

Date of Inspection: **16 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:	South Eastern Health and Social Care Trust
Responsible Individual/Responsible Person:	Ms Roisin Coulter
Registered Manager:	Ms Sarah Jayne Merrell
Service Profile – Ballymacoss Supported Living Service is a domiciliary care agency (supported living type) which provides a range of personal care services to 11 people living in their own homes. Service users have a range of needs including mental health issues and require support to live as independently as possible.	

2.0 Inspection summary

An unannounced inspection took place on 16 June 2025, between 10.00 a.m. and 4:40 p.m. This was conducted by a care Inspector who was accompanied by an inspector who was observing.

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 reviewed.

The last care inspection of the agency was undertaken on 21 September 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. Five areas for improvement were identified, these were related to medication auditing, documentation, restrictive practice, Annual Quality report and service user feedback.

Ballymacoss Supported Living Service 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.

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.

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

We spoke to a service user to seek their views of the agency.

The service user spoke very positively in regard to the support they received from the staff and were knowledgeable of who to talk to if they had any concerns.

3.3 Inspection findings

3.3.1 Staffing Arrangements

The manager confirmed that no new staff had been recruited to the agency since the last inspection.

Records of all staff training were retained and were noted to be up to date. The manager maintained oversight of the training matrix to ensure compliance. This training included Deprivation of Liberties Safeguards (DoLS), adult safeguarding, Dysphagia, at a level appropriate to their job roles.

Checks were made to ensure that staff were appropriately registered with Northern Ireland Social Care Council (NISCC); there was a system in place for professional registrations to be monitored by the manager.

Ballymacoss Supported Living Service use a handover document to provide information for staff, improvements to this document were advised. This will be reviewed at future inspections.

3.3.2 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. The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding.

All relevant staff had been provided with training in relation to medicines management. The monthly medication audit had not been consistently undertaken. Audit findings included vague statements and there was no evidence of corrective and preventative measures undertaken. An area for improvement has been identified.

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

A restrictive practice in relation to medication was evident during inspection, the agency has not established a restrictive practice register. Service users attended the office to receive their medications rather than these being securely stored in their homes. This would not be in keeping with the ethos of supported living. An area for improvement has been identified.

Care and support plans were reviewed, the agency is currently using a combination of hard copy files and Encompass for care files. The manager was unable to demonstrate how progress relating to identified goals or current risk assessments were recorded. An area for improvement has been identified.

3.3.3 What are the arrangements for promoting service user involvement?

From reviewing service users' care records, it was good to note that service users had an input into devising their own plan of care. The service users' care plans contained details about their likes and dislikes and the level of support they may require. Person centred support plans were reviewed and found to involve the service user.

Since the last inspection, the agency had not undertaken an evaluation of the service to include feedback from service users. An area for improvement has been identified.

Monthly service user meetings are facilitated by the agency. Advice was shared on how these meetings could be improved. This will be reviewed at future inspections.

3.3.4 What are the arrangements to ensure robust managerial oversight and governance?

Ms Sarah Jayne Merrell has been the manager in this agency since 4 April 2024. Service users commented positively about the manager.

There were monitoring arrangements in place. A review of the reports of the agency's quality monitoring established that there was engagement with service users, staff and HSC Trust representatives. The reports included details of a review of accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements. The manager was advised to check the content of these reports for inaccuracies and to ensure that progress was recorded for all identified actions. This will be reviewed at future inspections.

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.

Complaints were managed appropriately, but the documentation relating to the complaint required improvement. This will be reviewed at future inspection.

The annual quality report was not available. An area for improvement has been identified.

There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice.

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 Ms Jayne Merrell 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 Domiciliary Care Agencies Regulations (Northern Ireland) 2007

Area for improvement 1 **Ref:** Regulation 15 (3)(b) **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall keep the service user plan under review. This relates specifically to recording progress relating to identified goals and current risk assessments. Ref: 3.3.2
	Response by registered person detailing the actions taken: Staff will complete a monthly summary of the Care and Support, as identified on the Support Plan and Risk Assessment, on the Computerised system. This will form part of the Registered Manager's monthly audit and the Monthly Monitoring Report.
Area for improvement 2 **Ref:** Regulation 14 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The registered person shall make suitable arrangements to safeguard service users and promote independence. This relates specifically to the establishment of a restrictive practice register and the storage of medications in the office rather than service user's homes. Ref: 3.3.2
	Response by registered person detailing the actions taken: A Restrictive Practice Register has now been implemented to safeguard Service Users in relation to the storage and administration of their medication. This register is reviewed and updated a minimum of 6 monthly at the Care and Support Reviews or more often as individual assessed needs dictate.
Area for improvement 3 **Ref:** Regulation 15 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The registered person shall ensure that there is a safe system of work in relation to medication. This relates specifically to a lack of robust monthly medication audits Ref: 3.3.2
	Response by registered person detailing the actions taken: The medication audit template has been reviewed and updated with a clear schedule for audit on a monthly basis. These completed audits will be further reviewed by the Monthly Monitoring Officer.

Action required to ensure compliance with ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 4 **Ref:** Standard 1.8, 1.9 **Stated:** First time	The Registered Person shall ensure that a report is prepared and available of the formal seeking of views of service users and their carers / representatives Ref: 3.3.3
To be completed by: Immediately from the date of inspection	**Response by registered person detailing the actions taken:** Service Users and Carers questionnaires are being developed by a sub-group to include Registered Managers, Tenants and the Trusts Mental Health Service User Consultant, with agreement being sought on the format and questions asked. The themes and outcomes of these questionaires will inform the Annual Quality Report, due October 2025.
Area for improvement 5 **Ref:** Standard 8.12 **Stated:** First time	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
To be completed by: Immediately from the date of inspection	**Response by registered person detailing the actions taken:** The annual Service User feedback will be presented to Tenants in a 'You Said We Did' format. This will be shared with the key stakeholders and form the basis of an annual Team Development Day which will highlight the priorities for the year ahead and the development of an Annual Quality Report.

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