

Inspection Report

Name of Service: Shaftesbury Lisburn
Provider: Livability
Date of Inspection: 23 June 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:	Livability
Responsible Individual	Mr Stuart Dryden
Registered Manager:	Jamie Miller
Service Profile : Shaftesbury Lisburn is a supported living service (SLS), domiciliary care agency providing care and support to service users living at various locations in the Lisburn area. The office is located in Comber. The agency's aim is to provide care and support to service users; this includes helping service users with tasks of everyday living, emotional support and assistance to access community services, with the overall goal of supporting service users to live as independantly as possible and maximising quality of life. The agency seeks to enable people to achieve autonomy and choice in the support they receive and the lives they pursue.	

2.0 Inspection summary

A care Inspector completed an unannounced inspection on 23 June 2026 between 09.30 am. and 3.15 pm.

The last care inspection of the agency was undertaken by a care Inspector. No areas for improvement were identified.

This inspection was undertaken to evidence how Shaftesbury Lisburn SLS 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 managed.

The inspection examined the agency's governance and management arrangements, reviewing areas such as staff recruitment, professional registrations, staff induction and training and adult safeguarding. The reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS), Service user involvement, Restrictive practices and Dysphagia management.

An area for improvement identified related to recruitment practices.

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 we reviewed information held by RQIA about Shaftesbury Lisburn SLS. This included the 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 Shaftesbury Lisburn SLS 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 staff survey.

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

The Inspector spoke to relatives and staff to seek their views of living within, visiting and working within the service. The Inspector visited one of the houses in Lisburn on the day of inspection but unfortunately, service users were out with family at that time.

Two staff who described service users as having a "good quality of life". One member of staff stated that team leaders are supportive and have a very good understanding of the needs within the service. They said induction was good and training was very structured.

Relatives contacted following the inspection said they were generally happy with the support being provided. Comments made including those about turnover of staff, were discussed with the manager for consideration. A service user was described as being in "safe hands".

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. Consultation with staff, service users and their representatives established that there were no concerns regarding staffing levels although relatives commented that there appeared to be a frequent turnover of staff.

A review of the agency's staff recruitment records confirmed that criminal record checks (AccessNI), were completed and verified before staff members commenced employment and had direct engagement with service users. The Inspector noted that checks of full employment histories including reasons for leaving previous posts were not consistently evidenced. An area for improvement has been identified.

Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC), 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.

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to NISCC's 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. A robust, structured, induction programme also included shadowing of a more experienced staff member. RQIA was aware of an incident regarding agency staff allocated to the service. The Inspector advised that the induction process for agency staff could be strengthened. Following the inspection the manager outlined the plans to ensure the process is safe, this matter will be reviewed at a future inspection.

The agency has maintained a record for each member of staff of all training, including induction and professional development activities undertaken. Records of all staff training were available and the manager maintained oversight of the training matrix to ensure compliance. This training included Deprivation of Liberties Safeguards (DoLS), Adult Safeguarding, Dysphagia and Management of Epilepsy at a level appropriate to their job roles. Staff confirmed that they were provided with opportunities to complete training commensurate with their role and are actively encouraged to develop new skills and knowledge.

3.3.2 Care records.

There were daily handovers, at the beginning of each shift, which include information about any changes to the service users' care, which the staff needed to assist them in their roles.

The agency held staff meetings and retained the minutes to share with staff who were unable to attend.

Staff were knowledgeable of individual service users' needs, their daily routine wishes and preferences. Information on the service users' day and night routines were also detailed within the support plans; this assisted staff in providing consistency of care and support to service users. Care records were person centred, well maintained and regularly reviewed and updated to ensure they continued to meet the service users' needs. 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. The details of care plans were shared and signed by service users and/or their representatives as appropriate.

3.3.3 Care Delivery

There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had 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 Health and Social Care (HSC) Trust representative. There was a policy in place for the use of restrictive interventions and the agency maintained a register, which the agency reviewed and updated annually. The manager reported some restrictive practices concerned medication and others referred to supervision levels.

It was also positive to note that the agency had house meetings on a regular basis, which enabled the service users to discuss the provisions of their care.

3.3.4 Governance and managerial oversight

The Inspector reviewed a sample of monthly quality monitoring reports, which evidenced that a robust system for reviewing the quality of care and staff practices was in place. The Inspector reviewed the reports and confirmed that these included engagement with service users, service users' relatives, staff and HSC Trust representatives. The reports included details of a review of the care records of service users; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

Review of incident records identified that the manager had managed these appropriately. RQIA had been notified of any incidents in keeping with the regulations. No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure

There was a system in place to ensure that complaints are managed in accordance with the agency's policy and procedure. Staff demonstrated a good awareness of both the complaints procedure and whistleblowing policy. Details relating to the complaints process was included in the Statement of Purpose and Service Users Guide. Monthly quality monitoring visits also reviewed complaints received, permitting examination of any trends or patterns. There were processes in place to review the quality of the service on an annual basis. The Annual Quality Report was reviewed and was satisfactory.

The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. A review of records confirmed that these had been managed appropriately. There was evidence that the agency responded to concerns raised with them and implemented measures to enhance both practice and the quality of service provided.

Fire risk assessments had been completed for the service user dwellings. There was evidence that staff completed fire safety checks as required.

The agency's registration certificate was up to date and displayed appropriately along with current certificates of public and employers' liability insurance.

4.0 Quality Improvement Plan/Areas for Improvement

An Area for improvement has been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	1	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Jamie Millar (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 Domiciliary Care Regulations (Northern Ireland) 2007	
Area for improvement 1 Ref: Regulation 13 (d) (Schedule 3) Stated: First time To be completed by: Immediate from the date of 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 in Schedule 3. Ref: 3.3.1 Response by registered person detailing the actions taken: We will ask all relevant staff to complete a form outlining any gaps in their employment to ensure we have a full employment history available for all workers. This will also include ensuring reasons for leaving previous employment are indicated. The Registered Manager will check this prior to agreeing to proceed with employment of new staff members

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