The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Lisburn Supported Living Service**

Provider: **Southern Eastern HSC Trust**

Date of Inspection: **21 October 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:	Southern Eastern HSC Trust
Responsible Individual/Responsible Person: -	Ms Roisin Coulter
Registered Manager:	Mrs Claire Shaw (Acting)
Service Profile – Lisburn Supported Living Service is a domiciliary care agency (supported living type) which provides personal care and housing support for up to 13 service users to live as independently as possible within the local community. Services are provided at a number of addresses in the greater Lisburn area. The agency works in partnership with the Northern Ireland Housing Executive's Supporting People programme, the South Eastern Health and Social Care Trust (SEHSCT) and with a number of housing associations.	

2.0 Inspection summary

An unannounced inspection was conducted on 21 October 2025 between 10.25 am and 4.50 pm by a care Inspector.

The inspection was undertaken to assess the level of compliance with regulations and standards in the areas identified within the quality Improvement Plan arising from the previous inspection which took place on 5 November 2024. It also sought to determine if the agency is delivering safe, effective and compassionate care and if the service was well led.

Enforcement action resulted from the findings of this inspection. A number of breaches of regulations and standards were identified. This gave rise to serious concerns regarding: governance arrangements and managerial oversight; staff selection and recruitment arrangements; staff training and inductions; and monthly quality monitoring reports.

A Serious Concerns meeting was held on 13 November 2025 with representatives of the Responsible Individual, and the acting Manager to discuss these shortfalls.

During the meeting the representatives of the Responsible Individual and the acting Manager provided a full account of the actions taken/to be taken in order to drive improvements and ensure that the concerns raised at the inspection were addressed. A robust action plan was also submitted to RQIA after the meeting.

Following the meeting, RQIA decided to allow the Responsible Individual and the acting Manager a period of time to demonstrate that the improvements had been made in a sustained manner. The Responsible Individual's representatives were advised that a further inspection will be undertaken to ensure that any implemented improvements have been sustained.

During this inspection, two areas for improvement identified in the previous inspection relating to staffing arrangements and staff appraisals were assessed as having been met. This is discussed in more detail in Sections 4.1. and 4.5.

As a result of this inspection a further 10 areas for improvement were identified. Details of these can be found in the main body of the report and in the Quality Improvement Plan.

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 Lisburn Supported Living Service. 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.

Throughout the inspection process, inspectors will seek the views of those living, working and visiting the agency; and review/examine a sample of records to evidence how the service is performing in relation to the regulations and standards.

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

As part of the inspection process we spoke to a number of service users, a service user's relative and staff to seek their views of living, visiting and working within Lisburn Supported Living Service. A range of views were obtained regarding the quality of the care and support provided.

Service users we spoke with indicated that they had no concerns in relation to the service and support provided to them. Comments received included:

"I like it, the staff are good and I go to the shops for food".
"I like it and I feel safe".

A relative who spoke with the inspector said that they felt the quality of the service provided had deteriorated in the past five years and expressed concern around compatibility of service users living together, the inconsistency of staff, their training and the impact this had on their loved one.

Staff who spoke with the inspector expressed dissatisfaction in regard to staff shortages, consistent use of agency staff, staff conduct / induction and training arrangements. Staff also raised concerns about the compatibility of services users.

All of these concerns were discussed with the manager who agreed to liaise directly with those concerned and to address any issues raised as part of the action plan to drive improvement.

4.0 Inspection findings

4.1 Staffing 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 were no volunteers deployed within the agency.

An examination of the staffing rotas and discussion with staff and the manager evidenced regular consistent use of agency and bank staff. The manager advised that there was an overall reduction in agency use with some new staff having been appointed as a result of recent recruitment efforts.

The manager gave assurances surrounding safe staffing levels within the service and there was evidence of monthly forward planning to ensure that adequate staffing levels were maintained in order to meet the needs of service users. The manager also evidenced block bookings of regular agency and/or bank staff in an effort to provide a level of consistency for service users. On this basis, an area for improvement identified at the last inspection in regard to staffing arrangements was assessed as met.

Feedback from staff evidenced consistent levels of frustration regarding the adverse impact which regular assisting in induction of new agency staff was having on the time they had to care for service users. Despite efforts to ensure new staff are accompanied by an experienced staff member, staff reported that this did not always happen. Furthermore, staff highlighted challenges associated with the deployment of agency staff such as language barriers, varying skill levels, lack of appropriate training and inadequate engagement of agency staff with service users. An area for improvement has been identified.

A review of the agency's staff recruitment records confirmed that whilst 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, there was limited detail recorded in the recruitment records. For example, it was noted that one staff member's employment history recorded the preceding three years of employment and did not evidence that gaps in employment and reasons for leaving care positions had been robustly explored. An area for improvement has been identified

The inspector was unable to review staff induction records due to staff completing these records whilst on duty. The manager advised that these records are no longer stored in the registered office and were not available for inspection. An area for improvement has been identified. The training arrangements were examined and it was concerning to note that although there was an electronic record of staff training, this contained no information on training modules or staff names. This was discussed with manager and representatives of the Responsible Individual who advised that there are a number of staff with outstanding training in mandatory areas including fire safety. Plans to immediately review the training needs of staff and existing training matrix were outlined and this has been identified as an area for improvement.

There was an electronic matrix to record details of staff who are registered with the Northern Ireland Social Care Council (NISCC). It was concerning to note however that this did not record the expiry date of staff's registration and despite there being a system in place for professional registrations to be monitored by the manager, a staff member's NISCC registration had previously lapsed. An area for improvement has been identified

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 are required to complete adult safeguarding training during induction and every two years thereafter. The storage of induction records outside of the registered office and incomplete training matrix prevented confirmation by the inspector that all staff had completed requisite training in respect to Adult Safeguarding. This shortfall is addressed within the identified area for improvement relating to staff training as referenced within Section 4.1.

Discussions with staff 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. It was concerning to note that there was no centralised record of referrals made to the HSC Trust in relation to adult safeguarding to enable the tracking and trending of any safeguarding concerns arising within the service. Staff advised that any safeguarding referrals completed were accessed on the service user's electronic healthcare record system, Encompass. They confirmed however, that they had not received the necessary training to enable them to ascertain screening outcomes and any protection plans that may arise from Safeguarding referrals. This identified training need is included within the area for improvement relating to staff training referenced within Section 4.1.

Similarly, the agency's governance arrangements for the management of accidents/incidents was also examined and confirmed that although an accident/incident reporting policy and system was in place, the accidents/incidents tracker had not been updated since December 2024. The governance and oversight of both Adult Safeguarding incidents, and accidents/ incidents management was discussed with the manager and representatives of the Responsible Individual at the Serious Concerns Meeting and an area for improvement is identified.

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

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

Staff who spoke with the inspector demonstrated an understanding of their responsibility in identifying and reporting any actual or suspected incidents 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.

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.

There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had their capacity considered and, where appropriate, assessed. 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 a sample 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.

4.4 Management of Care Records and Care delivery

Service users' needs were assessed when they were first referred to the agency and 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 sample of care records were examined within the service user's electronic healthcare record. It was evident that these had been 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.

Staff recorded regular evaluations about the care and support provided. This included information about any changes to the service users' care needs so that staff could assist them as needed. Service user meetings were held on a regular basis which enabled the service users to express their wishes regarding any activities they would like to participate in as well as any issues arising that may affect them. On review of the minutes of service user meetings, it was noted that these were recorded within individual healthcare records and care plans rather than a separate service users' meetings record. An area for improvement has been identified.

4.5 Managerial oversight and Governance

Discussion with the manager confirmed that they have been the acting manager for this service effective from 6 May 2025 and that their substantive post is as the Registered Manager of Down Supported Living Service (RQIA ID: 10754).

The manager informed the Inspector that given the commitments of their substantive role, they could only provide managerial oversight of Lisburn Supported Living Service (RQIA ID: 12180) by way of on-site presence every Tuesday and were otherwise available to staff within Lisburn Supported Living Service via the telephone.

Despite these expected arrangements, it was noted that the manager was not on site at the commencement of the Inspection and while they eventually did attend, they were unable to remain for the duration of the inspection.

An identified staff member who was then tasked with assisting the Inspector in the absence of the manager advised that they had not completed a competency assessment in relation to being left in charge. Staff who spoke with the inspector also commented that they felt the manager was not readily available on occasion to provide guidance and that they did not feel confident that any concerns raised would be addressed. RQIA was therefore not assured that current arrangements allowed for robust and meaningful managerial presence within the service.

This was discussed at the Serious Concerns Meeting on 13 November and an action plan to address the lack of effective managerial presence within the agency on a full time basis was outlined. The Trust advised RQIA at the meeting that a newly appointed manager is to commence within the service on 8 December 2025; it was also agreed that until that time, the current acting manager will be supported by senior Trust management with regard to maintaining effective oversight of the service on a daily basis. RQIA will review managerial arrangements within this service at a future inspection.

A review of the monthly quality monitoring reports for the period June 2025 to September 2025 (inclusive) highlighted persistent and significant levels of dissatisfaction among staff and/or service users with regard to staffing arrangements within the agency and in particular, the ongoing use of agency staff and its impact on service users.

It was noted within one of these reports that one family member described communication within the service as poor and a recurring problem which was exacerbated by the inconsistency of managerial cover and use of agency staff. Staff interviewed by the quality monitoring officer also expressed concerns about the regular use of agency staff, some of whom were less engaged in their interactions with service users and were observed by the monitoring officer using their phone whilst on shift.

Quality monitoring reports also recorded that despite requests from the monitoring officer, no updates had been provided with respect to actions taken to address staffing issues.

These shortfalls were disappointing given that RQIA had previously stressed the importance of ensuring robust monthly monitoring arrangements during an Enhanced Feedback meeting with the Trust on 1 July 2024 following the unannounced inspection of the service on 11 June 2024.

Given these deficits and the shortfalls outlined further above, RQIA was not assured that robust monthly monitoring arrangements were in place so as to enable the manager to quality assure care delivery, identify deficits, and proactively drive service improvements. This was highlighted during the Serious Concerns Meeting on 13 November 2025 and an area for improvement has been identified.

There was a system in place for complaints to be managed in accordance with the agency's policy and procedure. On examination of the management of complaints, it was noted that a recent complaint had not been recorded within a centralised management system and the complaints template did not include an outcomes section in keeping with best practice; an area for improvement has been identified.

An area for improvement identified during the previous inspection related to staff appraisal. A review of the appraisal dates undertaken since the last inspection evidenced that all staff had received an appraisal and on this basis this area for improvement is assessed as met.

Supervision records were not held in the registered office at the time of inspection and were stored off site. This has been identified as an area for improvement.

There was a range of policies available to direct staff in care delivery and support planning based on individual risk assessments.

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. Ten areas for improvement have been identified during this inspection details of which are outlined in the quality improvement plan below and can be found in the main body of the report.

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	6	4

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Claire Shaw (Acting 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 Regulations (Northern Ireland) 2007	
Area for improvement 1 **Ref:** Regulation 13 (b) **Stated:** First time **To be completed by:** immediately from the date of the inspection and ongoing	The Registered Person shall ensure that no domiciliary care worker is supplied by the agency unless they have the experience and skills necessary for the work that they are to perform. This relates to the need for additional checks by the manager to ensure that agency staff have the requisite skills and experience to meet the service user's needs and to promptly review and address any concerns raised regarding their performance and conduct whilst on duty. **Ref: Section 4.1 and 4.5**
	Response by registered person detailing the actions taken: All pre-employment checks and records for all staff commencing employment within the service are conducted through Human Resources and held within Amiqus electronic system. All documetns are downloaded and saved in each individual staff file. Manager decision form and RSSC Progress checklist is to be printed and saved alongside pre employment details in staff files.
Area for improvement 2 **Ref:** Regulation 13 (d) **Stated:** First time **To be completed by:** immediately from the date of the inspection and ongoing	The Registered Person shall ensure that no domiciliary care worker is supplied by the agency unless full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 3 **Ref Section 4.1**
	Response by registered person detailing the actions taken: Prior to commencement of shifts with in the service, the agency provides management with a pre-engagement form advising of complaince of the agency framework for the South Eastern Trust. They also provide a profile with NISCC and trainging details along with a from of ID for all staff. These documents are held on file. Any concerns rasied are highlighted immedicately with the agency and addressed promptly.
Area for improvement 3 **Ref:** Regulation 21 (1) (c) **Stated:** First time **To be completed by** immediately from the date of the inspection and ongoing	The Registered Person shall ensure that the records specified in Schedule 4 are maintained and that they are at all times available for inspection. **Ref: Sections 4.1 & 4.5**
	Response by registered person detailing the actions taken: Records specified in Schedule 4 will be maintained and available for inspection.

Area for improvement 4 **Ref:** Regulation 11 (1) **Stated:** First time **To be completed by** immediately from the date of the inspection and ongoing	The Registered Person shall ensure that all staff who are in charge of the service in the absence of the manager have satisfactorily completed a competency assessment commensurate with that role. **Ref: Section 4.5**
	Response by registered person detailing the actions taken: All senior staff who are in charge of the service in the absence of the manager have completed a competency assessment and which will be reviewed annually. A competency tracker has been devised to show compliance and is regualrly audited.
Area for improvement 5 **Ref:** Regulation 23 (1)(2)(3)(4)(5) **Stated:** First time **To be completed by:** Immediately from the date of the inspection and ongoing	The Registered Person shall ensure that quality monitoring reports are robustly and comprehensively completed in keeping with Regulation; the reports must contain a time bound action plan; and must evidence meaningful and timely review by the manager and the Responsible Person. This should include, but is not limited to, a review of all reports in which there are risks identified surrounding the quality of care provided to service users by agency staff. **Ref: Section 4.5**
	Response by registered person detailing the actions taken: A monthly progress tracker has been implemented to record actions taken against identified issues highlighted in report. A standard operating procedure has been created and implemented to include escalation processes along with an improvement plan for monthly monitoring reports to an include audit process. Information within the monitoring reports are to be inlcuded within the monthly governance reports and shared with senior management.
Area for improvement 6 **Ref:** Regulation 22(8) **Stated:** First time **To be completed by:** Immediately from the date of the inspection and ongoing	The Registered Person shall ensure that a robust system is developed and implemented so as to ensure that every complaint is recorded in keeping with the agency's policy and procedures; the manager should regularly and meaningfully analyse all complaints to identify patterns/trends in order to drive any necessary improvements. **Ref: Section 4.5**
	Response by registered person detailing the actions taken: The complaints form has been revised and updated to include an outcome section to record action taken, timeframes and complainant satisfaction in compliance with the South Eastern Trust policy. All staff will complete the new complaints training. A monthly update will be provided to the Governance Lead.

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (Version 1.1: August 2021)	
Area for improvement 1 **Ref:** Standard 12.8 **Stated:** First time **To be completed by:** Immediately from the date of inspection and ongoing.	The Registered Person shall ensure there is a training and development plan that is kept under review and is updated at least annually reflecting the training needs of individual staff **Ref: Section 4.1** **Response by registered person detailing the actions taken:** All staff were provided with training audit sheets to be returned with completion dates. The training matrix for the service has been reviewed and updated with staff training completion dates. This will be kept under regular review. A monthly update is to be provided to the Governance Lead to record compliance within the monthly Directorate Governance Report.
Area for improvement 2 **Ref:** Standard 12.6 **Stated:** First time **To be completed by:** Immediately from the date of inspection and ongoing.	The Registered Person shall ensure that a robust system is developed and implemented in regard to ensuring that the professional registration of all staff is proactively and effectively monitored. **Ref: Section 4.1** **Response by registered person detailing the actions taken:** Individual records are held for all staff to advise of their professional registration details to include date of renewal. There is a centralised spreadsheet in place including dates which is reviewed monthly.
Area for improvement 3 **Ref:** Standard 10 **Stated:** First time **To be completed by:** immediately from the date of the inspection and ongoing	The Registered Person shall ensure that a robust system is developed and implemented in regard to the oversight of adult safeguarding incidents; and accident / incident analysis and reporting. **Ref: Section 4.2** **Response by registered person detailing the actions taken:** A robust system has been devised to record all accidents / incidents along with action plan and to identify any trends. A monthly datix report will be produced along with a central log for safeguarding. Notifications will be recorded appropiately on the portal.

Area for improvement 4 **Ref:** Standard 1.3 **Stated:** First time **To be completed by:** Immediately from the date of the inspection and ongoing	The Registered Person shall ensure that the minutes of service users' meetings are appropriately stored; these minutes should contain a clear action plan which details all steps being taken by staff to address service user issues / required improvements. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: Service user meeting minutes are stored appropaitely along with a clear action plan detailing necesaary steps to be taken.

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

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