

Inspection Report

Name of Service: The Heathers

Provider: Inspire Wellbeing

Date of Inspection: 25 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:	Inspire Wellbeing
Responsible Individual/Responsible Person:	Ms Kerry Anthony
Registered Manager:	Mr Andrew McMurray (Acting)
Service Profile – The Heathers is a domiciliary care agency (supported living type) based in Armagh. The agency offers care and housing support to up to 23 service users. Service users have their care commissioned by the Southern Health and Social Care Trust (SHSCT) the Belfast Health and Social Care Trust (BHSCT) and Supporting People.	

2.0 Inspection summary

An unannounced inspection took place on 25 June 2026, between 9.35 am and 5.20 pm. A care Inspector conducted the inspection.

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 3 April 2025; and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

It was established that staff treated service users with dignity and respect, effective and compassionate care was delivered to service users receiving support from the agency and care records were person centred and provided evidence of service user involvement. Details and examples of the inspection findings can be found in the main body of the report.

There were good governance and oversight arrangements in place, service users were observed to be relaxed and comfortable in their interactions with staff and spoke positively about the care and support they receive.

As a result of this inspection four of the five areas for improvement were assessed as having been addressed by the provider. One area for improvement has been stated for a second time. Full details can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

The Inspector would like to thank the manager, service users and staff team for their support and co-operation during the inspection.

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 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 those working for or being supported by the agency and review a sample of records to evidence how the agency 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

The Inspector spoke to service users and staff to seek their views of living and working within the agency.

Service users spoke positively about their experience of the support provided by the agency; they said they enjoyed living in the supported living service and that the staff supported them well. The service users told us that they were able to choose how they spend their day. Service users' comments included; "I like living here; this is my home", "I do my own cooking and go shopping for my groceries" and "I can't think of anything to make things better".

Staff told us that they were satisfied that the care and support was safe, effective, compassionate and well led. Staff spoke positively about the care delivery, training and management support in the agency. Staff comments included; "Care and support is of a high standard and based on individual needs and choice" and "Great communication and good teamwork".

Returned staff questionnaires confirmed that safe, effective and compassionate care was delivered to service users and the agency was well led.

The information provided indicated that those who engaged with us had no concerns in relation to the agency.

3.3 Inspection findings

3.3.1 Staffing Arrangements (recruitment and selection, induction and training)

Safe staffing begins at the point of recruitment and continues through to staff induction and through completion of regular staff training to ensure the agency safely and continually meets the needs of service users.

An area for improvement identified during the previous inspection related to obtaining a reference from the applicant's current or most recent employer. Review evidenced that this reference had been obtained. Further review of two staff recruitment records confirmed that references had been obtained from the applicants' current or most recent employer. On this basis, the area for improvement was assessed as met.

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.

An area for improvement identified during the previous inspection related to the monitoring of staffs' professional registrations. Review evidenced that monthly checks were completed to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC). These checks included staff supplied by recruitment agencies. On this basis, the area for improvement was assessed as met.

An area for improvement identified during the previous inspection related to timely referral to NISCC Fitness to Practice. Fitness to Practice ensures social care workers meet the standards of character, conduct and competence necessary to do their job, safely and effectively in line with the Social Care Council Standards of Conduct and Practice. Discussion with the manager confirmed that the agency's procedures were reviewed and updated to outline a referral is to be made with 24 hours of any alleged incident. On this basis, the area for improvement was assessed as met.

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. There was a robust, structured, programme which also included shadowing of a more experienced staff member.

Written records were retained by the agency of the person's capability and competency in relation to their job role. All staff received regular supervision and annual appraisal which supported their professional development and enabled them to discuss concerns and training needs.

There were competency assessments undertaken in respects of all staff involved in the management and administration of medication, which was reviewed on an annual basis. A number of weekly medication audits were also reviewed.

An area for improvement identified during the previous inspection related to food safety and medicines management training. Review of the staff training matrix evidenced that these trainings had been completed. On this basis, the area for improvement was assessed as met.

Staff provided positive feedback regarding the training they received and confirmed that it enabled them to fulfil the duties and responsibilities of their roles. Staff were provided with training appropriate to the requirements of their roles, which was recorded and monitored on a colour coded training matrix. The review concluded that staff had received mandatory and other role specific training since the last care inspection, including fire safety, dysphagia and medicines management. It was positive to note that service user specific training had also been provided to all staff including Autism Awareness and Learning Disability Framework training.

Discussion took place, with the manager, regarding the need for further service specific training in relation to mental health awareness. Confirmation was received, post inspection, that mental health awareness training had been sourced and staff are scheduled to attend. This will be reviewed at the next care inspection.

Staff confirmed that they were provided with opportunities to complete training commensurate with their role and are actively encouraged by the manager to develop new skills and knowledge.

There was evidence of effective systems in place to manage staffing. Staff reported collaborative team working and confirmed that they felt well supported in their roles by the manager. Staff also reported staffing levels were sufficient to meet the needs of the service users, and staff demonstrated a clear understanding of the needs, preferences and wishes of individual service users.

There was evidence of staff meetings. Staff stated they could add to the meeting agenda if there were items they wished to discuss. Minutes were maintained of the meetings for staff unable to attend, to read for information sharing.

3.3.2 Care Delivery

There was a handover at the beginning of each shift, which all staff attended. These meetings focused on information about any changes in the service users' care needs.

Discussion with staff confirmed that service users are in control of their day and are supported to choose activities and things to do that are meaningful to them. The service users availed of a variety of activities which included going to the cinema, shopping, Fit 4 U, swimming, bingo, games nights, barbeques and work placements. These activities were planned and reflected the individual choices of the service users.

The agency held meetings with service users on a regular basis which enabled the service users to discuss the provisions of their care and prepare for their annual care review meetings.

Staff were observed communicating patiently, respectfully and sensitively with service users. Staff were knowledgeable of individual service users' needs, their daily routine, wishes and preferences.

3.3.3 Management of Care Records

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.

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. There was evidence that staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate.

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.

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 (DoLS), the care records contained details of assessments completed and agreed outcomes developed in conjunction with the Health and Social Care (HSC) Trust representative. A central register was in place to enable tracking of any DoLS due for review.

There was a policy in place for the use of restrictive interventions and a register was in place which was reviewed and updated regularly.

Discussion with the manager and review of arrangements concerning the storage of confidential records confirmed that service users' records were stored safely and securely in compliance with legislative. Staff recognised the importance of maintaining accurate and contemporaneous records to guide their practice and ensure that care provided was safe, effective and timely.

Staff recorded regular evaluations about the care and support provided. A review of a sample of these records evidenced that they were person centred and detailed.

Care reviews had been undertaken in keeping with the agency's policies and procedures.

3.3.4 Quality of Management Systems

We discussed the acting management arrangements, which have been ongoing since 16 June 2026; RQIA will keep this matter under review. Those consulted commented positively about the manager and described him as approachable, responsive and supportive.

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

An area for improvement identified during the previous inspection related to the provision of monthly quality monitoring.

A review of quality monitoring reports evidenced that these visits were not always undertaken monthly, for example September's visit was undertaken on 13 November 2025. This area for improvement has been stated for a second time.

A review of the reports of the agency's quality monitoring established that there was engagement with service users, service users' relatives, staff and Health and Social Care (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 reports of these visits were completed in detail.

Incidents were managed appropriately and it was positive to note that any identified learning was shared with staff.

The manager described a transparent learning culture within the agency in which staff are supported and encouraged to engage in reflective practice; the manager stated that this approach allows staff to consider any lessons learnt and review how to improve service delivery.

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 was an individual within the organisation's senior management team who was identified as the appointed ASC for the agency. The annual safeguarding position report had been completed and was found to be satisfactory.

Discussions with the manager established that they were knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting and managing adult safeguarding concerns.

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 their responsibility in identifying and reporting any actual or suspected incidences of abuse and the process for reporting concerns. 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 whistleblowing.

Complaints were managed appropriately and it was positive to note that any identified learning was shared with staff.

Staff demonstrated an awareness of their role, responsibilities and knowledge of lines of accountability and knew when and who to discuss concerns with. All staff consulted with described an open door policy with the manager and that they were confident that any concerns or suggestions made would be listened to and addressed.

A range of policies were held electronically and available to direct staff in care delivery and support planning based on individual risk assessments.

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	1*	0

* one area for improvement has been stated for a second time.

An area for improvement and details of the Quality Improvement Plan were discussed with Mr Andrew McMurray, 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 (Northern Ireland) 2007	
Area for improvement 1 Ref: Regulation 23 (1) Stated: Second time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure that monthly quality monitoring visits are undertaken on a monthly basis. Ref: 3.3.4
	Response by registered person detailing the actions taken: The registered person has reviewed the requirement for timely completion of reports with those completing quality monitoring.

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



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