The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Triangle Housing Association

Provider: Triangle Housing Association

Date of Inspection: 3 February 2026

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:	Triangle Housing Association
Responsible Individual:	Mr Christopher Harold Alexander
Registered Manager:	Miss Martina Donaghy

Service Profile –

Triangle Housing Association is a domiciliary care agency, supported living type which provides 24 hour care and support to four individuals who have a range of complex needs. The service users have individual bedrooms and a range of shared facilities. The Belfast and South Eastern Health and Social Care Trusts (HSCT) commission the care provided.

2.0 Inspection summary

An unannounced inspection took place on 3 February 2026 between 10.50 am and 2.10 pm. A care inspector conducted the inspection.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; and to assess progress with the area for improvement identified, by RQIA, during the last care inspection on 12 February 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 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.

It was evident that staff promoted the dignity and well-being of service users and that staff were knowledgeable and well trained to deliver safe and effective care.

As a result of this inspection, an area for improvement previously identified has been assessed as met. Details of a new area for improvement identified can be found in the report and in the Quality Improvement Plan (QIP) in Section 4.

The inspector would like to thank the manager, service users, relatives and staff for their help and support in the completion of the 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 this agency. This included the 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 Rusheyhill Road; and review 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 User Friendly questionnaires and an electronic survey.

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

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans. We spoke to a range of service users, relatives and staff to seek their views of living within, visiting and working in the supported living service.

Service users were observed to be supported by staff with whom they appeared comfortable. One service user described staff as "brilliant" while others indicated that they liked living there and the house was quiet.

A relative told the inspector that staff were very good and always communicate well.
Staff spoke positively about the support offered by management. They confirmed that staffing was good and that induction was thorough. A Trust representative praised the input of management and staff as they encouraged and supported a service user to settle into the service.

The information provided indicated there were no concerns about the agency.

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 evidence of robust systems in place to manage staffing.
Staff said there was good communication between the manager and staff, and that they felt well supported in their role.

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.

Staff said there was good communication between the manager and staff, and that they felt well supported in their role. Observation during the inspection evidenced that there was enough staff present to respond to the needs of the service users in a timely manner.

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to the Northern Ireland Social Care Council's (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. The induction programme also included shadowing of a more experienced staff member until confidence and competence were achieved. Written records were retained by the agency of the person's capability and competency in relation to their job role.

Records of all staff training were retained and were noted to be up to date. Staff commented positively about the training they receive.

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 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 and 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.

Staff were required to complete adult safeguarding training during induction and every two years thereafter. Staff who spoke with the inspectors 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.

The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding

The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI). The review of information relating to incidents that had occurred indicated that one incident involving a referral to the PSNI had not been reported to RQIA in accordance with legislation. This matter is an area for improvement.

Staff were provided with Moving and Handling training appropriate to the requirements of their role. The manager reported that none of the service users currently required the use of specialised equipment. They were aware of how to source such training should it be required in the future.

All staff had attended training in relation to medicines management. The manager advised that no service users required liquid medicine to be administered orally with a syringe. The manager was aware that should this be required; a competency assessment would be undertaken before staff undertook this task.

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. Staff had completed appropriate Deprivation of Liberty Safeguards, (DoLS) training appropriate to their job roles. 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 assessments completed and agreed outcomes developed in conjunction with the HSC Trust representative.

3.3.3 Care Delivery and the management of care records

There was a daily handover at the beginning of each shift, which included information about any changes to the service users' care. Staff were knowledgeable in respect of individual service user's daily routine, wishes and preferences. There was a system in place that the activities offered to service users were tailored towards their individual needs and preferences. Service users' needs were met through a range of individual activities, including shopping trips and visits to family. Staff were observed to be prompt in recognising service users' needs. Staff were skilled in communicating with service users; they were respectful, understanding and sensitive to the needs of the service users. 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 and included any advice or recommendations made by other healthcare professionals.

Care records were person centred, well maintained, regularly reviewed, and updated to ensure they continued to meet the service users' needs. A review of a sample of care records evidenced that service users, where possible, were involved in planning their own care and

efforts had been made to ascertain service user's preferences and choices around how their support was provided. The details of care plans were shared and signed by service users and/or their representatives as appropriate.

Care reviews had been undertaken in keeping with the agencies policies and procedures. There was also evidence of regular contact with service users and their representatives, in line with the commissioning Trust's requirements.

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

3.3.4 Quality of Management Systems

There has been no change in the management of the agency since the last inspection. Mrs Martina Donaghy has been registered manager since 10 April 2017.

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 service user care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements. The inspector noted that the incident referred to in section 3.3.3 was not mentioned in the monthly monitoring report; monthly monitoring reports will be reviewed at a further inspection to check that incidents referred to PSNI are included for review and /or action.

The Annual Quality Report was reviewed and was satisfactory.

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 along with current certificates of public and employers' liability insurance.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Where complaints were received since the last inspection, these were appropriately managed and were reviewed as part of the agency's quality monitoring process.

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

4.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	1	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Martina Donaghy (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 Regulations(Northern Ireland) (2007)	
Area for improvement 1 **Ref:** Regulation 15.12,(b)(1) **Stated:** First time	The Registered Person shall ensure the Regulation and Improvement Authority to be notified of any incident reported to the police, not later than 24 hours after the registered person has reported the matter to the police Ref: 3.3.2
To be completed by: Immediate and ongoing	**Response by registered person detailing the actions taken:** The registered person will ensure that incidents that are reported to the police are also reported to the regulation and improvement authority within 24 hours of reporting it to the police.

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

The Regulation and Quality Improvement Authority

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James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews