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: 13 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:	South Eastern Health and Social Care Trust (SEHSCT)
Responsible Individual/Responsible Person:	Mrs Roisin Coulter
Registered Manager:	Mr Christopher Lowry (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 diagnosis.	

2.0 Inspection summary

An unannounced inspection was conducted on 13 April 2026, between 9.25 a.m. and 6.20 p.m. by a care Inspector.

The inspection was undertaken to evidence how the service 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 12 September 2025; and to determine if the service 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. However, improvements were required to ensure the effectiveness and oversight of certain aspects of the agency such as recruitment and selection processes, staff training, service user plans, service agreements, management of medication errors and quality monitoring reports.

Service users said that the care and support provided by 53 Ardglass Road was a good experience. Refer to Section 3.2 for more details.

As a result of this inspection six areas for improvement previously identified were assessed as having been addressed by the provider. Two previous areas for improvement will be carried forward and reviewed at a future inspection. Four areas for improvement have been stated again and one new area for improvement was identified. Full details 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 53 Ardglass Road 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 service. This included the previous Quality Improvement Plan issued, registration information, and any other written or verbal information received from service users, their representatives, 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, an electronic survey and via telephone.

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.

Feedback received from service users was positive. Those consulted spoke positively about the service and the environment, describing themselves as happy within their home. Service users discussed arrangements regarding shared areas and expressed the view that all service users treated one another's property with respect.

Service users consulted spoke highly of the staff describing them as "kind and caring", "friendly" and "funny". One service user spoke warmly about their relationships with staff stating that they enjoy their company. We were told how staff were always there to help when needed. Service users spoken with were aware of the complaints process and stated that they felt able to raise concerns with staff if required.

In respects to current arrangements for medication storage, service users confirmed that this had been discussed with them. It was also positive that service users were able to describe proposed adaptions to their bedroom which would allow for safe medication storage and self-administration where appropriate.

Service users explained how the service offered them the correct level of support whilst respecting and promoting their independence. One service user explained that they spent a lot of time out of the service engaging in activities within the community and visiting friends or family.

A service user explained how, upon information shared by staff, they had explored engagement in new hobbies, some of which having had enjoyed they now continue to participate in.

Staff consulted during the inspection described a marked improvement in overall team morale. Staff attributed this improvement to effective leadership, the establishment of clear professional boundaries applicable to all staff and improved staffing levels.

In relation to the acting manager staff described them as professional, approachable, fair, impartial and service user focused. They felt assured when concerns are shared that confidentiality would be maintained and that their concerns would be listened and responded to.

Staff also spoke positively about their colleagues, commenting that peers regularly went above and beyond in supporting both service users and one another. A concern was shared in relation to transportation of service users and this was discussed with the acting manager who agreed to review current practices and take any necessary action to address. This will be reviewed at a future inspection.

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 reported that there had been an improvement in staffing levels and felt that service users were benefiting as a result, with more staff available to facilitate activities within the community. In discussing measures taken by management to minimise the impact of current staffing levels upon the service, staff advised that they felt they were kept well informed and updated. A previous area for improvement relating to staffing levels was assessed as having been addressed by the provider.

Review of the agency's staff recruitment records was impeded due to the acting manager not having appropriate access. Information reviewed following the inspection evidenced that two employees did not have an updated Enhanced AccessNI check completed prior to commencing employment within 53 Ardglass Road.

RQIA recently issued communication to all providers outlining the responsibility under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (known as the 2003 Order) to undertake pre-employment checks for staff who work in the Establishment or Agency, with an effective date of compliance of 1 June 2026. This was shared and discussed with the acting manager and SEHSCT Human Resource representatives. An area for improvement previously stated will be carried forward and reviewed at a future inspection.

Newly appointed staff, including those supplied by recruitment agencies, had completed a structured orientation and induction, to ensure they were competent to carry out the duties of their job. One staff supplied by a recruitment agency told us that the standard of induction they had completed had been excellent.

They advised that they had opportunity to shadow a more experienced staff member and felt all of the staff inclusive of the acting manager had been readily available to offer any support or guidance needed.

A training matrix was maintained by the service to evidence compliance with mandatory requirements. On review of this it was identified that a number of training needed to be completed or had expired. In discussion with the acting manager concerns regarding placing accountability upon individual staff for the recording of training dates within the agency's training matrix were highlighted, with review of this practice encouraged.

Opportunity was provided to the acting manager to present accurate information pertaining to training compliance. Updated information provided, although evidencing a greater rate of compliance, indicated that a number of staff had not undertaken an annual medication competency assessment. An area for improvement has been stated for a second time.

There was evidence from the date of the previous inspection that staff had received regular supervision. In discussion with staff they also confirmed engagement in supervision. A previous area for improvement was assessed as having been satisfactorily addressed by the provider.

Procedures were in place for appraising staff performance and staff confirmed that appraisals had taken place.

3.3.2 Care Delivery

There were procedures in place for handovers at the beginning of each shift, ensuring effective communication occurred regarding any changes presenting needs and/or risks. It was positive to find that regular team meetings were now occurring within the service and that any staff who were unable to attend could easily access the minutes.

Through discussion with staff it was apparent that they were knowledgeable of individual service users' needs, their daily routine, wishes and preferences. Observations of service users' and staff interactions found them to be relaxed and comfortable. Staff demonstrated respect, recognising that their place of work was the home of the people they support. This was illustrated with staff seeking consent prior to entering a room and asking service users if they could join them prior to sitting within lounge areas.

It was positive to find evidence of regular service user meetings which featured discussions surrounding tenancy agreements, human rights, fire safety, health and safety, nutrition and the environment. Minutes of meetings illustrated active engagement with service users with their opinions sought regarding the quality of care provided and their environment. Service users were encourage to suggest ideas regarding desired activities or general means to improve the service they receive.

Staff explained how improvements in staffing have benefited service users, with greater consistency in availability of staff to facilitate engagement in the local community. Service users described how staff supported them in developing shopping lists, purchasing products and preparing meals. It was also reassuring to hear directly from service users that there was flexibility with regards to menu planners that if they changed their minds staff would support them in preparing an alternative meal.

Service users told us that staff were good at sharing information regarding to events occurring within the local community. One service user told us about an upcoming foreign holiday they had planned, explaining that they tend to go on a holiday annually. In addition to events such organised by the service it was good to find that peer relationships were encouraged, the formation of which had enabled service users to gain confidence to engage in community activities without staff support.

3.3.3 Management of Care Records

Service users care records were held confidentially in line with data protection regulations.

It was positive to find that service users had a copy of their tenancy agreements available to refer to as needed. This same however was not apparent in respect to service user agreements, with the acting manager unable to provide evidence that these were in place or regularly reviewed. The previous area for improvement will be stated for a second time.

Improvements were observed regarding service user plans, with the same templates now utilised across the service. There was also a greater sense of the person being supported, with information included regarding what and who is important to them, as well as their areas of interest.

A review of a sample of service user plans, however, identified inconsistencies in information contained within records. For example, one individual's diagnosis was not referenced within their support plan. Furthermore, an identified area of need was found not have associated actions to direct staff on how best to support the service user. Issues were also observed with the restrictive practice section of service user's support plan not being populated as required. In addition, one service user's plans relating to support with management of finances lacked clear and specific direction for staff. Concerns identified were discussed with the acting manager at the time of the inspection. A previous area for improvement has been stated for a second time.

It was positive to find that the service had implemented and were now maintaining a restrictive practice register. Suggestions were made to the acting manager as to how this could further be improved to evidence compliance with The Three Steps to Positive Practice Framework detailed within the Regional Policy on the use of Restrictive Practices in Health and Social Care Settings. This will be reviewed again at a future inspection.

Practices relating to medication management had been reviewed since the date of the previous inspection. There was evidence that service users had been consulted regarding the storage of medication and works were scheduled to enable storage of medications within service users own rooms.

A medication assessment tool has also been developed to determine the level of support service users require to safely manage their medications. It is expected that implementation of this tool will provide a robust evidence base to support decision-making, specifically relevant where restrictive practice interventions relating to medication management may be necessary. The acting manager agreed to confirm implementation of this tool. Based on this the previous area for improvement identified was determined to be satisfactorily met.

3.3.4 Quality of Management Systems

There has been a change in the management of the service since the last inspection. Mr Christopher Lowry has been the acting manager in this service since 3 October 2025. Assurances were provided that a retrospective notification as to acting manager arrangements would be made which aligned to previous communications received from the organisation. Due to this the previous area from improvement relating to notification of the absence of the manager was assessed as having been met.

Service users consulted spoke positively about the acting manager and staff commented positively about their leadership and interpersonal skills feeling that he was supportive, approachable and able to provide guidance.

Information relating to complaints were not available for review on the day of inspection. Information provided subsequent to the inspection was deemed insufficient to make an assessment if the previous area for improvement stated had been satisfactorily met. A previous area for improvement will be carried forward and reviewed at a future inspection.

Review of incident records identified that they were managed appropriately. It was positive to find that the SEHSCT Governance Team also reviewed incident reports and made suggestions, were appropriate, as to further actions to be considered in respects to the management of incidents.

Concerns were however identified in respects to inconsistencies in the agency's response to medication errors. Current procedures places responsibility for determining if an investigation into a medication incident is necessary with the manager without clear guidance or defined criteria. Risks associated with this practice were explored with the acting manager with it recognised potential inconsistencies in response to medication errors could see staff perceive processes as inequitable.

The service did not have a system in place to track the number of medication incidents that staff members had been involved in. Significant concerns regarding the absence of retraining for staff following involvement in a medication error were emphasised to the acting manager. It was discussed that completion of debriefs alone were unlikely to adequately address potential gaps in knowledge or competency. A previous area for improvement will be stated for a second time.

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. In the Trust, this person is called the Designated Adult Protection Officer (DAPO). There was a system in place to manage the safeguarding and protection of adults at risk of harm.

The service were found to have implemented a safeguarding tracker since the last inspection. This tracker was found to contained relevant details inclusive of any recommendations made. It was positive to find that the services retained all associated records relating to any safeguarding concerns in a centralised location allowing for effective monitoring. The previous area for improvement relating to safeguarding records was assessed as having been addressed by the provider.

Discussion occurred with the acting manager regarding an incident for which referral to adult safeguarding team was considered. The referral did not proceed due lack of consent. There was however no records to evidence this discussion occurred and furthermore the entry made within the incident report regarding the feedback from the service user did not contain the name of the staff member who made the entry nor the date this record was created. It was emphasised how such issues creates uncertainty regarding the validity of information. This will be reviewed again at a future inspection.

Review of the quality monitoring reports completed in respect to the agency were found to lack robust analysis, specifically in relation to incidents, accidents and safeguarding concerns. An area for improvement was identified.

The annual quality report was reviewed and noted to include reference to recently distributed service user and stakeholder questionnaires, with analysis to occur following receipt of feedback. It was positive to see inclusion of photographs, with consent of service users, which showed engagement in events and activities organised by the service.

The annual quality report demonstrated reflective practice, evidencing consideration of both achievements and challenges experienced over the previous year. While ongoing improvement actions were referenced throughout the report, these were not consolidated into a structured action plan. A previous area for improvement relating to completion of an annual quality report was assessed as having been addressed. It was however recommended that an action plan is formalised as part of this report to support and promote accountability and ensure identified objectives are progressed and achieved within defined timescales.

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	5*	2

* the total number of areas for improvement includes two that have been stated for a second time and two which have been carried forward for review at a future inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Christopher Lowry, Acting 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 from the date of the 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 16 (2)(a) **Stated:** Second time **To be completed by:** 30 June 2026	The Registered Person shall ensure that training provision corresponds to the presenting needs of service users to assure safe delivery of care and support. They agency is to ensure an efficient system is utilised to monitor training compliance and this is reviewed on a regular basis. Ref: 2 and 3.3.1
	Response by registered person detailing the actions taken: The training matrix has been updated to record training completed to date. A colour coding system has been introduced for ease of identifying those courses approaching an expiry date (amber) and those already expired (red). New training needs and the training matrix will be kept under review by the Manager and form part of the Manager's monthly audit. The Senior Manager will also audit two different types of training monthly as part of the monthly monitoring visit.
Area for improvement 3 **Ref:** Regulation 15(2)(b)(c) **Stated:** Second time	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: 2 and 3.3.3

To be completed by: Immediate from the date of the inspection	**Response by registered person detailing the actions taken**: The information already contained within the risk register has also been detailed in the Tenant Support Plans. These plans are reviewed a minimum of 6 monthly or more often if there is a change in need.
Area for improvement 4 **Ref:** Regulation 22(8) **Stated:** First time **To be completed by:** Immediate from the date of the 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 retained to enable analysis of any developing patterns and/or trends. Ref: 2 and 3.3.4
	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 5 **Ref:** Regulation 23 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure quality monitoring reports include analysis of data enabling identification of emerging patterns and/or trends whilst providing assurance/recommendations relating to necessary interventions. Ref: 2 and 3.3.4
	Response by registered person detailing the actions taken: Monthly monitoring reports will contain those trends and actions agreed at the monthly governance meeting for supported living.This information will be further disseminated to the wider staff team allowing opportunity for further discussion at team meetings. The annual quality report will also encapsulate the trends and actions taken for the previous year and help inform service plans for the year ahead.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 4.2, 4.3 **Stated:** Second time **To be completed by:** 13 July 2026	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: 2 and 3.3.3
	Response by registered person detailing the actions taken: Service agreements have been composed for sharing with Tenants for their review and any comment(s). Their agreement is evidenced by their date and signature and uploaded onto Encompass via media. This will be reviewed annually at a minimum or more often should the need arise.

Area for improvement 2 **Ref:** Standard 7.5, 7.6 and 7.13 **Stated:** Second time **To be completed by:** 13 July 2026	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 action taken as a result are to be available for the purpose of inspection. Ref: 2 and 3.3.4
	Response by registered person detailing the actions taken: A medication policy specific to mental health supported living is in its final stages of completion. The actions following medication incidents will be clearly recorded to evidence the decision making and review process to ensure equity across the staff team and identifying common gaps in knowledge or process to inform training needs. This will be shared wih the Community Pharmacist and Nurse Lead for their professional opinion before 'sign off.'

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

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