The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Supported Living North Down & Ards

Provider: South Eastern HSC Trust

Date of Inspection: 28 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:	South Eastern HSC Trust
Responsible Individual/Responsible Person:	Ms Roisin Coulter
Registered Manager:	Mr Michael Hutchinson (Acting)
Service Profile: Supported Living North Down & Ards aims to provide a supported living environment for adults diagnosed with a Learning Disability to support them to live in the community. Properties are dispersed across North Down and Ards area, with all 23 service users tenants of the properties in which they live. The service is commissioned by South Eastern Health and Social Care Trust (SEHSCT).	

2.0 Inspection summary

An unannounced inspection was conducted on 28 October 2025, between 10.30 a.m. and 4.20 p.m. by a care Inspector.

The last care inspection of the agency was undertaken on 15 October 2024 by a care Inspector. No areas for improvement were identified. This inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that improvements were required to ensure the effectiveness and oversight of certain aspects of the agency such as manager oversight and presence, staff induction and training, the use of agency staff, staff supervision and appraisal, incident management, safeguarding procedures, service user plans, safe storage of information, maintenance of a safe environment and monthly monitoring arrangements.

Enforcement action resulted from the findings of this inspection.

A Serious Concerns meeting was held on 14 November 2025 with representatives of the Responsible Individual and with 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 improvement and ensure that the concerns raised at the inspection were addressed. A robust action plan was also submitted.

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 and advised that a further inspection will be undertaken to ensure that the concerns had been effectively addressed.

As a result of this inspection 18 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 service 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 Supported Living North Down & Ards. This included, 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 being supported by and working for the agency; and 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

Through active listening, RQIA aims to ensure that the lived experience of service users is reflected in our inspection reports and quality improvement plans.

Two service users provided consent for us to visit their home. One service user was observed to be relaxing in a lounge area along with staff. They appeared comfortable in the presence of staff. This service user explained that they had their own areas within the property which they shared with a co-tenant. The service user said that they were happy in their home and with the staff that supported them.

Another service user returned home a short time later from a local day care setting that they attend during the week. Observations of interactions between them and staff on duty was positive; they immediately came in and greeted staff, sought assurances, which was provided by staff. The service user told the Inspector that they liked staff. They explained that they were planning to go out with staff later to a local park for a walk.

Service users consulted stated that they enjoy trips within the local community with one service user stating that their favourite activity was go to coffee shops.

Service users described how staff helped them with “cooking, cleaning, everything really”. One service users had also attended a Halloween disco, with staff supporting them to acquire a wear a Halloween costume. The service user told the Inspector that they had won ‘best costume’ at the event.

Staff stated that staffing levels within the service have been challenging for some time. Staff stated that some agency staffs’ lack of knowledge surrounding service users and local procedures had increased the workload of substantive staff. Staff stated that poor communication abilities and/or inadequate skill levels among some agency staff had the potential to adversely impact the quality of care delivery to service users. Staff also stated that felt improvement would be achieved with greater consistency in staffing.

Despite staffing difficulties, staff told us that they were proud of the work completed by the team and considered that care they provided was of a very good standard. Discussion with staff evidenced that they possessed a comprehensive knowledge of the service users they supported. One staff member spoke confidently regarding a service user’s positive behavioural support plan (PBSP), demonstrating awareness as to known triggers and prescribed interventions to reduce the individual’s experience of anxiety/distress.

Staff also used resources which they had created to aid new staff during their induction and to help inform those staff regarding individual service user’s routines/behaviours; however, the detail contained within these resources was not consistently evident within service user’s care plans. Issues relating to service user plans is detailed within section 3.3.3 of this report.

Interactions observed between staff and service users was positive. Staff demonstrated respect when speaking with the service users they were supporting and were actively seen promoting choice.

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.

The Acting Manager was not available at the registered office at the start of the inspection. When the Acting Manager arrived they advised they had been providing staff cover at another location within the service due to unforeseen staff absence. We were advised by the Acting Manager that the service had been experiencing staffing challenges due to absences, increased service user need and recruitment difficulties.

The Acting Manager acknowledged that the quality of managerial oversight within the service had been negatively impacted as a result of these staffing challenges. An area for improvement was identified.

Due to the aforementioned staffing challenges, the service was utilising agency staff from other domiciliary care agencies in order to maintain staffing levels. Documentation relating to agency staff was not up to date nor did profiles retained contain accurate employer information. An area for improvement was identified.

Review of governance records identified that one staff member currently employed within the agency had transferred internally by means of an expression of interest without an enhanced AccessNI checks having been completed. There was discussion with the Acting Manager about the need to ensure that robust selection and recruitment of staff is maintained at all times.

There was a process in place for newly appointed staff to complete a structured orientation and induction, to ensure they were competent to carry out the duties of their job; however, induction records were not retained within the personnel folders reviewed. Information submitted following the inspection evidenced noncompliance with the agency's own induction procedures. An area for improvement has been identified.

The agency's training arrangements were examined and although an electronic record of staff training was maintained the Acting Manager advised that this had not been kept under review. It was also noted that records relating to the mandatory training of staff was either incomplete and/or evidenced significant levels of non-compliance. An area for improvement was identified.

Deficits were also noted in regard to competency assessments for staff such as: the management of medications, and being in charge in the absence of the Manager. An area for improvement was identified.

Staffs' personnel folders were unavailable during the inspection as they were not retained within the registered address of the Agency. An area for improvement has been identified.

Personnel folders that were made available for review evidenced that supervision was not being provided on a regular basis in line with the organisation's policy. An area for improvement has been identified.

Although procedures were in place for appraising staff performance, records evidenced that this was not being adhered to. Furthermore, there was no system in to highlighted non-compliance, for example it was not recognised that an employee had not received an appraisal since 2023. An area for improvement has been identified.

3.3.2 Care Delivery

There was a handover at the beginning of each shift, which included information about any changes to service users' care, which helped to inform staff when providing care. There was evidence of small cohorts of staff meeting to discuss specific service users however lack regular staff meetings occurring, the Acting Manager provided assurances that staff meetings had now been scheduled. This will be reviewed at a future inspection.

It was positive to observe that staff respected service users' privacy by their actions such as knocking on doors before entering, discussing service users' care in a confidential manner, and by offering personal care to service users discreetly. Staff were observed to promote service user autonomy, ensuring choice was provided in relation to activities.

Staff interactions with service users were observed to be friendly and supportive. Staff were observed providing support with domestic tasks such as food preparation and cleaning. The interactions observed illustrated that staff were skilled in communicating with service users; they were respectful, understanding and sensitive to service users' needs.

Where service users displayed behaviours which may be considered challenging, staff spoke knowledgably about PBSPs prescribed. The staff demonstrated awareness as to one service user's known triggers and were seen to proactively intervene in order to minimise the service user's experience of anxiety.

There were personalised activity planners completed with service user's involvement where possible evident in service users' home. It was also positive to note that these were updated were a change had occurred. Activities engaged in were varied and reflective of the service user's interests and likes, for instance regular visits to a local park to feed ducks. Service users were supported to complete elements of everyday living such as completion of household shopping as well as larger events such as holidays.

3.3.3 Management of Care Records

Service users care records were not stored appropriately to ensure confidentiality in keeping with best practice. An area for improvement was identified.

Service user agreements and consent forms were not available for review during the inspection. The Acting Manager advised that hard copies of these were retained solely within service users' folders kept in service users' homes. Expectations outlined within Regulations as to records to be available for the purpose of inspection were again discussed and suggestions provided as to how to achieve this in a dispersed service. This shortfall is addressed within the identified area for improvement relating to records as referenced within Section 3.3.1.

It was concerning to note that the Acting Manager was unable to confirm which specific records were being completed by staff to direct care delivery to service users. In addition, a review of a sample of service users' care records highlighted that these were either contradictory, lacking detail and/or incomplete. Feedback from the Acting Manager highlighted inadequate arrangements in place so as to enable quality assurance of service user records on a regular basis. An area for improvement was identified.

Review of a sample of service users' care plans and risk assessments evidenced that these inadequately reflected restrictive practices and/or agreed Deprivation of Liberty (DoLs) arrangements in place.

The Agency's restrictive practice register contained duplicate and generic entries that did not appropriately reflect restrictions in place for individual service users.

In addition, requested DoLs documentation was unable to be retrieved by the Acting Manager during the inspection. An area for improvement was identified. Upon receipt of DoLs documentation following the inspection direction was provided for the service to liaise with SEHSCT Adult Safeguarding Team.

3.3.4 Quality and Management of the Environment

Service users provided consent for the Inspector to visit them within their homes. It was positive to observe that the property was personalised and reflective of each individual's own interests. The service users themselves had selected the décor and furnishing.

Concerns were shared following observation of fire doors being wedged open. An area for improvement was identified. Discussion occurred with the Acting Manager regarding fire safety practices and risks associated with fire doors being wedged open specifically as one service user's bedroom was located on the third floor of the property. Immediate action was taken and the Acting Manager provided assurances that there was a Personal Emergency Evacuation Plan (PEEP) in place.

Staff communicated concerns regarding staff facilities describing them as "poor" and "inadequate". Observation of one staff room found it to be cluttered, containing disused and broken items that staff advised had been intended to be discarded.

While Monthly monitoring reports identified environmental deficits within the service, there was no evidence that these had been addressed in a meaningful, timely and/or effective manner. An area for improvement was identified.

During the Serious Concerns meeting on 14 November 2025 representatives of the Responsible Individual and the Acting Manager were asked to complete a review of the quality of the living environment of all service users supported by the service by 21 November 2025. Assurances were provided and will be considered at a future inspection.

3.3.5 Quality of Management Systems

There has been a change in the management of the service since the last inspection. Mr Michael Hutchinson has been the Acting Manager in service since 13 January 2025. An application has been submitted by Mr Michael Hutchinson to become registered manager for this service; assessment of this application remains ongoing.

Those staff consulted with described the Acting Manager as approachable. Interactions observed between service users and the Acting Manager were friendly and service users appeared comfortable speaking with him.

While there was a complaints policy and procedure in place, review of records evidenced that this was not consistently adhered to by staff. Additionally, the agency had no system in place to enable meaningful review and analysis of complaints received. An area for improvement was identified.

The agency's governance arrangements for the management of accidents/incidents was also examined and confirmed that although an incident/accident reporting policy and system was in place, it had not been updated since May 2025. An area for improvement was identified.

Domiciliary Care Agencies are required to have a person known as the Adult Safeguarding Champion (ASC), who has responsibility for implementing the regional protocol and the setting's adult safeguarding policy.

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. The person in charge advised that any safeguarding referrals completed were accessible on the electronic healthcare record system, Encompass. Total number of referrals, screening outcomes and any protection plans that may have arisen from safeguarding referrals made were unable to be ascertained. The governance and oversight of both Adult Safeguarding incidents was discussed with the Acting Manager and an area for improvement was identified.

There was no documentation available to evidence that the agency had sufficient governance arrangements in place to ensure the safe handling and management of service user's monies or medications. The lack of finance and medication audits was discussed with the Acting Manager during the inspection and an area for improvement was identified.

Although quality monitoring visits, had been undertaken on a monthly basis, review of these records did not provide assurance that the quality of care delivery and service provision was being robustly and consistently quality assured. An area for improvement was identified.

4.0 Quality Improvement Plan/Areas for Improvement

15 areas for improvement have been identified where action is required to ensure compliance with the Regulations and three areas for improvement have been identified to ensure compliance with the Standards.

	Regulations	Standards
Total number of Areas for Improvement	15	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Michael Hutchinson, Acting Manager, as part of the inspection process.

Further discussion occurred during the Serious Concerns meeting on 14 November 2025 with representatives of the Responsible Individual who provided assurances as to the plans in place to address areas for improvement identified.

Quality Improvement Plan

Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007	
Area for improvement 1 **Ref:** Regulation 11(1) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure the registered manager maintains a meaningful and sustained managerial presence within the agency to provide effective managerial and governance oversight. Ref: 3.3.1
	Response by registered person detailing the actions taken: New interim manager in post , also Interim Deputy Manager in post. Oversight from management is in place to include governance of the service as a whole scheduled Audits and supervsions compliant. Managers timetable for the week ahead has been compiled and shared weekly. Manager also places a message out to staff on chats to advise of location and how to contact if out of office.
Area for improvement 2 **Ref:** Regulation 13 (a), (b), (c), (d) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	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. This is inclusive of those supplied by an alternative agencies. Ref: 3.3.1
	Response by registered person detailing the actions taken: All agency staff employed within the service are required to have met the threshold of the organisational Job description. This is shared with the agency prior to commencing employment. A profile outlining the individuals training, experience is recived and verified by the manager. Local induction documents are held locally on site and copy to online shared folder for all to review moving across locations. Recruitment of new staff - all information is shared and a checklist is completed by manager detailing the date access NI and references are reviewed and approved by manager prior to agreed start date.

Area for improvement 3 **Ref:** Regulation 16 (5)(a) **Stated:** First time	The Registered Person shall ensure that all care staff are provided with an appropriately structured induction with records of the induction retained. Ref: 3.3.1
To be completed by: 14 November 2025	**Response by registered person detailing the actions taken**: Inductions are in place for staff , collective induction was provided to a team of agency staff, records of such are held locally and on the online shared folder.Records are maintained for staff within the service of when there organisational induction took place on commencement of post on the training matrix for review.
Area for improvement 4 **Ref:** Regulation 16(2)(a) **Stated:** First time	The Registered Person shall ensure there is a robust system to maintain adequate oversight of staff training assuring provision to each employee of training requisite per role. Ref: 3.3.1
To be completed by: 31 December 2025	**Response by registered person detailing the actions taken:** Monthly audit tool is in place and reviewed monthly for action by Manager and deputy Manager. This is then sent to senior staff for discussion with those they supervise and organise within a timely manner. Manager meets with band 5 staff and addresses the band 5 staff based on this audit also. New Matrix has been designed to calculate complaince and is RAG rated.
Area for improvement 5 **Ref:** Regulation 15(7) & 16(d) **Stated:** First time	The Registered Person shall ensure competency assessments are completed and retained; this should include competency assessments in regard to: being in charge in the absence of the Manager and the administration of medicines. Ref: 3.3.1
To be completed by: 31 December 2025	**Response by registered person detailing the actions taken:** Tracker has now been created in relation to finance, medication and band 5 competencies.This is audited and reviewed by the manager to ensure complaince monthly. Band 3 Medication and finance competencies are reviewed alongside band 5.

Area for improvement 6 **Ref:** Regulation 21(1) (c) **Stated:** First time **To be completed by:** 5 December 2025	The Registered Person shall ensure that the records specified in Schedule 4 are maintained and that they are at all times available for inspection at the agency premises by any person authorized by the Regulation and Improvement Authority. Ref: 3.3.1 & 3.3.3
	Response by registered person detailing the actions taken: Care records are being transferred to current encompass systems and transferred to grab files in each facility. Audit of the care plans is set monthly to review appropriate actions/updates are reflected following any MDT or review decsions.
Area for improvement 7 **Ref:** Regulation 21(1)(a) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure records specified in Schedule 4 are maintained, and that they are kept in good order and in a safe and secure manner. Ref: 3.3.3
	Response by registered person detailing the actions taken: Audit is comlpeted of care plans held on encompass system, grab files within facilities to ensure service users needs are met within facilities , when updated this can be printed and reviewed by staff. Any changes to a service users care is shared via a memo to staff to be read and signed at handover in each facility. This information is also held within shared folder for the purpose of on call.
Area for improvement 8 **Ref:** Regulation 15 (2)(a)(b)(c) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that each service user has robust plans in place that specify the service user's needs and how those needs are to be met by the provision of prescribed service. Ref: 3.3.3
	Response by registered person detailing the actions taken: Encompass care plans refelct current care provision of individuals. NISAT now being completed by community teams. Service specific training dates to review current plans and actions required completed over 3 weeks. Staff have now been advised to update and ensure all plans are availble for review and audit. Audit will be completed monthly to ensure any changes to care or MDT decsions are reflected accodringly.

Area for improvement 9 **Ref:** Regulation 15 (2)(b)(c), (11) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure service users' plans contain all necessary information to adequately and safely respond to identified needs and presenting risks inclusive of restrictive practices and Deprivation of Liberty Safeguards agreed. Systems must be in place to permit regular review of such interventions assuring that those agreed reflect the least restrictive approach for the least amount of time possible. Ref: 3.3.3
	Response by registered person detailing the actions taken: Encompass care plans refelct current care provision of individuals. Within these, Deprivation of liberty or restriction of liberty is included. ROL documents have been devised on an individual basis, these will be signed by the MDT and reviewed as part of annual review or when relevant changes or reduction in restrcitions are identified. This is auditted on a monthly basis by manager and deputy manager.
Area for improvement 10 **Ref:** Regulation 25 **Stated:** First time **To be completed by:** 21 November 2025	The Registered Person shall ensure that there is a robust system in place to assess the quality of the environment for service users and address identified deficits in a meaningful, timely and effective manner. Ref: 3.3.4
	Response by registered person detailing the actions taken: Health and safety checks to include environmental checks are in place monthly. Action plan within a larger site is to be reviewed weekly and ensure actions are raised and managed in an appropriate manner.
Area for improvement 11 **Ref:** Regulation 22(6)(8) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	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 best practice; the manager should regularly and meaningfully analyse all complaints to identify patterns/trends in order to drive any necessary improvements. Ref: 3.3.5
	Response by registered person detailing the actions taken: New Complaint management system is held on Datix system. This is utilised for informal and formal complaints. Local tracker for those identified is noww held on ab online shared folder.

Area for improvement 12 **Ref:** Regulation 15(12) (a) (b)(i)(ii) **Stated:** First time **To be completed by:** 28 November 2025	The Registered Person shall ensure that a robust system is developed and implemented to permit adequate review of incidents and accidents arising within the agency to allow for identification of any patterns/trends so as to drive necessary improvements. Ref: 3.3.5 **Response by registered person detailing the actions taken:** Monthly audit of incidents is being completed by Manager/Deputy manager. Aduit is completed for all safeguarding concerns to include notifications to RQIA.
Area for improvement 13 **Ref:** Regulation 15 (12)(a) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure written records are kept of all safeguarding concerns and include details of any investigations completed, the outcome, and action taken by the agency. The agency should ensure systems permit review to allow for identification of any developing patterns and/or trends. Ref: 3.3.5 **Response by registered person detailing the actions taken:** Safeguarding tracker has been implemented, these are reviewed monthly alongside datix incidents and notifications.
Area for improvement 14 **Ref:** Regulation 15(6)(b) (d) **Stated:** First time **To be completed by:** 30 November 2025	The Registered Person shall ensure that there are safe systems of work in relation to the handling of service users' monies and medications. Ref: 3.3.5 **Response by registered person detailing the actions taken:** Audit of both medication andfinance competncy is commenced. This included those otstanding and action plan for completion. Full medication audit has been completed and report 6.03.2026 Finance audit of full service underway with report to follow Competecy tracker now in place to ensure compliance and staff oversight by manager/deputy manager
Area for improvement 15 **Ref:** Regulation 23(1),(4) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that quality monitoring reports are robustly and comprehensively completed in keeping with Regulation. Ref: 3.3.5 **Response by registered person detailing the actions taken:** Monthly montioring reports are printed and held locally in individual properties to ensure staff awareness and agreed areas for improvement are completed. Copies of these are also held within managers office and on shared folder.

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 January 2026	The Registered Person shall ensure that staff have recorded formal supervision meetings in accordance with the procedures. Ref: 3.3.1
	Response by registered person detailing the actions taken: Supervsion of staff is compliant and agreed dates for the year ahead with staff. Monthly review and email sent to staff to ensure complaince remains and action plan if missed to be included.Band 5 meetings and in house staff meetigns have been held to discuss the improtance of supervsion and attendance by all staff.
Area for improvement 2 **Ref:** Standard 13.5 **Stated:** First time **To be completed by:** 31 January 2026	The Registered Person shall ensure that staff have recorded appraisal with their line manager to review their performance against their job description and agree personal development plans in accordance with the procedures. Ref: 3.3.1
	Response by registered person detailing the actions taken: Appraisal of staff yearly has been audited and agreed action plan. All Band 5 staff have completed their appraisal and competency with goals for the year ahead
Area for improvement 3 **Ref:** Standard 16.3 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall promote safe and healthy working practices through the provision of information, training, supervision and monitoring of staff. This specifically relates to fire safety with all staff having completed relevant training and assuring fire doors are not wedged open. Ref: 3.3.4
	Response by registered person detailing the actions taken: Monthly audit plan is in place , this is to review ,supervision, training , finances , Care plans , DOLs and ROLs , medications. Another audit has been compiled for review of cometencies of staff in finance, medication and band 5 role in absence of manager.

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The Regulation and Quality Improvement Authority

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