The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Rigby Close Supported Living Service

Provider: Belfast Health and Social Care Trust

Date of Inspection: 11 December 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:	Belfast Health and Social Care Trust (BHSCT)
Responsible Individual/Responsible Person:	Ms Jennifer Welsh
Registered Manager:	Mrs Arlene Kerr
Service Profile: Rigby Close Supported Living Service is a domiciliary care agency, supported living type service operated by the BHSCT, which currently provides care and support to adults with a learning disability. Service users receive care and support in individual and shared accommodation adjacent to or in close proximity to the registered office; a small number of service users live in the local vicinity. Staff are available to the needs of service users 24 hours per day. This organisation also provides floating support to a number of service users who live in the community. RQIA does not regulate these elements of support.	

2.0 Inspection summary

An unannounced inspection took place on 11 December 2025, between 9.45 am and 2pm by a care Inspector.

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, by RQIA, during the last care inspection on 30 December 2024; 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. Improvements were required, however, to ensure the effectiveness and oversight of certain aspects of the agency, such as staff supervisions, the care records; and the recording of safeguarding records.

Service users said that the care and support provided by the agency was a positive experience.

As a result of this inspection the areas for improvement previously identified were assessed as having been addressed by the provider. Full details, including new areas 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 the previous Quality Improvement Plan 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 seek the views of those working for or being supported by the agency; and review/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 told us they liked the staff, describing them as being 'very helpful' and 'always good'. They described being 'well looked after' and how they could speak to the staff if they had any problems.

Staff told us that they had no concerns about the care and support provided; they said that they felt it was good that there were long-serving staff working there, as they can support the service users as they get older.

3.3 Inspection findings

3.3.1 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 was sufficient on duty to meet the needs of the service users.

It was identified that a number of staff currently employed within the agency had been working within the BHSCT in other registered services, before they started working in Rigby Close. It was explained that, given that the staff had been working in the Trust already, an enhanced AccessNI check had not been undertaken, before they started work in Rigby Close.

This was discussed with the manager in relation to the need for the provider organisation to be fully assured they have a robust system in place for completing criminal checks for all staff. RQIA is aware of ongoing discussion between the Department of Health and HSC Trusts in respect of this, and will keep this matter under review.

Employment references were also reviewed. The importance of retaining evidence of the receiving email from which references are received was discussed. This will be reviewed at a future inspection.

Newly appointed staff, had completed a structured orientation and induction, to ensure they were competent to carry out the roles and responsibilities of their job.

Records of all staff training were retained and were noted to be up to date. It was positive to note that where staff compliance fell below 80 percent, the manager implemented an action plan, to address this. Compliance with training was discussed by the manager at weekly governance meetings. Competency assessments were completed, in keeping with the staffs' roles and responsibilities.

Procedures were in place for appraising staff performance. A number of staff did not have regular supervision undertaken in keeping with the provider's policy and procedures. An area for improvement has been identified.

Staff received an appraisal of their performance on an annual basis.

3.3.2 Care Delivery and Management of Care Records

There was a daily handover at the beginning of each shift; this contained comprehensive information, which is important for the staff to know.

Regular staff meetings were held and minutes maintained for staff who may not have been able to attend.

Service users' meetings were held on a regular basis. An area for improvement previously identified in this regard had been addressed by the provider.

Service users' needs were met through a range of individual and group activities. It was reassuring to note that service users were consulted about the activities they preferred, ensuring their views informed and shaped the day-to day activities.

When service users were first referred to the agency, Trust representatives completed a referral form. This contained comprehensive information about the service users' background, medical information and information on their ability level. Discussion with the manager identified, that the agency staff used this referral form, to develop care plans. Whilst, this process forms part of the service users' assessment process, the agency did not have a procedure in place for them to complete an assessment of need, in keeping with the minimum standards. An area for improvement has been identified.

Furthermore, discussion with the manager and a review of records identified that there was a need for Service User Agreements to be developed. An area for improvement has been identified.

A review of the care records evidenced that service users, where possible, were involved in planning their own care and efforts had been made to ascertain service users' preferences and choices around how their support was provided. The care plans also included any advice or recommendations made by other healthcare professionals, such as Speech and Language Therapists (SALT).

Care records were regularly reviewed and updated to ensure they continued to meet the service users' needs. The service users' keyworkers completed an update on the service users on a monthly basis.

Promoting Quality Care (PQC) is regional guidance on the assessment and management of risk in mental health and learning disability services. A core function of mental health and learning disability services is to assess the treatment and care needs of people presenting to them. An integral part of such an assessment is the consideration of risks posed by some people with a mental disorder to either themselves or others. Understanding the level of risk that a service user may present forms part of the service users' overall assessment, nevertheless it is an integral part of formulating an appropriate care package.

Where a service user was under PQC, a Comprehensive Risk and Management Plan was in place. A multidisciplinary review of the PQC had recently been undertaken. Whilst it is the responsibility of the Trust to ensure that multidisciplinary reviews are undertaken on a six monthly basis, advice was given in relation to the need for the manager to track the dates of the PCQ meetings, to ensure that no risks are missed.

It was positive to note that medicines audits had been completed on a regular basis; an area for improvement previously identified in this regard had been addressed by the provider.

3.3.3 Quality of Management Systems

There had been no changes in the management of the agency since the last inspection. Mrs Arlene Kerr has been the manager since 16 December 2020; and she is also the manager of another registered service (short break service). Staff spoken with said that they felt well supported by the management team and described them as being 'very approachable'. One staff member described how they could go to the manager with anything.

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. Whilst there was no indication that safeguarding incidents had not been managed appropriately, the system for recording them were not sufficiently robust. An area for improvement has been identified.

The agency 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. Advice was given in relation to ensuring the reports for the supported living service do not include comments made by staff that are working in the short break unit and visa versa. Advice was also given in relation to the need for the section pertaining to the RQIA QIP to contain meaningful and ongoing review of each area for improvement, to the date of the next inspection.

There was a system in place to ensure that complaints were managed appropriately; and it was good to note that these were reviewed as part of the monthly monitoring visits. An area for improvement previously identified in this regard had been addressed by the provider.

Review of incident records identified that they were managed appropriately. It was evident that incidents were audited on a monthly basis, to ensure that incidents and trends were identified and actioned, as appropriate.

RQIA had been notified appropriately of any incidents in line with requirements; an area for improvement previously identified in this regard had been addressed by the provider.

An annual service user survey had been undertaken. An area for improvement previously identified in this regard had been addressed by the provider.

The annual quality report was due to be reviewed. Following the inspection, this was submitted to RQIA by email and deemed to be satisfactory.

There was evidence that the management team responded to concerns raised with them, and implemented measures to enhance both practice and the quality of service provided.

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	0	4

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Arlene Kerr, 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:** Standard 13.3 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered persons shall ensure that all staff receive regular supervision in keeping with the provider's policy and procedures. Ref: 3.3.1
	Response by registered person detailing the actions taken: The registered person has ensured that all staff receive supervision as per the Belfast Health and Social Care Trust's Policy and Procedures. A supervision schedule has been developed.
Area for improvement 2 **Ref:** Standard 3.2 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that an assessment of need is completed when service users first receive care and support from the agency; this should subsequently be updated to reflect any change in the service users' needs. Ref: 3.3.2
	Response by registered person detailing the actions taken: An assessment of need document has been developed. The registered person will ensure that the assessment of need is completed when service users first receive care and support and then will be updated if any of the service user's needs change.
Area for improvement 3 **Ref:** Standard 4.1 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that Service User Agreements are developed and implemented. Ref: 3.3.2
	Response by registered person detailing the actions taken: The registered person has developed and implemented Service User Agreements.
Area for improvement 4 **Ref:** Standard 10 **Stated:** First time	The registered person shall ensure that a robust system in put in place to centrally record safeguarding incidents. Ref: 3.3.3

To be completed by: Immediate from the date of the inspection	**Response by registered person detailing the actions taken:** The registered person has developed a Safeguarding Incident Register. The regisitered person will ensure that all safeguarding incidents are recorded on the register.

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

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