

Inspection Report

Name of Service: Learning Disability Supported Housing

Provider: Belfast HSC Trust

Date of Inspection: 14 May 2026

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

1.0 Service information

Registered Provider:	Belfast HSC Trust
Responsible Individual/Responsible Person:	Ms Jennifer Welsh
Registered Manager:	Mrs Maureen Hunter
Service Profile Learning Disability Supported Housing is a supported living type domiciliary care agency operated by the Belfast Health and Social Care Trust. The service provides care and supported housing services to 34 service users living with a mild to moderate learning disability. Service users live within their own home environments in Belfast, which are owned by various housing associations and landlords. Services provided include support with shopping, laundry, social and recreational activities, budgeting, maintaining service users' tenancy, support to attend medical appointments and support with personal care, as necessary.	

2.0 Inspection summary

An unannounced inspection was undertaken on 14 May 2026 between 9.10am and 3.35pm by a care Inspector.

The last care inspection of the agency was undertaken on 11 April 2025 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 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. One new area for improvement was identified during this inspection relating to adult safeguarding reporting and recording.

Details of the findings of this inspection can be found in the main body of the report and in the Quality Improvement Plan (QIP) in section 4.0.

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 the service. This included registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning trust.

Information was provided to service users, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included easy read questionnaires and an electronic survey.

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

Throughout the inspection process inspectors will seek the views of those who receive support, those working within and those visiting the agency and review a sample of records to evidence how the service is performing in relation to the regulations and standards.

We spoke to service users, relatives, staff and a Health and Social Care Professional to seek their views of the care and support provided by the agency. The information provided indicated that good care and support was provided to service users by staff working for the agency. Service users who spoke with the inspector said that they liked the staff and that they got support to partake in activities they enjoyed.

Relatives who provided feedback on the service indicated that staff were good at communicating any issues or concerns regarding their relatives and that they were satisfied that the care provided was compassionate, effective and that the service was well led.

Staff who spoke with the Inspector said that they really enjoyed working with service users and the care delivery, training and management support provided by the agency was of a good standard. Several staff members completed the staff electronic survey. The information provided indicated that staff had no concerns in relation to the agency and that they were 'very satisfied' that care provided was safe, effective and compassionate and that the service was well led.

A healthcare professional who provided feedback on the service during the inspection indicated that the service worked well in partnership with them and other professionals to ensure that the service is meeting the needs of its service users.

3.3 Inspection findings

3.3.1 Adult Safeguarding and Incident Management

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).

Staff were required to complete adult safeguarding training during induction and every two years thereafter. Staff who spoke with the inspector had a clear understanding of the process for reporting and managing adult safeguarding concerns and their responsibility in identifying and reporting any actual or suspected incidences of abuse. They could also describe their role in relation to reporting poor practice and their understanding of the agency's policy and procedure with regard to raising concerns in the public interest (Whistleblowing). The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any concerns.

The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. The manager advised that three adult safeguarding referrals had been made since the last inspection. A review of these records confirmed that the agency had responded appropriately to the concerns raised in line with the Adult Safeguarding Policy and procedures. On review of records relating to accidents and incidents however, it was identified that an allegation of harm reported by a service user to staff and unexplained bruising was not recorded within Adult Safeguarding records. Whilst assurances were provided by the manager that consultation with the appropriate professionals had taken place at the time in accordance with adult safeguarding procedures, this was not recorded. There was no evidence of an investigation to establish how bruising may have occurred or if a protection plan was implemented in response to allegations made. Furthermore, it was identified that body maps had not been completed at the time. An area for improvement was identified.

The agency's governance arrangements for the management of accidents/incidents were reviewed and confirmed that an effective reporting policy and system was in place. Accidents/incidents were recorded centrally within the organisation and a monthly tracker document was developed for reviewing and identifying any trends or patterns. The manager was advised to ensure that the type of incident is succinctly recorded for swift identification of incident trends. A review of these records confirmed that the agency had responded appropriately to the concerns raised in line with the with the Trusts' reporting requirements. On examination of a medication error by staff, it was established that whilst this had been discussed in supervision with the identified staff member, a reflective exercise to demonstrate learning from the error had not been completed in line with relevant guidance procedures. This was discussed with the manager who confirmed that a revised template had been developed and that the staff member had since completed a medication competency assessment in the administration of medication. The management of medication incidents will be reviewed at a future inspection.

On review of all notifications submitted to RQIA, it was identified that two incidents reported to the Police Service of Northern Ireland (PSNI) had not been reported to RQIA within 24 hours of the manager being informed that the matter had been reported to the police. Reasons for this were outlined by the manager who submitted both notifications retrospectively during the inspection. Assurances were also given by the manager to ensure understanding of the requirements under Regulation 15 (12) (b).

Staff who spoke with the Inspector could describe their role in relation to reporting poor practice and their understanding of the agency's policy and procedure with regard to raising concerns in the public interest (whistleblowing).

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure.

3.3.2 Mental Capacity and Restrictive Practice

The Mental Capacity Act (Northern Ireland) 2016 (MCA) provides a legal framework for making decisions on behalf of service users who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, service users make their own decisions and are helped to do so when needed. When service users lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles.

The manager reported that none of the service users were subject to Deprivation of Liberty Safeguards (DoLS). The service maintained a Restrictive Practice register in place to record service users that were subject to restrictions such as locked medication boxes. The manager advised that this was reviewed on a quarterly basis to ensure that all restrictions noted were proportionate and necessary for service user's safety. It was recommended that evidence of multi-disciplinary consultation and input be recorded within the restrictive practice documentation to ensure that all restrictive interventions are appropriately assessed and implemented under their direction and guidance; and that they are subject to regular review. This would ensure adherence to principles of proportionality and necessity in line with best practice guidance.

3.3.3 Staff Recruitment, Induction and Training

A 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. Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC) or the Nursing and Midwifery Council (NMC) or any other relevant regulatory body; there was a system in place for professional registrations to be monitored by the manager.

A review of training records of the most recently appointed staff concluded staff had received mandatory and other training relevant to their roles and responsibilities to ensure they were competent to carry out the duties of their job in line with the agency's policies and procedures. This included shadowing of a more experienced staff member.

A review of the agency's electronic training records identified that training had lapsed for a number of staff in respect of Fire Safety Awareness, Manual Handling training, safety intervention and Infection control. The manager provided confirmation that arrangements had been made for the identified staff to complete refresher training. A further recommendation was made to the manager in respect of training in relation to Diabetes management. The manager welcomed this advice and agreed to make enquiries around this training for staff. This will be kept under review.

3.3.4 Management of Care Records

From reviewing service users' care records and through discussions with service users, it was positive to note that service users had an input into devising their own plan of care. Service users were provided with easy read reports which supported them to fully participate in all aspects of their care. The service users' care plans contained details about their likes and dislikes and the level of support they may require. Care and support plans are kept under regular review and service users and /or their relatives participate, where appropriate, in the review of the care provided on an annual basis, or when changes occur. One service user was outstanding their annual care review. The manager agreed to follow this up immediately with the relevant professional.

Discussions with staff and review of service users' care records reflected the multi-disciplinary input and the collaborative working undertaken to ensure service users' health and social care needs were met within the agency. Where there was input from SALT, recommendations were recorded within care plans along with associated SALT dietary requirements to ensure the care received in the setting was safe and effective.

The agency held service users' meetings on a regular basis which enabled service users to discuss the provisions of their care and to arrange activities of their choice. The minutes of these meetings were reviewed and included good detail around the service user's hopes and planning for attending social events and recreational holidays of their choosing.

3.3.5 Governance and Managerial Oversight

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 Annual Quality Report was reviewed and was satisfactory.

The agency's registration certificate was up to date and displayed appropriately.

There was a system in place to ensure that complaints and compliments were documented. The manager advised that all staff are required to complete training in complaints management and that no complaints had been received since the last inspection. The complaints policy was available in Easy read and kept within the service user's home.

The agency had an operational policy and system in place to direct staff on actions they should take in the event that they cannot gain access to a service user's home to ascertain their well-being.

4.0 Quality Improvement Plan/Areas for Improvement

An area for improvement was identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	1

The area for improvement and details of the Quality Improvement Plan were discussed with Mrs Maureen Hunter (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 Minimum Standards (revised) 2021	
Area for improvement 1 Ref: Standard 14.7	The Registered Person shall ensure that a robust system is developed and implemented in regard to the management of all adult safeguarding incidents; this should ensure that relevant written records are retained of suspected, alleged or actual incidents of abuse and includes details of the investigation, the outcome and action taken by the agency. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Registered Manager will implement a robust system to ensure the management of all Adult Safeguarding Incidents. The Registered Manager will ensure that a written record is retained of suspected, alleged or actual incidents of abuse. The existing Adult Safeguarding tracker template has been reviewed and revised by the Registered Manager to ensure that all details of investigation, the outcome, and action taken by the Agency is documented.

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



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