

Inspection Report

Name of Service: Braidwater Quay

Provider: Northern HSC Trust

Date of Inspection: 28 May 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:	Northern Health and Social Care Trust
Responsible Individual/Responsible Person:	Ms Suzanne Pullins
Registered Manager:	Mr Alan Mc Ninch
Service Profile: This is a supported living type domiciliary care agency based in Ballymena. The service is managed by the Northern Health and Social Care Trust (NHSCT) and is designed to provide care and support to 21 individuals, with enduring mental health needs. The service users live at two separate locations; the majority live in flats at Braidwater Quay; and other service users live at a separate address in Ballymena, which is comprised of a number of bedrooms with shared kitchen/dining and living room spaces. Braidwater Quay also provides community outreach to a small number of 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 28 May 2026, between 9:00 am and 3:00 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 23 June 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. Improvements were required, however, to ensure the effectiveness and oversight of certain aspects of the agency, such as staff training and supervision. The storage of medicines and the self-administration of medicines required to be addressed. Additionally, improvements were required in relation to the governance and managerial arrangements.

RQIA were also concerned regarding the operation of the office, located at a second address, RQIA invited representatives of the Responsible Individual and the Registered Manager to a meeting on 23 June 2026.

The purpose of the meeting was to discuss how the matter will be addressed. During this meeting, details of the actions taken or those they planned to take to address the matters raised were discussed. RQIA will continue to engage with the provider in this regard.

Service users said that the care and support provided by Braidwater Quay was a positive experience. Refer to Section 3.2 for more details.

As a result of this inspection two of the four areas for improvement previously identified were assessed as having been addressed by the provider. Two areas for improvement were stated for the second time. Full details, including new areas 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 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 information held by RQIA about this agency was reviewed. This included the previous QIP issued, 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 the service users/relatives who are in receipt of care and support; the staff who work for 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 happy to have the support and that they liked living there. Comments included that they felt '100 percent safe' there; and that it was 'the best place I have lived in'.

The staff spoken with said that they had no concerns to raise.

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 service users established that there were no concerns regarding staffing levels.

There was a system in place to ensure that recruitment safety checks were verified prior to staff commencing in post. Further detail regarding the inaccessibility of records on the day of the inspection is detailed in section 3.3.3.

Newly employed staff completed a structured induction at the commencement of their employment. It was good to note that this had been further developed since the last inspection, to include mental health awareness.

Review of records, however, identified that an incorrect induction proforma had been completed for an identified staff member. Following the inspection, this was discussed with the manager, who provided assurances that the correct proforma was in the process of being completed. This will be reviewed at a future inspection.

There was a system in place to ensure that all staff were compliant with pre-determined mandatory training requirements. An area for improvement, previously identified in relation to Deprivation of Liberty Safeguards (DoLS) training had been assessed as met.

An area for improvement was also identified in relation to Fire Warden training; and in relation to the need for Bank staff training dates to be recorded.

The inspector was unable to verify whether or not the medicines competency of all staff had been assessed. This was incorporated into the aforementioned area for improvement on training.

Staff supervisions were generally undertaken in keeping with the agency's policies and procedures. Improvements were required, however, in relation to recording the supervision dates of Bank staff, who work for the agency on a regular basis. An area for improvement was identified.

3.3.2 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.

Regular staff meetings were held, with minutes recorded and circulated to ensure staff unable to attend remained informed.

Service users' needs were met through a range of individual and group activities. Review of records, however, identified that service users' meetings had not been held for a significant period; therefore there was no evidence available to demonstrate improvement or outcomes arising from service user consultation. Whilst it was confirmed to RQIA, following the inspection, that a tenants meeting had been held after the inspection, an area for improvement was identified, to ensure that the meetings are consistently held, in keeping with the agency's policy and procedures.

The system for managing medicines was examined. Whilst the majority of service users had their medicines stored within their own flats, the area for improvement, previously identified in relation to the storage of medicines had not been addressed. This would not be in keeping with the ethos of supported living. Additionally, it was identified that the service users were not consistently assessed in relation to their ability to self-administer their medicines. An area for improvement previously identified in relation to the storage of medicines was stated for the second time; and a new area for improvement was identified in relation to self-administration of medicines.

Review of the care records consisted of both the electronic records management system (Encompass); and hard-copy versions. There was evidence that the Encompass system had been audited on a monthly basis. All the risk assessments and support plans had been uploaded to Encompass; however, the audit highlighted that the care plans had not been uploaded to Encompass. Support plans are completed by the agency's staff; and the completion of the care plans is the responsibility of the Trust Community Mental Health Team. Whilst the records indicated that the manager had followed up with the relevant persons in the Trust, it was concerning that these had not been uploaded, given the length of time since this was first identified. Following the inspection, it was confirmed to RQIA that the care plans had been uploaded.

Some service users may require a specialist approach due to their mental health needs and may be subject to Promoting Quality Care (PQC). PQC is regional guidance on the assessment and management of risk in mental health and learning disability services. Understanding the level of risk that a service user may present is an integral part of formulating an appropriate care package.

Where service users are under PQC, a Comprehensive Risk and Management Plan was in place. However, Multidisciplinary reviews of the PQC had not been undertaken on a six monthly basis, in keeping with good practice guidance. Whilst it is the responsibility of the Trust Community Mental Health Team to ensure that multidisciplinary reviews are undertaken on a six monthly basis, advice was provided to the manager to adopt a more integrated approach to partnership working to support the regular review of Comprehensive Risk and Management Plans and ensure emerging risks are not missed.

Review of the care records, identified that the PQC was not referenced in the risk assessment or support plan. In another record, where a service user demonstrated behaviours requiring specific support strategies, this was not reflected in the support plan.

Whilst there was some evidence that staff had received training in relation to support plan writing, it was evident that the learning had not resulted in significant improvements in the quality or standard of the support plans. The area for improvement in relation to staff training was stated for the second time.

Staff recorded regular evaluations about the care and support provided; this promotes oversight by enabling review of the quality of care and identifying any emerging issues or needs.

The manager had been advised at the previous care inspection of the need for all records to be retained within the registered office. During this inspection, it was identified that an office located at another address, had been operating as a separate fully-functioning office, with only a small number of records being returned to the registered office for filing.

RQIA invited representatives of the Responsible Individual and the Registered Manager to a meeting on 23 June 2026. The purpose of the meeting was to discuss how the matter will be addressed. During this meeting, details of the actions taken or those they planned to take to address the matters raised were discussed. This should ensure that all records are available for inspection going forward, and historical records dating back to 2009 are archived. RQIA will continue to engage with the provider in this regard.

Areas of the communal environment at this address requiring attention were also highlighted to the manager to ensure alignment with a homely and supported living ethos.

3.3.4 Quality of Management Systems

There has been no change in the management of the agency since the last inspection. Mr Alan McNinch has been the manager in this agency since 18 November 2015.

Review of a sample of records evidenced that a system was in place 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. A review of these monitor reports identified some gaps in the oversight arrangements. There was insufficient assurance that visits had been undertaken consistently across both addresses, two of the four areas for improvement previously identified by RQIA had not been addressed, and one service user was referenced under an incorrect unique identifier. This indicates that the monitoring process requires greater scrutiny to ensure it is robust and effective. An area for improvement was identified.

There was no process in place to assess the competency of the persons in charge, in the absence of the manager. An area for improvement was identified.

Review of the staffing roster identified that the manager's presence was not recorded when in the aforementioned office. Advice was given in relation to ensuring that the manager's presence is recorded on both staffing rosters whilst both addresses are operating under the registration of Braidwater Quay. This will be reviewed at a future inspection.

The monthly quality monitoring reports included details of any incidents which had occurred and any which may be reportable to RQIA, in keeping with the regulations. Review of incident records in the second property identified one incident that should have been reported to RQIA. An area for improvement was identified.

There was a process in place to manage any complaints.

The annual quality report was reviewed and noted to include stakeholder feedback.

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.

There were processes in place to manage the safeguarding and protection of adults at risk of harm. However, an issue was identified whereby staff did not consistently recognise their role to advocate for service users to report concerns relating to the timing, completion, or quality of calls from an external provider, where these may impact on care needs. This was raised with the manager, who agreed to provide further guidance to staff to reinforce correct reporting procedures.

There was a protocol in place for staff to follow should they be unable to gain access to the service users' homes.

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	3*	6**

* the total number of areas for improvement includes one that was stated for a second time.

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Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Alan McNinch, 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	
Area for improvement 1 Ref: Regulation 14 (c) (e) Stated: Second time To be completed by: Immediate from the date of the inspection	The registered person shall ensure that service users are provided with a secure facility for the storage of medicine within their individual rooms. Ref: 3.3.2 Response by registered person detailing the actions taken: Secure storage of medicines has been provided in individual rooms for those tenants who consented to same. Where an individual has declined to have their medication stored in their room this has been documented in their support plan. RQIA Inspector has been advised of this change in respect of recommendation made. Where tenants' medication is required to be stored outside their room, it is held in a medicine cabinet in the staff office.
Area for improvement 2 Ref: Regulation 16 (2) (a) Stated: First time To be completed by: Immediate from the date of the inspection	The registered person shall ensure that appropriate training is up to date and recorded for all relevant staff; this relates specifically to: - Fire Warden training for staff who may be in charge of the building in the absence of the registered manager - Bank staff, who work regularly within the service - completed medicine competency assessments for all staff who administer medicines. Ref: 3.3.1 Response by registered person detailing the actions taken: All permanent staff working within Supported Living Units attend Fire Warden Training. All bank staff working within BWQ and Carniny court have now applied for Fire Warden training and this was completed on 29.07.2026. The training matrix has been update to reflect this change and this information is retained on the managers' shared drive. The medication competency assessments for all staff who administer medications was to be completed by 24.07.26 unless staff were on sick leave. This was for 9 staff in Carniny Court and 5 staff in Braid Water Quays. There is still 1 member of staff to complete training when they are next on shift. These records will be maintained in the schemes medication folder and on the managers' shared drive.

Area for improvement 3 Ref: Regulation 15 (12) (b) Stated: First time To be completed by: Immediate from the date of the inspection	The registered person shall ensure that RQIA is notified of any incident involving the Police Service of Northern Ireland (PSNI). Ref: 3.3.3
	Response by registered person detailing the actions taken: The manager of BWQ was on leave and RQIA were informed by the manager covering who reported this incident via the portal aligned to Church Lane Mews. Following a discussion with the RQIA inspector, it has been agreed that in future the covering manager will send an email regarding any such incident to RQIA and on their return the scheme manager will upload the details via their unit aligned portal.

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 Ref: Standard 12.3 Stated: Second time To be completed by: Immediate from the date of the inspection	The registered person shall ensure that all staff receive training in respect of support plan writing, as appropriate to their roles and responsibilities; evidence of the training must be retained for inspection purposes. Ref: 3.3.2
	Response by registered person detailing the actions taken: All staff in post at time of the inspection had completed training in support plan writing and this was recorded on the training matrix. New starts will complete this training by 31.08.26.
Area for improvement 2 Ref: Standard 13.3 Stated: First time To be completed by: Immediate from the date of the inspection	The registered person shall ensure that completion dates of Bank staff supervisions are recorded and made available for inspection; this relates to Bank staff who work regularly and/or exclusively in the service. Ref: 3.3.1
	Response by registered person detailing the actions taken: All bank staff will have 6 monthly supervision and this information will be maintained within the schemes records and on the managers' shared drive. This will be printed and signed and saved in their personal file.
Area for improvement 3 Ref: Standard 1 Stated: First time To be completed by: Immediate from the date of the inspection	The registered person shall ensure that tenants' meetings are held in keeping with the agency's policy and procedures. Ref: 3.3.2
	Response by registered person detailing the actions taken: Records of all future tenants' meetings will be held and records maintained in keeping with the TRust's policies and procedures. Meetings will be held monthly and date & time advertised on the board.
Area for improvement 4 Ref: Standard 8.6 Stated: First time	The registered person shall ensure that service users' ability to self-administer their own medicines is assessed and reviewed on a regular basis. Ref: 3.3.2

To be completed by: Immediate from the date of the inspection	Response by registered person detailing the actions taken: The ability to self administer medication is assessed using the documentation in the scheme and discussion with the service user, GP/CMHT or other service involved, including the pharmacy supplying same. Review of self-administration is completed on an agreed schedule as part of the agreed support plan depending on the individuals progress and through regular communication and/or spotchecks with the service-user. All this information is recorded and updated as required within the service user's care and support plans, risk assessments and any other documentation included in the process.
Area for improvement 5 Ref: Standard 8.11 Stated: First time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure that the monthly quality monitoring reports, reflect review of any RQIA QIP, on a monthly basis, up to the next inspection; and that any unique identifier reference numbers used are recorded accurately. Ref: 3.3.3 Response by registered person detailing the actions taken: Any further RQIA QIP will be recorded and remain in section 11 of the monthly monitoring report until the next RQIA inspection at each monthly monitoring meeting. Staff will be reminded to be diligent when entering the unique identifier reference.
Area for improvement 6 Ref: Standard 8 Stated: First time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure that the persons in charge of the agency, in the absence of the registered manager, have their competency assessed in this regard. Ref: 3.3.3 Response by registered person detailing the actions taken: All staff complete their induction and ongoing mandatory and scheme-specific training. Supervisions and annual appraisals ensure that development is ongoing and standards of practice are maintained. RQIA inspector has provided a Competency assessment template to help inform a scheme checklist to help achieve consistency across all schemes and all grades.

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