The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Greystone Support Centre

Provider: Belfast Health and Social Care Trust

Date of Inspection: 23 April 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:	Belfast Health and Social Care Trust
Responsible Individual/Responsible Person:	Mrs. Jennifer Welsh
Registered Manager:	Mrs. Lisa-Jane Cathcart
Service Profile – Greystone Support Centre is a supported living type domiciliary care agency which provides care and support to service users with a learning disability. Service users live in their own flat or house in the community. Whilst the agency is operated by the Belfast Health and Social Care Trust (BHSCT), the Northern Health and Social Care Trust (NHSCT) fund the care of a small number of the service users.	

2.0 Inspection summary

An unannounced inspection took place on 23 April 2026, between 9.20 am and 2.40 pm. It was carried out by two care Inspectors.

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 20 February 2025; 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. As a result of this inspection, the areas for improvement previously identified were assessed as having been addressed by the provider. Full details, including a new area for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

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

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

The Inspectors would like to thank the manager, service users and staff for their help and support in 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 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 information held by RQIA about this service was reviewed. 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 service; 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

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.

Service users told us that they liked living in Greystone and are supported by staff to make choice as to how they spend their day. One told us that staff gave them the support that they need to live in the community.

Staff described the service as very person centred and told us that they felt very well supported in their role.

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.

Review of the 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. An area for improvement stated at the last inspection in this regard is recorded as met.

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. Staff commended the high quality of their induction. An area for improvement stated at this last inspection in regard to the recording of staffs' inductions was noted to have been met.

Checks were made to ensure that staff were appropriately registered with NISCC or any other relevant regulatory body; there was a system in place for professional registrations to be monitored by the manager.

Records of all staff training were retained in the form of a matrix. It was noted that this record was not fully up to date. Information received after the inspection offered the assurance that the updates had been completed. Staff confirmed that they had received sufficient training for their roles. Service users told us that the staff were very well trained. Service user specific training had also been provided to staff. For example, where a service user required a specialist emergency system for the management of a medical condition, all staff had been provided with the required training.

Procedures were in place for appraising the staffs' performance and supervisions were undertaken in keeping with the agency's policy and procedures.

Medicines competency assessments were completed for those staff who administered medicines. An area for improvement at the last inspection identifying the need for the recording proforma of these competency assessments to be developed to include a section on anticoagulants (such as warfarin) and antipsychotics (such as clozapine) is recorded as met.

Service users fed back that staff were good at listening to them; one described the staff as 'angels'.

3.3.2 Care Delivery

There was a daily handover at the beginning of each shift, which included information about any changes to the service users' care that the staff needed to assist them in their roles.

Staff were knowledgeable of individual service users' needs, their daily routine, wishes and preferences. 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.

One service user told us that they were looking forward to an upcoming foreign holiday with staff; another told us that they liked 'getting on line with staff support'.

It was also good to note that the service had service users' meetings on a regular basis which enabled the service users to discuss the provisions of their care. Some matters discussed included health and safety, gifts to staff, the service vehicle and staffing.

Service users said they had no concerns regarding their safety; they described how they could speak to staff if they had any concerns about safety or the care being provided. The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any concerns.

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

3.3.3 Management of Care Records

Service users' needs were assessed when they were first referred to the service 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.

Service users care records were held confidentially.

Care and risk plans were found to be comprehensive and reflective of individual's assessed needs. The care plans were underpinned by a human rights approach which is good practice. 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 users' preferences and choices around how their support was provided.

It was noted, however, that a sample of service users' risk assessments had not been kept up to date and were not signed by the service user or staff. This has the potential to put service users at risk. This has been identified as an area for improvement.

3.3.4 Quality of Management Systems

There has been no change in the management of the service since the last inspection. Mrs. Lisa Cathcart has been the registered manager in this service since 2010. Those consulted with commented positively about the management team and described them as supportive, approachable and able to provide guidance. One staff member described the manager as 'having very good oversight'. Another told us that if they raised a concern, they were confident that it would be dealt with.

There was no formal competency assessment in place for the staff required to be in charge of the service in the absence of the manager. Following discussion with the manager, it was agreed that this will be developed by the service and reviewed at the next inspection.

The service 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 service. The reports of these visits were completed in detail.

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. There was a robust process in place for retaining details of the nature of any complaints received, investigations undertaken, outcome and learning and

satisfaction of the complainants. It was positive to note that there was a Resource File in place to guide staff in regard of the timely management of any potential or actual complaints. The manager had completed training in regard to complaints management and investigation.

The Annual Quality Report was reviewed and was satisfactory.

RQIA had been informed of incidents that had occurred, in keeping with the Regulations. Discussions took place with the manager regarding the type of incidents which are required to be notified to RQIA to ensure compliance is maintained. No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure.

The service had an identified Adult Safeguarding Champion (ASC). The manager was knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting adult safeguarding concerns. The agency has a system for retaining a record of any referrals made to the HSCT in relation to adult safeguarding.

The Statement of Purpose required updating to ensure compliance with the Standards. Discussion after the inspection with the manager and senior staff offered assurances that these updates will take place to all Statement of Purposes for the provider's Learning Disability supported living services. This will be reviewed at the next inspection.

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

An area for improvement and details of the Quality Improvement Plan were discussed with manager, Operations Manager and 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 15(3)(c) **Stated:** First time	The Registered Person shall ensure that service user risk assessments are kept up to date and signed by the service user and appropriate staff member. Ref: 3.3.3
To be completed by: Immediate and ongoing from date of inspection	**Response by registered person detailing the actions taken:** All service user risk assessments will be reviewed and updated / signed by service user and key worker by 19/07/2026. Moving forward, peer review of care & support plans and risk assessments will be implemented.

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