

Inspection Report

Name of Service: WHSCT Learning Disability Supported Living Service

Provider: Western HSC Trust

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:	Western HSC Trust
Responsible Individual/Responsible Person:	Mrs Karen Hargan (Pending)
Registered Manager:	Mrs Moira Millar
Service Profile: WHSCT Learning Disability Supported Living Service is a supported living type domiciliary care agency which supports 20 service users with learning disability needs. The service users live in individual and shared housing across the Derry/Londonderry and Limavady areas.	

2.0 Inspection summary

An unannounced inspection was undertaken 23 June 2026, between 10.10 am and 5.50 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 19 May 2025; and to determine if 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. However, improvements were required to ensure the effectiveness and oversight of certain aspects of the agency, such as provision of supervision, selection and recruitment practices and safeguarding procedures.

It was evident that staff promoted the dignity and well-being of service users and that staff were knowledgeable and well trained to deliver safe and effective care.

Service users said that the care and support provided by WHSCT Learning Disability Supported Living Service was a good experience. Refer to Section 3.2 for more details.

As a result of this inspection two areas for improvement previously identified were assessed as having been addressed by the provider. Two previous areas for improvement have been carried forward and will be reviewed at a future inspection. One previous area for improvement will be stated for a second time. Two new areas for improvement were identified during this inspection. 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 WHSCT Learning Disability 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 we reviewed information held by RQIA about this service. This included the previous Quality Improvement Plan 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 being supported by and working for the agency; and examine a sample of records to evidence how the service is performing in relation to the regulations and standards.

Information was provided to service users, their representatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included questionnaires, an electronic survey and contact details of the Inspector.

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.

Three service users were consulted all of which were highly complementary about staff describing them as "brilliant" and advising that they "couldn't do enough for us". One service user kindly offered to show the Inspector around their home which was decorated in keeping with their own personal preference. Items reflecting the interests of each individual were apparent throughout the property.

The service user spent time showing the Inspector their bedroom which was large and spacious, with personal items such as family photos displayed as they talked about the sense of security they have living within their home supported by staff.

The service users told us that staff assist them in preparing meals, domestic tasks and with engaging with community services. We were told how staff had supported them in organising a holiday, which they spoke about having been a good experience as they presented their photo album. It was positive to hear service users discuss the hopes they held for their future and the support they have received from staff to achieve outcomes.

One service user expressed some concerns regarding proposed changes to provision of care and support. These were discussed with the registered manager who agreed to take appropriate action to address.

Staff consulted advised that they were happy within their work. Staff told us that they received good support from Team Leaders who were readily available should advice or guidance be required. It was also positive that staff had awareness as to the on call arrangements. Staff spoke positively about the registered manager advising that they had an open door policy and would seek to help in whatever manner they could.

Discussions with staff demonstrated values for promoting person-centred care, dignity, choice and respect. Staff spoke knowledgeably about service user plans and recognised the importance of delivering care in accordance with each individual's assessed needs and preferences. Some concerns were expressed regarding the planned reduction in support for identified service users, with staff advising that updated plans had not yet been provided. This was discussed with the registered manager who agreed that all required information would be appropriately communicated to the staff team prior to implementation.

Feedback received from HSC professionals in relation to the service was highly complementary. HSC professionals consistently described communication with the service as "excellent", advising effective communication was maintained with both professionals and, where appropriate, service users' representatives. They told us they were kept well informed of any changes to service users' needs, enabling timely review and coordination of care. One HSC professional expressed confidence in staff's ability to respond appropriately to incidents and safeguarding concerns.

HSC professionals described staff as having "great knowledge and insight" into the needs of the individuals they support. A consistent theme within the feedback was staff's commitment to promoting and upholding the rights of service users. Several HSC professionals' described staff as "strong advocates" who routinely went "over and above" to enhance the quality of life, wellbeing and outcomes of those supported by the service.

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. Forward planning was evident in respect of staff schedules.

The service was utilising agency staff supplied by external organisations to maintain staffing levels. A review of records held in respect of agency staff identified that the training of several agency workers had lapsed. The provider took immediate action to address these findings, and evidence of completed, up-to-date training was made available to the inspector. As such the inspector was satisfied that prompt action had been taken to mitigate against immediate risk.

The importance of maintaining robust oversight of agency staff compliance, including regular verification of training and other employment-related documentation, was discussed with the person in charge. They acknowledged the need to strengthen existing monitoring arrangements and agreed to implement more effective systems. This will be reviewed again at a future inspection.

Review of the agency's staff recruitment records identified that a new criminal record check (AccessNI) had not been completed in respects of one employee who had worked in a different role with the same provider. Provider communication sent by RQIA 14 April 2026 regarding AccessNI Enhanced Disclosure Checks was discussed with the person in charge, who provided assurances regarding knowledge of, and compliance with its contents from 1 June 2026.

Review of one employee's recruitment records identified concerns pertaining to a lack of assurance regarding the authenticity and veracity of references. RQIA had sent communication to providers, 28 October 2025 highlighting the importance of ensuring existing selection and recruitment policies and procedures are robust and fit for purpose, which highlighted associated risks were systems fail. A references received from personal email address had not seen any additional action taken to assure the legitimacy of the sender. An area for improvement was identified.

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. One employee's records reviewed however did not contain dates for which shadowing was completed of a more experienced member of the team. Additionally, in speaking with the person in charge changes to the service's induction programme, to date has not been undertaken with substantive staff. Due to this the area for improvement previously stated will be carried forward and reviewed again at a future inspection.

A review of the agency's training records found that the system utilised to monitor training did not produce overall compliance rates, limiting the provider's ability to effectively monitor workforce compliance. A number of training courses had expired at the time of inspection.

During discussions, the person in charge advised that training dates had been secured to address identified gaps. Evidence submitted following the inspection demonstrated that progress had been made in arranging outstanding training. The inspector was satisfied with the actions taken to date. The previously identified area for improvement will be carried forward and reviewed at a future inspection to ensure all required training remains up to date and that effective systems are in place to monitor ongoing compliance.

The system utilised by the agency to monitor supervision and appraisal was unable to generate compliance rates. This limitation made it difficult to determine whether practice was consistently aligned with the agency's policies and procedures. This was brought to the attention of the person in charge, who agreed to discuss the issue internally.

Review of records illustrated that a number of staff were outstanding an appraisal. In discussion, the person in charge advised as to a plan to address this within the month. Upon further review it was identified that a number of staff had not participated in supervision at the frequency stipulated by the agencies policy and procedures. An area for improvement was identified.

3.3.2 Care Delivery

Staff advised there was a 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.

There was evidence of recent team meetings for which senior representatives had also attended. We were advised that minutes of team meetings were held and maintained to enable those staff who were unable to attend, to read for information sharing.

Staff spoken with were knowledgeable of individual service users' needs, their daily routine, wishes and preferences. Activities offered to service users were varied and geared towards their individual needs and personal interests. Staff interactions with service users were observed to be friendly and supportive. Staff were skilled in communicating with service users; they were respectful, understanding and sensitive to service users' needs.

It was observed that staff respected service users' privacy by their actions such as knocking on doors before entering and discussing service users' care in a confidential manner. Staff were also observed offering service users choice in how and where they spent their day or what meals they wished to prepare.

Where service users required support with domestic tasks, the level of support required was included in their support plan. Information on the service users' routines were also detailed within the support plans; this assisted staff in providing consistency of care and support to service users.

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.

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. An area of good practice was recognised with the service seeking consent from service users in relation to any restrictive practice interventions utilised as part of their care and support.

Care records were 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.

There was evidence that the service had completed medication assessments with service users to ascertain the level of support required in relation to the management of medication. This information was clearly detailed within service users' plans. A previous area for improvement was assessed as having been satisfactorily addressed by the provider.

Review of records identified that the care plans were reflective of the recommendations outlined within the Speech and Language Therapy (SALT) Care Plan. Issues identified in respects of one service users care plan were immediately rectified during the inspection.

A review of service users' care plans identified that some documented risks and associated risk management plans were not always proportionate to the individual's assessed needs or reflective of their known history. This resulted in care plans being unnecessarily lengthy, and in places, difficult to navigate, reducing their effectiveness as a practical guide for staff.

These findings were discussed with the person in charge and the importance of ensuring proportionate, person-centred risk assessments which are concise, relevant and well organised are maintained was stated. An agreed action plan was developed for the service to review service users' records and ratify issues identified. This will be reviewed again at a future inspection.

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. None of the current service users supported by WHSCT Learning Disability Supported Living Service were experiencing a deprivation of liberty.

Restrictive Practice interventions deployed by the agency to assure the safety and wellbeing of service users and/or others were reviewed alongside the service user plans during the annual care review and subject to multidisciplinary consideration. As noted above service user consent was also sought. Such interventions were identified clearly within service user plans.

The service however were found not to retain a centrally held register. Direction was given to the person in charge to review current service practice and ensure compliance with the Regional Policy on the use of Restrictive Practices in Health and Social Care Settings. This will be reviewed again at a future inspection.

3.3.4 Quality of Management Systems

There has been no change in the management of the service since the last inspection. Mrs Moira Millar has been the manager in this service since 5 December 2019. Staff consulted commented positively about the manager describing her as supportive and approachable.

Clear and accessible information was available to service users and their representatives regarding how to raise a complaint. The agency had established procedures to ensure any concerns received would be managed in a transparent and structured manner.

Review of incident records identified that they were managed appropriately. There was evidence that incidents were audited on a regular basis. It was good to note that these were reviewed as part of the monthly quality monitoring process. It was suggested however that greater detail regarding any developing patterns/trends would be beneficial to aid the response of the service. The person in charge was receptive to this and agreed to implement the proposed change with immediate effect.

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 found that the service did not maintain a system to follow the progression of safeguarding concerns. As such the inspector was unable to determine the number of safeguarding concerns reported since the date of the previous inspection. Information was later produced, however, this failed to appropriately advise as to the status of the safeguarding concern or as to outcomes of associated investigations. An area for improvement was identified.

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. As noted above advice was given in relation to ensuring sufficient detail was included in relation to incidents, accidents and safeguarding concerns. This will be reviewed again at a future inspection.

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*	2*

* the total number of areas for improvement includes two which has been carried forward from the previous inspection

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms, Kirsty McKelvey, Community Services 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 16(2)(a) Stated: First time To be completed by: Immediate from the date of inspection	The Registered Person shall ensure that all staff complete mandatory training requirements; awareness training in respect of service users with forensic histories should also be provided to staff; records of this training, by whatever means it is provided, should be retained for inspection purposes. Ref: 2.0 & 3.3.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 Ref: Regulation 16 (4) Stated: Second time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure that all staff are provided with supervision in keeping with the agency's policy and procedures. Ref: 2.0 & 3.3.1
	Response by registered person detailing the actions taken: All staff have either received supervision or have planned date. Manager has an oversight process in place to review Supervision and appraisals weekly. This is also audited by Community Service Manager 8a and also via Monthly Monitoring.
Area for improvement 3 Ref: Regulation 15(12)(a) Stated: First time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure written records are retained and made available for the purpose of inspection of safeguarding concerns relating to the agency and any additional documentation evidencing associated action taken in response. Ref: 3.3.4
	Response by registered person detailing the actions taken: Actioned. Written records in place for all ASG incidents and new ASG database is being developed and overseen by Head of Service.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 Ref: Standard 11.2 Stated: First time	The Registered Person shall ensure that all efforts are made to assure the legitimacy of references received in respects of applicants. Ref: 3.3.1

To be completed by: Immediate from the date of the inspection	Response by registered person detailing the actions taken: Manager of agency has spoken with HR and AMIQUUS management regarding process of screening candidate references. References received are screened with any concerns escalated to the recruiting manager alongside HR. If the professional reference is not satisfactory this will trigger a HR and manager response. This includes receipt of references from a personal email.
Area for improvement 2 Ref: Standard 12.4 Stated: First time	The Registered Person shall ensure that the induction process is further developed to ensure that it is reflective of the needs of the service users currently being supported by the agency; this includes the induction of substantive staff and the induction of agency staff. Ref: 2.0 & 3.3.1
To be completed by: Immediate from the date of the inspection	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.

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



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