The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Shaftesbury North Down and Ards**

Provider: **Livability**

Date of Inspection: **28 August 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:	Livability
Responsible Individual/Responsible Person:	Mr Stuart Dryden
Registered Manager:	Mrs Debora Turkington
Service Profile – Shaftesbury North Down and Ards is a domiciliary care agency, supported living type service, located in Comber. The agency's aim is to provide care and support to service users in their own homes; this includes helping service users with tasks of everyday living, emotional support and assistance to access community services, with the overall goal of supporting service users to live as independantly as possible and maximising quality of life. Services are commisioned by the South Eastern Health and Social Care Trust (SEHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 28 August 2025, between 9.30 am and 4.15 pm by a care Inspector.

The 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 agency was delivering safe, effective and compassionate care and if the agency was well led.

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), restrictive practices and service users' care records and finance and tenancy agreements were also examined.

Areas for improvement identified related to financial support agreements; risk assessments and financial capacity assessments.

As a result of this inspection the areas of concern were discussed with RQIA's Finance Inspector and it was agreed to seek further information from both the commissioning Trust and the Agency's Responsible Individual in relation to service users' finances and tenancy arrangements; discussions are ongoing.

Good practice was identified in relation the completion of the monthly quality monitoring reports and training compliance, which included additional training based on learning from a serious adverse incident (SAI).

Shaftesbury North Down and Ards uses the term 'people who we support' 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 will seek the views of those living, working and visiting the agency; and review a sample of records to evidence how the agency is performing in relation to the regulations and standards.

RQIA shares this vision and want to review the support individuals are offered to make choices and decisions in their life that enable them to develop and to live a safe, active and valued life. RQIA will review how service users who have a learning disability are respected and empowered to lead a full and healthy life in the community and are supported to make choices and decisions that enables them to develop and live safe, active and valued lives.

Information was provided to service users, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included user friendly questionnaires and an electronic survey for staff.

3.2 What people told us about the service and their quality of life

We spoke to one service user and a number of staff members to seek their views of living, and working within agency. Staff stated the manager was supportive and approachable, they confirmed they received training commensurate to their role and were very happy working at the agency. The service user indicated they were satisfied with the care and support they received and staff treated them with dignity and respect.

Trust staff spoke very highly of the manager and staff at the agency; they described them as having a "very good value system".

3.3 Inspection findings

3.3.1 Governance and Managerial Oversight

The agency's registration certificate was up to date and displayed appropriately along with current certificates of public and employers' liability insurance.

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 a sample of service user' care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

There were processes in place to review the quality of the service on an annual basis. The Annual Quality Report was reviewed and was satisfactory.

There was a system in place to ensure that complaints are managed in accordance with the agency's policy and procedure. Staff demonstrated a good awareness of both the complaints procedure and whistleblowing policy. There was evidence of a system to ensure oversight of complaints; this included a review of complaints during the monthly quality monitoring visits. The Complaints Policy, dated October 2024, required updating to include the correct address for RQIA, the Trust's Complaints Department contact details and those of the Patient Client Council (PCC) and Northern Ireland Public Sector Ombudsman (NIPSO). The manager agreed to revise this policy, this document will be reviewed at the next care inspection.

There was a selection of policies available to direct staff in care delivery and support planning based on individual risk assessments. Staff confirmed they had access to policies.

The service has an operational policy and procedure that clearly directs staff from the agency as to what actions they should take if they are unable to gain access to a service user's home. This policy includes information on how to manage and report such situations in a timely manner.

There was evidence of monthly team meetings following which information was cascaded to staff unable to attend. The manager confirmed staff were provided with updates on policies and additional training requirements. Staff stated they could add to the meeting agenda if there were items they wished to discuss.

3.3.2 Staffing (recruitment and selection, induction and training).

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 meets the needs of service users.

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 the Northern Ireland Social Care Council

(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.

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to the 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, three-day induction programme, which also included shadowing of a more experienced staff member. Written records were retained by the agency of the person's capability and competency in relation to their job role.

All registrants must maintain their registration for as long as they are in practice. This includes renewing their registration and completing Post Registration Training and Learning. Staff said they get an opportunity to discuss the post-registration training requirements during supervision and appraisal meetings.

RQIA is aware of a SAI that is being investigated by the Trust. Whilst RQIA is satisfied that measures have been put in place to reduce the risk of recurrence, RQIA awaits the SAI report, which will be available when the investigation is concluded. This will be reviewed at future inspection to ensure that any recommendations are embedded into practice.

Records of all staff training were available and there were mechanisms in place to support oversight of the training matrix to ensure compliance. It was evident staff had completed additional training in relation to Falls Awareness, which was implemented in response to the learning from a previous, unrelated SAI.

There were no volunteers deployed within the agency.

3.3.3 Care Records

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. Care and support plans were kept under regular review. The manager reported that the Trust did not routinely share the records of these meetings; however there was evidence of the agency contacting the Trust to request the relevant documents. It was evident services users and /or their relatives participate in this process, where appropriate, and a review of the care provided was completed on an annual basis, or when changes occur.

It was also good to note that the agency had service users' meetings, which enabled the service users to discuss the provisions of their care.

The manager reported that a number of the service users currently required the use of specialised equipment. It was evident staff had received training in the use of hoists and other relevant manual handling equipment. The care records accurately reflected the use of specialist equipment.

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.

Service users should have a tenancy agreement outlining basic rights and obligations under the terms of their individual tenancy agreement. The agency supports service users to maintain their tenancy; this includes ensuring arrangements for communication between the 'landlord and tenant' are put into place. This helps to deal with many of common issues that arise (dealing with repairs, neighbour disputes or other matters). A number of service users did not have tenancy agreements in place. Whilst it was evident, the agency had taken some action to address the issue they had not managed to secure tenancy agreements for all service users who required them. A meeting was held following the inspection with the Responsible Individual to seek further information in relation to this matter and agree next steps. As a result, it was agreed, further engagement with all relevant stakeholders was required in order to progress this matter to a satisfactory outcome. These discussions are ongoing.

Financial Support Agreements set out financial arrangements for service users. It was evident following a review of a number of financial support plans that they did not clearly document the income and expenditure for service users. The agreements and plans did not provide details of the amounts agreed for utilities and other services paid by each service user. An area for improvement has been identified.

3.3.4 Safeguarding

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). The agency's annual Adult Safeguarding Position report was reviewed and found to be satisfactory.

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.

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. They could also describe their role in relation to reporting poor practice and their understanding of the agency's policy and procedure with regard to whistleblowing.

The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. A review of records confirmed that these had been managed appropriately.

RQIA had been notified appropriately of any incidents that had been reported to the Police Service of Northern Ireland (PSNI) in keeping with the regulations. Incidents had been managed appropriately.

3.3.5 Deprivation of Liberty Safeguards (DoLs)

The Mental Capacity Act (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 who spoke with the Inspector demonstrated their understanding that service users who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the MCA.

Staff had completed appropriate DoLS training appropriate to their job roles. The manager reported that a number of the service users were subject to DoLS, and the agency maintained a register. The care records did not contain all the appropriate documents and the manager reported they had requested the forms relating to the service users care plans however, the Trust had not provided them. It was therefore difficult to assess if the agency's care plans reflected the MCA care plan. Following the inspection the manager confirmed they would engage with the Trust to address the issues raised during the inspection. This will be followed up at the next inspection.

A number of restrictive practices were employed. The agency did not maintain a restrictive practices register; the manager may wish to consider this suggestion as it would support robust governance and oversight of restrictive practices. The agency was unable to provide evidence of the completion of risk assessments for all restrictions that were in place. An area for improvement has been identified.

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. Where a service user was experiencing a deprivation of liberty, the care records contained details of some assessments completed and agreed outcomes developed in conjunction with the HSC Trust representative; however, financial capacity assessments were not available for service users who had appointees manage their finances. An area for improvement has been identified.

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	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Debora Turkington, Manager, and Mr Stuart Dryden, Responsible Individual, 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 15- (1) (6) (d) **Stated:** First time **To be completed by:** Immediate from the date of inspection	The registered person shall ensure that financial support plans are in place for every service user. Ref: 3.3.3
	Response by registered person detailing the actions taken: Finance support plans are in place for each person we support where we support individuals with their finances. We will work with relevant appointees to seek information to further develop our support plans to include income and expenditure information. If this information is not forthcoming we will refer the matter to the Trust as a potential risk for people we support
Area for improvement 2 **Ref:** Regulation 14 (b) **Stated:** First time **To be completed by:** Immediate from the date of inspection	The registered person shall ensure that restrictive practice and financial capacity assessments have been completed, are available in the service users' care records; and kept up to date. Ref: 3.3.5
	Response by registered person detailing the actions taken: We have advised the Trust of the need to undertake assessments regarding financial capacity and restrictive practices in place to ensure the wellbeing of the people we support. We have been advised there is a waiting list and these will be undertaken in due course. We will regularly raise this with the Trust to understand likely date for completion

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

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