The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Threshold – Taylor Cheshire House

Provider: Threshold Services NI

Date of Inspection: 24 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:	Threshold Services NI
Responsible Individual/Responsible Person:	Mrs Fiona McCabe
Registered Manager:	Miss Zoe Alexander
Service Profile: Threshold - Taylor Cheshire House is a supported living type domiciliary care agency which provides care and housing support services for up to 22 service users with physical/sensory disabilities. Service users live in their own flats and have the use of communal indoor and outdoor space.	

2.0 Inspection summary

An unannounced inspection was conducted on 24 July 2025 between 9.05 a.m. and 5.30 p.m. by a care Inspector.

The last care inspection of the agency was undertaken on 3 December 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; the inspection also sought 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 service user plans.

It was evident that staff promoted the dignity and well-being of service users and that staff were knowledgeable and well trained to deliver safe and effective care.

Service users said that the care and support provided by Threshold – Taylor Cheshire House was a good experience.

Full details, including the area for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

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.

Throughout the inspection process, inspectors seek the views of those supported by the service and those working for the agency and 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

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

Service users spoke about their relationships with staff who they described as "excellent". One service user said, "Living here in Taylor House is excellent, staff know what my day to day needs are and are always on stand-by to help when I need them". They told us that they felt able to speak with staff about concerns, and considered staff to be honest, friendly and approachable.

Those requiring support with personal care and manual handling advised that staff were considerate in completion of these tasks. Additionally, they advised that they felt safe.

Some service users expressed a degree of dissatisfaction with regard to matters relating to housing. Whilst this aspect is not directly managed by Threshold Services NI, it was apparent that the Manager was actively engaging with the housing provider to achieve resolution.

Some service users indicated dissatisfaction that communal space was used for staff training. This was discussed with the Manager who agreed to give consideration to reducing the impact for those living within the service.

A few of the service users told us that they "love it here" with one advising that they felt "staff aren't recognised enough for what they do". It was also positive to note that they felt staff were always impartial and that "there's no favourites".

Staff told us that they received a comprehensive induction that offered opportunity to shadow a more experienced member of the team. Staff stated they were satisfied with continuous training provided.

The staff told us that there were effective communication systems in place that ensure all members of the team are aware of any changes in the needs or risks of the people they support. They confirmed they received regular supervision and felt they could readily seek support whenever needed. The staff spoke positively about their colleagues as well as the Deputy Manager and the Registered Manager.

Staff were knowledgeable as to safeguarding procedures and able to name the organisation's adult safeguarding champion (ASC). In relation to responding to accidents and incidents, staff were aware as to expected responses to reduce risk of further harm arising, as well as who should be notified following such occurrences. They also described multiagency work that occurs to promote best outcomes for service users.

3.3 Inspection findings

3.3.1 Staff Recruitment, Induction and Training 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. Staff said there was good teamwork and that they felt well supported in their role.

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 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.

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to the Northern Ireland Social Care Council's (NISCC) 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.

Records of all staff training were retained and the Manager maintained oversight of the training matrix to ensure compliance. There was evidence that outstanding training had been booked to be completed. Training completed by service included Deprivation of Liberties Safeguards (DoLS), adult safeguarding and Dysphagia, at a level appropriate to the job roles of staff.

Competency assessments were undertaken on all staff expected to lead a shift.

All staff received regular supervision and there was a clear process in place for appraising staff performance on an annual basis.

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 needed by staff to assist them in their roles. Staff were knowledgeable of individual service user's needs, their daily routine, wishes and preferences. Regular staff meetings were held and minutes retained of the meetings for staff who were unable to attend to read for information sharing.

Service users' needs were met through a range of individual activities whilst other group activities were organised and available within the service such as barbeques, music and pet therapy. Service users' opinions regarding activities that they would like to see were actively sought by the agency. Service users were well informed of the activities planned for the month and of their opportunity to be involved.

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

It was observed that staff respected service users' privacy by their actions such as knocking on doors before entering, discussing service user care in a confidential manner, and by offering personal care to service users discreetly.

Service users had the choice to avail of meals prepared by the service that took into consideration those service users who required a modified diet. Where individuals wished not to avail of this, individual support was available as required.

Where service users required support with medication, their preferences surrounding storage and the way they like to take their medication was detailed within their care plans.

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.

A review of records identified that service user consent was sought in relation to delivery of care and support, access to their home in the event of an emergency, and staff contacting/requesting information from other healthcare professionals on their behalf. Service users were given the choice as to whether they wanted their photograph taken and used in any organisational promotional material or social media. Service users had tenancy agreements in place.

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

Whilst service users had a care and support plan in place, and risk assessments were also completed where necessary, it was identified that some aspects of the information contained in these documents was inaccurate.

For example, the medications prescribed for the management of epilepsy were wrongly recorded in one care file, and there was no direction for staff as to how to respond in the event of a seizure. The care plans lacked sufficient detail to direct staff in the delivery of personal care, particularly with regard to catheter care.

Those service users who needed assistance with moving and handling for personal care had risk assessments in place, however, the care plans did not always provide explicit direction to staff as to how to assist with this. In one instance, the records referred to a SALT assessment which was outdated; a more recent assessment was in place, but the care plan did not reflect this.

The need to ensure accurate and sufficient detail within care plans was discussed with the Manager. This was identified as an area for improvement.

There were arrangements in place to ensure that service users who required restriction had their capacity considered and, where appropriate, assessed. 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 and care review.

3.3.4 Quality of Management Systems

There has been no change in the management of the agency since the last inspection. Miss Zoe Alexander has been the Registered Manager in this agency since 12 September 2019.

Those consulted with commented positively about the manager and described her as supportive, approachable and able to provide guidance.

A review of a sample of records evidenced that a robust system for reviewing the quality of care and staff practices was in place. The agency setting 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.

There was a process in place to manage any complaints received. Information regarding external agencies who could also be contacted in relation to any complaint was also readily available.

A review of incident records identified that they were managed appropriately. There was evidence that incidents were audited on a regular basis to establish any patterns/trends. It was good to note that these were reviewed as part of the monthly quality monitoring process.

The annual quality report was reviewed and noted to include stakeholder feedback. It was also positive to note that an annual service user survey was completed and that responses were taken into consideration to improve the service, where necessary.

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. 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.

The annual safeguarding position report had been completed.

There was evidence that the agency responded to any concerns raised with them or by their processes, and took measures to bring about improvements required.

4.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with the Regulations.

	Regulations	Standards
Total number of Areas for Improvement	1	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Zoe Alexander, Registered 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, revised 2021	
Area for improvement 1 **Ref:** Regulation 15 (2) (b) (c) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that all records relating to provision of care and management of risk are accurate, up to date and offer clear directions to staff. This is in particular reference to the following: • the recording of medications prescribed for epilepsy • the management of epilepsy in emergency situations • the management of catheter care • moving and handling needs • SALT assessments. Ref: 3.3.3
	Response by registered person detailing the actions taken: Service Manager has ensured the information is now completely uptodate, robust and appropriate for all service users' health information in relation to the following areas: Catheter care, Epilepsy management, Diabetes management, Manual handling, SALT guidance/ dysphagia management and Personal care. Following consideration of our current documentation, our Head of Quality and Learning has plans to review service user paperwork to ensure there is a streamlined approach to the information, reducing opportunities for inconsistencies due to duplication, and robust information is available and clear for staff.

Please ensure this QIP is completed in full and submitted via Web Portal

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