The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: L’Arche

Provider: L’Arche, Belfast

Date of Inspection: 16 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:	L'Arche Belfast
Responsible Individual/Responsible Person:	Mr Scott William Shively
Registered Manager:	Mr Scott William Shively

Service Profile:

L'Arche is a domiciliary care agency (supported living type) which provides a range of personal care and support services to service users living in shared accommodation in the local community. Service users have a range of learning disability needs and require support to enable them to live as independently as possible. Their care is commissioned by the Belfast Health and Social Care Trust (BHSCT), the Southern Health and Social Care Trust (SHSCT) and the South Eastern Health and Social Care Trust (SEHSCT).

This agency also provides community outreach and day opportunities to service users who live in the community. RQIA does not regulate these elements of support.

2.0 Inspection summary

An unannounced inspection took place on 16 April 2026, between 9.45 am and 3.30 pm 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 the areas for improvement identified, by RQIA, during the last care inspection on 7 April 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. However, improvements were required to ensure the effectiveness and oversight of certain aspects of the agency, such as the recruitment process and in relation to the transport charges.

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

Service users and their representatives said that the care and support provided by L'Arche was a positive experience. Refer to Section 3.2 for more details.

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

L'Arche uses the term 'core members' to describe the people to whom they provide care and support. For the purposes of the inspection report, the term 'service user' is used, in keeping with the relevant regulations.

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 previous QIP, 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 agency; and review/examine a sample of records to evidence how the agency is performing in relation to the regulations and standards.

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.

Service users told us that they were very happy with the care and support and described L'Arche as being 'amazing'.

Relatives told us that the care and support provided by the L'Arche staff was 'brilliant' and the staff were described as being 'very caring' and that they were 'delighted overall'. One relative commented that they felt very proud of their loved one and the way they have learned to live independently and that they attributed this to the structure within Larche.

Staff told us they had no concerns to raise; the staff spoken with were very welcoming of the inspection process.

3.3 What has this service done to meet any areas for improvement identified at or since the last inspection?

3.3 Inspection findings

3.3.1 Quality of Management Systems

Mr Ciaran Doole has been the registered manager in this agency since 8 December 2025.

There were effective systems and processes in place to manage the safeguarding and protection of adults at risk of harm. In addition to staff training, the staff were also prompted through the written records process to consider any safeguarding issues on a daily basis. Service users were also provided with information on safeguarding so that they would be able to recognise the different types of abuse.

Agencies 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. The responsible individual was the appointed ASC for the agency, who completed an Annual Safeguarding Position report every year.

Review of a sample of records evidenced that a robust system for reviewing the quality of care and staff practices was in place.

The annual quality report was reviewed and noted to include stakeholder feedback. An area for improvement previously identified in this regard had been addressed. Advice was given in relation to including the feedback received from relatives and HSCT' representatives.

There was a process in place to manage any complaints; none had been received since the last inspection. Information was provided to service users in relation to the complaints process; this included photographs of both the registered manager and the responsible individual.

Review of incident records identified that they were managed appropriately. No incidents had occurred which required RQIA to be notified, in line with requirements.

Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC); there was a system in place for professional registrations to be monitored by the manager. An area for improvement previously identified in this regard had been addressed.

3.3.2 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.

Consultation with service users and relatives established that there were no concerns regarding the staffing levels.

Where service users had an assessed need for support with care needs at night time, a waking night-shift was provided. Where there were no assessed care needs, a volunteer was present at night time. The manager advised that the commissioning trusts were aware of this and that on-call arrangements are in place to support the volunteers, if required.

There was a process in place to ensure that recruitment was managed appropriately; this ensured that criminal record checks (AccessNI), are completed and verified before staff members or volunteers commenced employment and have direct engagement with service users. Improvements were identified in relation to the lack of full employment histories and gaps in employment not being consistently explained. An area for improvement previously identified in this regard was stated for the second time.

Additionally, advice was given in relation to ensuring that applicants provided the addresses of all their previous employers on the application forms.

Newly appointed staff, had completed a structured orientation and induction, to ensure they were competent to carry out the roles and responsibilities of their job. The induction process included two weeks where the staff member shadowed another staff member; this enabled them to get to know the service users. Advice was given in relation to including the Induction dates on the training matrix. The person in charge welcomed this advice and agreed to undertake an audit of all induction records in the process.

Records of all staff training were retained and a training calendar was in place to address any training that was due to be updated. Service user specific training had also been provided to staff. For example, where an emergency medicine was prescribed for the management of epilepsy, specific training had been provided to staff in this regard.

There was a process in place to assess the competency of staff who were responsible for administering medicine. Advice was given in relation to adding a column for this aspect of training to the training matrix. Similarly, whilst staff were trained in relation to the management of service users' finances, a finance competency assessment should similarly be recorded on the training matrix.

Procedures were in place for appraising the staffs' performance and supervisions were undertaken in keeping with the agency's policy and procedures. The matrix used to record the dates these were due was out of date. However, this had been identified through the agency's quality monitoring processes and an action plan had been developed to ensure that all completed supervision and appraisal records were added to the matrix. This will be reviewed at a future inspection.

3.3.3 Care Delivery and care records

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 meetings were held on a weekly basis; with a larger staff meeting being held on a monthly basis. Service users' meetings in each house were held on a weekly basis; and once a month, efforts were made to get all the service users together for a meeting attended by the responsible individual.

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. Service users were supported to attend activities such as going to Kilcreggan Farm, horse-riding, yoga, art, dance classes and mixed martial art classes, depending on the service users' preferences. Service users were also supported to visit Portrush for a day trip. One service user was supported to give a talk to a Womens' Group; other service users were supported to go to see live television shows such as Strictly Come Dancing and Gladiators.

Staff interactions with service users were observed to be friendly and supportive.
Service users' needs were assessed when they were first referred to the agency. Following this initial assessment, the staff completed a 'Listen to Me, My First Person-Centred Description'. This was completed with the input from the service users and their relatives and included information on what people liked and admired about the service user, who was important to them and what their hopes and dreams were. This process also documented what the service users' typical working/non-working day looked like and included details regarding their daily routines; and how they liked to communicate.

Risk Assessments were undertaken to reduce any identified risks.

The care and support plans were developed to direct staff on how to meet service users' needs and included any advice or recommendations made by other healthcare professionals. The care and support plans were very person centred, well maintained and regularly reviewed and updated to ensure they continued to meet the service users' needs. The care plans were noted to be underpinned by a human rights approach. Where service users were prescribed specific medicine, the care plan included a description of the reason the medicine was prescribed. Additionally if the service users were prone to any particular ailment, this was detailed within the care plans. The care plans were written in the first person and were very detailed about every aspect of the service users' day; the care plans focused on promoting the service users' respect and dignity throughout. This is commended.

Where service users had specific medical needs, such as epilepsy, the Trust epilepsy care plan was in place.

Service users were provided with service user agreements and all had tenancy agreements in place.

Each service user had a Finance Agreements in place which outlined the contributions they were required to pay towards rent and utility bill etc. Advice was given in relation to developing finance assessments, which would ensure the service users were formally assessed on a regular basis, in effort to promote their independence in as much as possible.

L'Arche have a number of cars, which the staff use to bring service users to different activities. A review of the transport agreement identified the need for charges to be explicit, when service users were sharing car journeys with other service users. For example, the cost of a solo journey would be less per service user, if there were more than one service user in the car. Following the inspection, the manager advised that when there are shared journeys, the cost is split between the number of passengers. However, it is important that this is explicit with the transport agreement. An area for improvement was identified.

Similarly, advice was given in relation to developing assessments for self-administration of medicine. The person in charge welcomed this advice and agreed to develop and implement these processes.

Review of records identified that the care plans were reflective of the recommendations outlined within the Speech and Language Therapy (SALT) Care Plan.

At times some service users may have items removed from them for their own safety, such as medicines or monies; or having their medicines stored in a locked cupboard; these could be considered as restrictive practices. There were systems were in place to safeguard service users and to manage this aspect of care and there was evidence that the restrictive practice assessments were reviewed bi-annually, or more frequently if required.

There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had their capacity considered and, where appropriate, assessed. Where a service user was experiencing a deprivation of liberty, the care records contained the relevant authorisation documents.

There was a protocol in place to ensure that medicines which were required on an as needed basis were monitored, to ensure that these were given appropriately to service users. These were also reviewed as part of the monthly quality monitoring process.

Staff recorded regular evaluations about the care and support provided. A review of a sample of these records evidenced that they were detailed and up to date. It was good to note that the proforma for recording the daily notes, prompted staff to raise any issues that may need to be discussed at staff/service user meetings.

There was a good focus within the care records on consent. For example, service users were also asked to consent to whether or not they agreed with staff holding a key to their homes.

Service users care records were held confidentially. Advice was given in relation to the records that required to be kept in the service users' homes and the need for regular return of notes to the registered office.

4.0 Quality Improvement Plan/Areas for Improvement

An area for improvement was identified where action is required to ensure compliance with the Regulations

	Regulations	Standards
Total number of Areas for Improvement	1*	1

* the area for improvement was stated for a second time

The area for improvement and details of the QIP were discussed with Mr Scott Shively, Responsible Individual, 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 schedule 3 **Stated:** Second 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 relates specifically to full employment histories with explained gaps in employment and references to include current employer were not consistently evident Ref: 3.3.1
	Response by registered person detailing the actions taken: The following actions have been implemented: Revised Recruitment Procedure: All applicants must now provide a complete employment history with written explanations for any gaps. Applications cannot progress until this is verified and documented. Mandatory Reference Protocol: Two references are now required as standard, including one from the current or most recent employer. Enhanced Compliance Checks: A pre-employment audit checklist has been introduced to ensure all Schedule 3 documentation is present, accurate, and signed off before any worker is supplied. Staff Training: The recruitment team has received updated training on regulatory requirements, documentation standards, and escalation procedures where information is incomplete. Ongoing Monitoring: Monthly internal audits of personnel files will be conducted to ensure continued compliance, with any gaps addressed immediately.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 8 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the transport agreements explicitly detail the costs to service users of shared journeys. Ref: 3.3.3
	Response by registered person detailing the actions taken: Transport policy has been updated clarifying the costs to service users for shared journeys.

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

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