The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: 53 Ardglass Road

Provider: South Eastern Health and Social Care Trust

Date of Inspection: 12 September 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:	South Eastern Health and Social Care Trust
Responsible Individual/Responsible Person:	Ms Roisin Coulter
Registered Manager:	Mrs Colleen Murray (Acting)
Service Profile: 53 Ardglass Road is a domiciliary care agency, supported living type, located in Downpatrick. Staff provide 24-hour care and support to a number of service users living in shared accommodation. Service users have a range of enduring mental health issues.	

2.0 Inspection summary

An unannounced inspection was conducted on 12 September 2025, between 9.45 a.m. and 8 p.m. 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 areas for improvement identified, by RQIA, during the last care inspection on 9 August 2024. Additionally, the inspection sought to determine if the agency is delivering safe, effective and compassionate care and if the service is 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, staffing levels, staff training, supervision, management of medications, service user records, restrictive practices, complaints management and safeguarding processes.

A Serious Concerns meeting was held on 3 October 2025 with representatives of the Responsible Individual to discuss these shortfalls.

During the meeting the Responsible Individual's representatives provided a full account of the actions taken/to be taken in order to drive improvement in a meaningful and sustained manner.

Following the meeting, RQIA decided to allow the Responsible Individual and the Manager a period of time to demonstrate that the improvements had been made and advised that a further inspection will be undertaken to ensure that the concerns had been effectively addressed.

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

Furthermore, one previous area for improvement was not met and has been stated for a second time. One previously stated area for improvement has also been carried forward to be reviewed at a future inspection.

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 53 Ardglass Road. This included the previous Quality Improvement Plan issued, registration information, and any other written or verbal information received from service users' relatives, staff and the commissioning trust.

Throughout the inspection process, inspectors seek the views of those receiving the service, their representatives and those working in the agency and examine a sample of records to evidence how the agency is performing in relation to the regulations and standards.

Information was provided to service users, their representatives, staff and other stakeholders on how they could provide feedback on the quality of the service. This included questionnaires and an electronic survey.

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

The majority of service users consulted told us that they "get on well with staff" and described them as "approachable" and "helpful". One service user stated, "sure you couldn't get better". Where other service users' perception differed, this was discussed with the person in charge. It was good to note however that service users were aware of the complaints procedures.

Service users told us that they appreciated having their own space. They explained that there was good public transportation links that enabled them to travel into the local town independently. It was positive to note that service users felt empowered to access and attend groups and pursue personal interests within the community, for example, language classes. Service users also described attending group activities organised and facilitated by staff such as, weekly shopping trips followed by coffee shop attendance and a recent go-karting trip.

One service user's representative expressed their gratitude were for the service and the support for their loved one receives. They felt the quality of life provided to their loved one by 53 Ardglass Road was good. Service users' representatives told us that the staff kept them informed following incidents/accidents. The potential allocation of a dedicated keyworker for

service users' representatives to liaise with was discussed with Fiona McVeigh, Community Services Manager for their consideration.

Staff were familiar with the system in place for managing incidents and adult safeguarding events. Staff also spoke about Serious Adverse Incidents which had occurred within the service and the personal impact of these. Feedback from staff indicated that they would like to have greater access to bespoke training in relation to managing risks, and any learning for staff that might arise from such incidents. All staff feedback was discussed with the Manager and Responsible Individual's representatives during and/or following the inspection for consideration and action, as needed.

One allied professionals feedback received advised that "the team do all they can to support the service users". They described good communication when concerns arise regarding the health and wellbeing of service users and outlined the complexity of need of those supported by staff. They told us about collaborative working that occurs between the service and other HSC teams. Professionals consulted told us that they had no concerns regarding the standard of care and support provided to service users within 53 Ardglass Road.

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.

Examination of the staff duty rota, discussions with the person in charge and staff confirmed that the planned number of staff on duty had been adversely impacted on a significant number of occasions due to sick leave and vacant posts. However, review of the staff rota did evidence some recent improvements with regard to maintaining adequate staffing levels. An area for improvement was identified.

The agency's recruitment records were not available on the day of the inspection, as such, one previously stated area for improvement will be carried forward for review at a future inspection.

The person in charge advised that there was a process in place to ensure that newly appointed staff completed a structured orientation and induction, to ensure they were competent to carry out the duties of their job; however, completed induction records were not available for review. This will be reviewed at a future inspection.

Arrangements for the training of staff were also reviewed. There was a lack of effective managerial oversight of staff training compliance with several areas of staff training either not completed or lapsed. Moreover, given the complexity of needs among those service users supported by the service, there was no evidence of bespoke training commensurate with the assessed needs of service users having been provided to staff, for example: mental health awareness; recovery model; drugs and alcohol awareness; or diabetes. Medicines Competency assessments had not been completed for two staff, with inaccuracies also found in information retained by the agency regarding medication training. An area for improvement was identified.

The person in charge stated that competency assessments were undertaken with staff expected to be in charge of the agency in the absence of the Manager. These competency assessments were not available for review and will be reviewed at a future inspection.

While there was a system in place for the formal supervision of staff, there was conflicting feedback from staff regarding the expected frequency. Review of the supervision matrix evidenced a decline in compliance since April 2025; out of 20 supervisions required, 17 had been completed in April 2025, seven completed in June 2025 and none recorded as having been completed in August 2025. An area for improvement has been stated.

3.3.2 Care Delivery

There was a daily handover at the beginning of each shift, which included information about any changes to the assessed needs of service users. While there was evidence of staff meetings, the person in charge acknowledged that these had not occurred as scheduled due to staff absences. Assurances were provided by the person in charge that these would recommence on a regular basis and minutes retained for staff who are unable to attend. This will be reviewed at a future inspection.

Service users' needs were met through a range of individual and group activities. Activities information was evident on whiteboards throughout the property. However, some of this information was repetitive and staff confirmed that it was not regularly updated. The need to ensure that this information is kept under regular and meaningful review for service users was stressed.

Service users spoke positively about the activities that took place such as: shopping, visiting local cafes, attending cultural events and group outing such as go-karting. However, discussion with the person in charge and staff highlighted that service users had been negatively impacted due to staff sickness and vacancies, for example, cancelled outings. Review of the service rota and incident tracker also highlighted 27 instances of "service disruption" due to inadequate staffing levels since July 2025.

Staff interactions with service users were observed to be friendly and supportive. Staff were skilled in communicating with service users. They also possessed a good understanding of how to recognise symptoms associated with mental health diagnosis; they were respectful, sensitive and patient. Observations of engagement between a service user and staff demonstrated them responding in a calm manner, permitting the individual who was becoming distressed time to self-regulate.

It was observed that staff respected service users' privacy by their actions such as knocking on doors and seeking consent before entering, actively seeking their views and opinions and discussing service users' care in a confidential manner.

For service users requiring assistance in managing their food stocks, the staff assisted by undertaking daily food checks to ensure that the food was always in date and that the fridge was maintaining the optimum temperature to keep the food safe for eating.

There were also robust arrangements in place for service users requiring assistance with medicines management.

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.

Whilst evidence was available that consent and service agreements were in place it was found that these were not kept under regular or meaningful review. This was identified as an area for improvement.

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

Whilst care plans were in place, these often lacked sufficient detail. For example, management of symptoms associated with diagnosis of paranoid schizophrenia failed to include any reference to encouraging compliance with prescribed medication, monitoring compliance and, failed to outline relapse indicators and direct staff as to when external intervention would be required. In relation to another service users' support and risk plan, information relating to the safe and effective management of their diabetes was inadequate.

Records reviewed evidenced that some care interventions had no corresponding risk assessment in place. For example, 'eyes on supervision' in the use of electrical equipment and two staff being required to enter a service user's room. The importance of evidencing the necessity and proportionality of such interventions was stressed with the person in charge. An area for improvement has been stated in regard to service users' care plans.

The agency did not have a restrictive practice register in place. It was also found that service users' who were subject to restrictive practices did not have these interventions clearly highlighted within their plans. There was no evidence that restrictive practices were kept under review to ensure they were not used disproportionately or for longer than is necessary.

Further concerns relating to restrictive practice were identified in relation to the storage and management of medications. The majority of service users were identified by staff as requiring full assistance with managing their medicines. This was despite no individual assessments having been completed to determine the level of support required in relation to safe management of medications. Medicines for all service users were stored in a locked office and service users were observed queueing for their medicines to be administered. This practice is not in keeping with the ethos of supported living and concerns were discussed with the person in charge. This was identified as an area for improvement.

3.3.4 Quality of Management Systems

There has been a change in the management of the agency since the last inspection. Mrs Colleen Murray has been the Acting Manager in this agency since 6 January 2025; an application to register the Manager has been received and is ongoing.

Despite the Registered Manager having been on a period of continuous absence since 4 August 2024 RQIA had not been notified in keeping with the Regulations; this deficit had been previously identified as an area for improvement during an unannounced care inspection

conducted on 9 August 2024. Furthermore, discussion with staff evidenced that there was no designated person in charge of the service on a daily basis in the absence of the Registered Manager. An area for improvement has been stated for a second time.

Processes relating to management of complaints were found to require improvement. There was evidence of feedback having been received by the agency for which management of matters raised should have been considered under complaints procedures. The complaints log was found not to be up-to-date. An area for improvement was identified.

The system in place for managing medicines related incidents was noted to be inadequate. An area for improvement was identified.

A review of adult safeguarding records highlighted that these were disorganised and lacked clarity. It was also concerning that some protection plans were insufficiently person centred and failed to accurately and comprehensively reflect identified risks. Feedback from staff also highlighted the need for improvement in relation to how potential adult safeguarding incidents are screened by staff in keeping with best practice. An area for improvement was identified.

It was noted that monthly monitoring reports for the period August 2024 to August 2025 were unavailable on the day of inspection as required by the Regulations. This area for improvement had been stated for a third and final time during the previous unannounced inspection conducted on 9 August 2024.

As such, RQIA was not assured that robust governance arrangements were in place so as to enable the Responsible Individual and Registered Manager to quality assure care delivery, identify deficits, and proactively drive service improvements. This deficit was discussed during the Serious Concerns meeting on 3 October 2025 and assurances received; however, it was stressed to the Responsible Individual's representatives that future non-compliance in regard to this issue may lead to further enforcement action.

The annual quality report required by the Regulations was not available during the inspection; staff stated it had not been completed by the Agency. 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	7*	5

* the total number of areas for improvement includes one that has been stated for a second time, one stated for a fourth and final time and one which has been carried forward for review at the next inspection

Areas for improvement and details of the Quality Improvement Plan were discussed with Fiona McVeigh, Community Service 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(a) (b) (c) (d) Schedule 3 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The Registered Person shall ensure that no domiciliary care worker is supplied by the agency unless – (a) He is of integrity and good character; (b) He has the experience and skills necessary for the work that he is to perform; (c) He is physically and mentally fit for the purposes of the work which he is to perform; and (d) Full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 3. This relates specifically to ensuring that AccessNI checks are completed for all staff supplied by the agency prior to commencement of employment. Ref: 2 and 3.3.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref:** Regulation 27 (1)(b) **Stated:** Second time **To be completed by:** Immediate and ongoing from the date of inspection	The Registered Person shall ensure that RQIA is notified of any absence of the registered manager lasting longer than 28 days. Ref: 2 and 3.3.4
	Response by registered person detailing the actions taken: The Senior Manager will oversee the appointment of an Interim Manager in the absence of the substantive Manager beyond a absence of 3 weeks and communicate this through the RQIA portal. There is an Interim Manager in place currently.
Area for improvement 3 **Ref:** Regulation 16 (1)(a) **Stated:** First time **To be completed by:** 29 December 2025	The Registered Person shall ensure that there is a robust system in place for the Manager to regularly and meaningfully determine and review safe and effective staffing levels. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Registered Manager will review staffing levels a minimum of weekly, ensuring adequate skill mix and safe staffing levels, escalating to Senior Management as required. There is a well established process of recruitment of staff through bank shifts, expression of interest and agency use if required. This process is

	also followed by the senior support staff on duty in the absence of the Manager.

Area for improvement 4 **Ref:** Regulation 16 (2)(a) **Stated:** First time **To be completed by:** 29 December 2025	The Registered Person shall ensure that training provision corresponds to the presenting needs of service users to assure safe delivery of care and support. The agency is to ensure an efficient system is utilised to monitor training compliance and this is reviewed on a regular basis. Ref: 3.3.1
	Response by registered person detailing the actions taken: Service User needs have been reviewed and training planned to upskill staff in those co-morbilities outlined by assessment. Such training includes Diabetic Awareness and The Management of Hypaneutraemia. There is a commitment to sourcing training as and when identified. There is an electronic Training Matrix in place with clearly defined Mandatory and Best Practice training. The Manager audits this monthly to monitor compliance.
Area for improvement 5 **Ref:** Regulation 15(2)(b)(c) **Stated:** First time **To be completed by:** 31 October 2025	The Registered Person shall ensure service user plans contain all necessary information to adequately and safely respond to identified needs and presenting risks. This is to include interventions such as the use of any restrictive practices. Ref: 3.3.3
	Response by registered person detailing the actions taken: Restrictive practices are clearly detailed both within the Service User support plans and a Restricted Practice Register. Engagement and agreement with the practice will be evidenced by the Service Users signature, reviewed a minimum of annually.
Area for improvement 6 **Ref:** Regulation 22 (8) **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The Registered Person shall ensure that all complaints received are responded to according to the agency's' policy and procedure and an appropriate record is retain to enable analysis of any developing patterns and/or trends. . Ref: 3.3.4
	Response by registered person detailing the actions taken: Complaints records are now contained within a folder with clear monthly division and an overarching template for that month detailing the complaint and any action taken. This is further audited monthly by the Registered Manager and forms part of the Monthly Monitoring Report carried out by the Senior Manager.
Area for improvement 7 **Ref:** Regulation 15(12)(a)	The Registered Person shall ensure written records kept of all safeguarding concerns and include details of any investigations completed, the outcome and action taken by the agency are well

Stated: First time **To be completed by:** Immediate and ongoing from the date of inspection	organised. Protection plans developed by the agency in association with a safeguarding concern are to be personalised and see any required updates made to the service users care and risk plans. Ref: 3.3.4
	Response by registered person detailing the actions taken: Original records of APP1's and the screening are contained within Encompass. Copies of the APP1's are printed and contained within a safeguarding folder, divided into each month. There is an overarching summary template per month, detailing the APP1, the screening outcome and any agreed protection plan. These incidents are audited monthly by the Registered Manager and form part of the Monthly Monitoring Report carried out by the Senior Manager.

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:** 31 October 2025	The Registered Person shall ensure all employees receive appropriate and regular supervision associated with their role. Ref: 3.3.1
	Response by registered person detailing the actions taken: Social care support staff receive individual supervision 8 weekly with group supervision 4 weekly. There is a clear supervision schedule detailed within the electronic shared Supported Living folder, accessible to all staff within Ardglass Rd.
Area for improvement 2 **Ref:** Standard 4.2, 4.3 **Stated:** First time **To be completed by:** 31 October 2025	The Registered Person shall ensure relevant written service agreements are in place and contain all necessary details. These agreements should be kept under review. Ref: 3.3.3
	Response by registered person detailing the actions taken: Service agreements have been reviewed and updated for every Service User. These are presented to each new Service User at a commitment meeting alongside the Tenancy.
Area for improvement 3 **Ref:** Standard 7.3, 7.4 **Stated:** First time **To be completed by:** 29 December 2025	The Registered Person shall ensure a person-centred assessment of need is undertaken for each service user specifically surrounding level of support required with the management of medication. Where restrictive practice is required, associated risks and interventions agreed by the multidisciplinary team involved must be clearly detailed in service users plans. The agency must retain a restrictive practice register and keep these under regular review in compliance with the Regional Policy on the use of Restrictive Practices in Health and Social Care Settings. Ref: 3.3.3
	Response by registered person detailing the actions taken: A scoping exercise of Medication assessment tools has taken place. An extensive Medication Policy specific to Mental Health Supported Living is nearing completion to include a tool to assess compliance and the level of support required from staff.This support will then be detailed within the support plan and kept under review with clearly defined timesclaes.
Area for improvement 4 **Ref:** Standard 7.5, 7.6 and 7.13	The Registered Person shall ensure there are robust policies and procedures in place to direct practice relating to the safe management of medication. This is particularly applicable regarding the management of medication errors. Records relating to medication errors and

Stated: First time **To be completed by:** 29 December 2025	action taken as a result are to be available for the purpose of inspection. Ref: 3.3.4
	Response by registered person detailing the actions taken: There is a detailed Medication policy nearing completion specific to mental health supported living.All incidents, to include medication incidents, are recorded, reviewed and approved via Datix and available for viewing on the Datix system. Manual copies are also contained within a Datix folder, audited monthly by the Registered Manager and Senior Manager during the Monthly Monitoring visit. A report of these incidents is composed by the governance team and discussed with the Registered Managers monthly.
Area for improvement 5 **Ref:** Standard 8.12 **Stated:** First time **To be completed by:** 29 December 2025	The Registered Person shall ensure that the quality of the agency is evaluated on, at least, an annual basis and follow-up action is taken as required. Ref: 3.3.4
	Response by registered person detailing the actions taken: An annual quality report has commenced based on the feedback from Service Users and Carers and review of the Monthly Monitoring reports. The final report will be completed in Apr 2026.

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

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