

Inspection Report

Name of Service: Sperrin Drive Supported Living Service

Provider: Autism Initiatives NI

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:	Autism Initiatives NI
Responsible Individual/Responsible Person:	Ms Adele Leighton
Registered Manager:	Mr Stephen McGuigan
Service Profile: Sperrin Drive Supported Living Service is a domiciliary care agency, supported living type. Care and support is delivered within a two storey detached house located in Belfast for which service users are tenants. Each service user has their own individual bedroom whilst there is a range of communal areas. The agency's registered office is located within the service users' home. Service users are provided with care and support in a range of activities of daily living with encouragement provided to develop self-care skills and increase independence within the local community.	

2.0 Inspection summary

An unannounced inspection was undertaken on 23 April 2026 between 9.45 am and 5.10 pm 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 13 December 2024; 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. Improvements were required, however, to ensure the effectiveness and oversight of certain aspects of the agency, such as restrictive practice and service agreements specifically pertaining to cost of amenities.

Service users said that the care and support provided by Sperrin Drive Supported Living Service was a positive experience. Service users who were unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

It was evident that staff were knowledgeable and well trained to deliver safe and effective care.

As a result of this inspection one new area for improvement was identified and one area for improvement previously identified will be stated for a second time. Full details, including the 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.

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 Sperrin Drive Supported Living 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 QIP 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 supported by or working for the agency; and review a sample of records to evidence how the service 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 "happy" within Sperrin Drive Supported Living Service. The service users' home was found to be bright, welcoming, and filled with natural light. The environment was well decorated and personalised, with personal belongings and items reflecting the individuality, preferences and interests of each service user displayed throughout. This contributed in creating a homely atmosphere and demonstrated that service users were supported to make their living space their own.

Information was readily available to service users, this included photographs and names of staff. The images of staff were utilised to advise service users what staff would be attending their home to offer care and support. It was positive to see that the communication needs of all service users had been considered, with information about the service, complaints processes and such, also available in accessible formats, including pictorial resources, which promoted understanding and engagement.

One service user kindly provided consent to view their bedroom which was personalised and reflective of the individuals' interests and preferences. There was various photographs displayed throughout and it was assuring that staff were able to identify and speak about the significant persons within service users' lives.

Service user survey feedback reviewed saw staff described as “fun”, “friendly”, “supportive and reliable” and “excellent”. One service user advised, “Sperrin has made me a happier and better person”.

During the course of the inspection, consent was obtained from a service user to observe part of their morning routine. Despite the service user’s need for a structured approach in relation to timing and sequencing, it was positive to observe that their independence and autonomy continued to be actively promoted. The service user was supported to complete tasks independently, were assessed safe to do so, and was offered meaningful choices throughout.

The staff supporting the service user demonstrated a comprehensive knowledge and understanding of the service user’s assessed needs and plans. They were able to clearly describe key aspects of the service user’s positive behavioural support plan, including proactive strategies used to reduce the likelihood of the individual experiencing anxiety and distress.

Staff spoken with illustrated knowledge and understanding as to diagnosis and associated best practice interventions ensuring care was therapeutically effective. In discussion with staff they spoke passionately about promotion of service user’s rights and person-centred practice. Staff felt that there was effective teamwork and described a positive culture within Sperrin Drive Supported Living Service. Staff expressed pride in the quality of care and support provided to service users.

Communication aids were found to be personalised and reflective of the service user’s individual preferences, interests, and communication needs. There was evidence of this being regularly updated. It was encouraging to hear that multidisciplinary working was being actively progressed to further enhance one of the service user’s opportunities, experiences and overall quality of life.

Staff commented positively about the registered manager, describing them as knowledgeable, approachable and easy to talk to. They advised that the registered manager is committed to ensuring the best possible outcomes for the people they support and demonstrates a genuine investment in both service users and staff.

Staff reported feeling comfortable raising concerns or discussing any issues with the registered manager and were confident that matters brought to their attention would be addressed appropriately and in a timely manner.

Staff also advised that they are actively encouraged to engage in ongoing professional development and training. It was positive to learn that for some staff, this support had facilitated career progression and advancement within the organisation, demonstrating a commitment to developing and retaining a skilled workforce.

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 that the service had a robust system in place to ensure safe staffing levels were maintained. It was positive to note that the rota was prepared in advance permitting opportunity to acquire cover as needed.

Observation of the delivery of care evidenced that service users' needs were met by the number and skills of the staff on duty. Staff expressed satisfaction with current staffing levels feeling that these aligned with the assessed needs of the people they support. Staff told us there was effective teamwork and that they felt well supported in their role. Staff were observed assisting service users in a caring and compassionate manner.

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 Northern Ireland Social Care Council (NISCC) or any other relevant regulatory body; there was a system in place for professional registrations to be monitored.

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. An area of good practice was observed in relation to records relating to induction with the agency clearly recording shifts completed by new staff for which they shadowed a more experienced member of the team.

The agency had a robust system in place to assess the competency of staff assuring capability in undertaking duties and responsibilities associated with their role. Competency was examined with regards to knowledge, understanding and practical application of the agency's safeguarding policy and procedure, employee's responsibilities as a registration with NISCC, communication and recording as well as others.

There was a robust system evident in respects to the management of service user medications which saw audits conducted on a weekly, monthly and quarterly basis by senior staff within the service. This is in addition to checks conducted as part of quality monthly monitoring visits.

Competency assessments were in place for staff involved in the management and administration of medications. Preparation of medications observed during the course of the inspection and found to be satisfactory, with the staff member found to comply with prescribing instructions, hygiene standards and completion of the medication administration record sheet (MARs) post administration.

Records of all staff training were retained and the registered manager maintained oversight of the training matrix to ensure compliance.

There was evidence of forward planning, with training sessions booked in advance. It was positive to find that bespoke training was delivered to staff in respects of autism which focused on individualised interventions and practical guidance in effective implementation of these strategies.

Records were reviewed which illustrated provision of regular supervision. In discussion with staff they confirmed participation in supervision. Procedures were in place for appraising staff performance.

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 know to safely assist them in their roles. There was evidence of effective communication occurring amongst the staff team during handover.

There was evidence of regular staff meetings, with minutes maintained of the meetings for staff, unable to attend, to read for information sharing. The registered manager advised that there was a set agenda for team meetings and that staff were provided opportunity to add topics to this.

It was reassuring to find evidence of service users' active involvement in the development and review of their own care plans. Records offered a sense of each individual's identity, providing insight into them as individuals, reflecting service users' preferences, interests, aspirations, and what mattered most to them.

Activities were found to be person-centred and the range of activities engaged in varied greatly from attending the gym, cinema, conventions and sporting events, volunteering, gaming, reading, dining out, day trips and holidays. There was evidence that staff promoted autonomy and choice, supporting service users to make decisions about how they wished to spend their time and engage with their communities.

Staff interactions with service users was observed to be warm, friendly and supportive. Staff consistently sought consent prior to commencing care or support tasks, demonstrating respect for individuals' rights, dignity and personal autonomy.

An area of good practice was identified in relation to tenant meetings, which were facilitated both on an individual and collective basis. The frequency of one to one meetings was determined in consultation with each service user, reflecting a person-centred approach and ensuring that engagement was tailored to individual preferences and needs. These meetings provided valuable opportunities for service users to express their views and opinions regarding the quality of care and support received, with evidence that feedback was considered and action taken when necessary.

Service user participation in all aspects of daily living was actively promoted and encouraged. There was evidence of staff working alongside service users to develop existing skills and acquire new ones, with a clear focus on increasing independence. This promoted service users to exercise choice and control in their daily lives.

3.3.3 Management of Care Records

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

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

Copies of tenancy agreements between service users and the housing association were available within the service. These documents offered clarity regarding the rights and responsibilities of both parties which could be easily referred to as required.

Financial agreements reviewed demonstrated that these were subject to review at least annually. However, there was a lack of consistency regarding those involved in the review process. During discussion, the registered manager advised that two service users did not currently have an allocated social worker, and, consequently, reviews had been undertaken in their absence.

Concerns were identified regarding the apportionment of costs associated with shared household amenities. It was recognised that the assessed needs of an individual service user may have direct impact on the consumption of utilities, potentially resulting in an inequitable financial burden being placed on their co-tenants. The registered manager acknowledged these concerns and advised that they had previously sought input from the organisation's finance department to review the arrangements and ensure that costs were allocated fairly.

The registered provider should ensure multidisciplinary review of current arrangements is undertaken to confirm service users are not disadvantaged financially as a consequence of the assessed needs of others. An area for improvement was identified.

Review of records identified that service users consent was sought in relation to the staff contacting/requesting information from other healthcare professionals on their behalf. It was also positive to find reference to consent contained within service users plans. There was emphasis on service users' rights to make choices and to refuse care and support where they had capacity to do so.

A sample of service users care records found to contain detailed information relating to service users assessed needs, preferences and support requirements. Whilst the quality and comprehensiveness of the information recorded was positive, concerns were highlighted to the registered manager regarding the size and layout of service users plans which made it challenging to locate information efficiently. Moreover, it was felt that this contributed to deficits identified by the Inspector, which were addressed on the day of the inspection. The registered manager acknowledged this and advised that an organisational review of templates utilised was currently ongoing to improve accessibility and succinctness of records. This will be reviewed again during a future inspection.

Evidence of multidisciplinary review of service users' care and support was provided subsequent to the inspection. It was positive to see service users and/or their representative proactively engaged in this process.

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 details of assessments completed and agreed outcomes developed in conjunction with the HSC Trust representative. Any service user subject to authorised Deprivation of Liberty Safeguards (DoLS) had their care plan reviewed by an HSC professional annually to ensure that they were not used disproportionately or for longer than is necessary. Any changes to the DoLS were communicated to the manager and updated documents shared and stored within the service users care records. A central register was in place to enable tracking of any DoLS due for review.

A previous area for improvement relating to restrictive practice was assessed as not having been appropriately addressed by the provider. Noncompliance with the Department of Health Regional Policy on the use of Restrictive Practices in Health and Social Care Settings was found with the agency not maintaining a centralised register detailing the number and type of restrictive interventions deployed. Additionally, two service users plans failed to stipulate restrictive interventions deployed and as such there was no evidence of regular review or planned reduction of these interventions. The area for improvement will therefore be stated for a second time.

3.3.4 Quality of Management Systems

There has been no change in the management of the service since the last inspection. Mr Stephen McGuigan has been the manager in this service since 16 July 2018.

Service users and staff consulted with commented positively about the registered manager describing them as supportive, approachable and able to provide guidance.

There was a process in place to manage any complaints received by the service in line with organisational policy and procedure. It was positive to find complaints information readily available should service users wish to refer to this. The service were in the processes of providing complaints training for all staff, this will be reviewed at a future inspection.

There was a system in place to monitor and review accidents and incidents. An area of good practice was identified in respects to a system utilised by the service to monitor and review behaviours associated with amber phase of positive behavioural support plans. Records reviewed were very detailed in respects to behaviours displayed, possible function of behaviour and promoted consideration of potential triggers in the hopes that once identified these could be eliminated or minimised hence reducing the experience of distress of the individual supported.

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. A specific individual was identified as the agency's ASC. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm.

Information regarding safeguarding concerns reported in respect of the service were stored in a centralised location. Upon review it was acknowledged however that information relating to a recent safeguarding concern had not been recorded within the tracker. This was highlighted to the attention of the registered manager who immediately addressed this.

There was evidence of regular managerial audits in respects of the management of service user's finances and medications. This demonstrated effective oversight and monitoring arrangements were in place.

Review of a sample of records evidenced that a robust system for reviewing the quality of care and staff practices was in place. The agency 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 agency. The reports of these visits were completed in detail and found to contain analysis, establishing appropriate actions to be taken by the agency to drive improvement.

The annual quality report was in the process of being completed at the date of the inspection, this will be reviewed during a future inspection. Reports however analysing feedback received from surveys distributed to service users, their representatives and stakeholder were reviewed and found to be of a good standard.

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	0	2*

* the total number of areas for improvement includes one that has been stated for a second time

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Stephen McGuigan, Registered 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 4.2, 4.3 Stated: First time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure that all agreements, specifically those which include financial arrangements, are monitored, reviewed and up-dated assuring equity regarding financial contributions. Ref: 3.3.3
	Response by registered person detailing the actions taken: Autism Initiatives are in the process of organising dates for MDT meeting's for the three People Supported in Sperrin Drive. During the annual review meetings we will be reviewing financial arrangements for all three people supported. This is to ensure all parties are in agreement, with the finance agreement's in place, for the people we support. In attendance of review will be People We Support, Trust Represtative's, Next Of Kin, During the MDT/Annual review's we will ensure financial agreement are monitored and reviewed to ensure quality regarding financial contributions. Two dates have been agreed, for MDT meetings on 1.7.26 & 30.7.26
Area for improvement 1 Ref: Standard 3.3 Stated: Second time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure that the care plan includes information on: • The care and services to be provided to the service user; • Directions for the use of any equipment; • The administration or assistance with medication; • How specific needs and preferences are to be met; and • The, management of identified risk. This relates specifically to DoLs information and/or any practices deemed to be restrictive. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Registered Manager will ensure the Care Plan for the three people we support includes the above five action points. As of 23.4.26, Person we support has been removed from DOLS and Autism Initiatives have been provided with appropriate documentation- Form 21- Discharge of detention form. Registered Manager will ensure that all documentaion is reviewed and updated to reflect this. At the agreed MDT/ annual review meetings the restrictive practices will be reviewed and monitored.

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



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