The Regulation and Quality Improvement Authority

# Inspection Report

**Name of Service:** Glanree House Supported Living Scheme

**Provider:** Southern Health and Social Care Trust

**Date of Inspection:** 25 November 2025

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

## 1.0 Service information

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| **Organisation/Registered Provider:** | Southern Health and Social Care Trust |
| **Responsible Individual:** | Mr Steve Spoerry |
| **Registered Manager:** | Mrs Katherine Cairns |

**Service Profile –**

Glanree House Supported Living Scheme is a supported living type domiciliary care agency, located in Newry. The agency provides care and support to enable service users to live in their own home. The care and support is provided by staff employed by the Southern Health and Social Care Trust (SHSCT).

## 2.0 Inspection summary

An unannounced inspection took place on 25 November 2025, between 8.25 a.m. and 2:25 p.m. This was conducted by a care Inspector.

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 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 6 January 2025.

The inspection found that safe, effective and compassionate care was delivered to service users and that the agency was well led. Details and examples of the inspection findings can be found in the main body of the report.

As a result of this inspection, the areas for improvement previously identified were assessed as having been addressed by the provider. No areas for improvement were identified.

## 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 areas 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.

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

We spoke to a number of staff to seek their views of the agency.

Staff spoke very positively about the care delivery and management support in the agency, and the positive impact on service users from teamwork.

## 3.3 Inspection findings

### 3.3.1 Staffing Arrangements

A review of the agency's staff recruitment records confirmed that criminal record checks (AccessNI) were completed and verified before new staff members commenced employment and had direct engagement with service users, however, this was not evident for one staff member whose employment had changed from one regulated service within the Trust to another. This is contrary to RQIA's expectation that this would be completed for every staff member, regardless of whether or not they moved internally within the trust.

There was evidence that all newly appointed staff had 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 agency's policies and procedures. There was a robust, structured, induction programme which also included shadowing of a more experienced staff member.

Checks were made to ensure that staff were appropriately registered with 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.

The agency has maintained a record for each member of staff of all training, including induction and professional development activities undertaken.

Procedures were in place for supervision and for appraising staff performance and staff confirmed that appraisals had taken place. Staff told us they felt supported and involved in discussions about their personal development.

### 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 agency has established a clear record of all safeguarding concerns. This system is well maintained and allows ease of review and trending.

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.

All staff had been provided with training in relation to medicines management. Monthly medication audits have been consistently undertaken. A system for recording actions taken in relation to medication management were clearly recorded.

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.

The agency maintained a restrictive practice register which had clear review periods and evidence on working towards least restrictive practices.

Care and support plans are kept under regular review. Evidence was viewed on inspection of prompt identification of actual or potential issues with proactive management and evaluation.

### 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.

Service user plans also included details of activities offered and undertaken by the individual service users. These included work placements, day opportunities, holiday cruises, concerts as well as meal planning, cookery assistance and visits with family.

### 3.3.4 Care Delivery

There was a handover meeting held at the beginning of each shift, this included the sharing of information about any changes to the service users' care. A document was available for the handover, which was used to communicate any specific information pertaining to service users' care.

Staff were knowledgeable of individual service users' needs, their daily routine wishes and preferences.

Records reviewed evidenced that staff were prompt in recognising service users' needs and any early signs of distress or illness, including those service users who had difficulty in making their wishes or feelings known.

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

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

There has been a change in the management of the agency since the last inspection. Mrs Katherine Cairn has been the manager in this agency since 26 May 2025. They also manage another supported living service. Staff spoken with commented positively about the manager, describing them as "knowledgeable", and "someone who binds the team and makes us look at things from different perspectives". The manager arrangements were discussed at inspection and an application for registration will be welcomed.

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 comprehensive overviews of the service. Each report contained details of a review of accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements. The monitoring officer consistently reviewed action plans and evidenced improvement.

There was a process in place to manage any complaints; the complaints recording was clear, detailed and well maintained. The review of complaints and shared learning was evident.

Review of incident records identified that they were managed appropriately.

The annual quality report was reviewed and noted to include stakeholder feedback.

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

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.

## 4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Katherine Cairns, Manager, as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority

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