

Inspection Report

Name of Service:	Bryansford Road
Provider:	Autism Initiatives NI
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:	Autism Initiatives NI
Responsible Individual/Responsible Person:	Ms Adele Leighton
Registered Manager:	Mrs Sinead Houston
Service Profile: Bryansford Road is a supported living type domiciliary care agency which provides personal care and housing support to a maximum of four adults with Autistic Spectrum conditions, learning disability and/or mental health diagnosis. The agency also provides an outreach service, to service users who live in the community. RQIA does not regulate this element of support.	

2.0 Inspection summary

An unannounced inspection took place on 25 June 2026, between 9.30 am and 1.00 pm by a care Inspector.

The last care inspection of the agency was undertaken on 13 May 2025 by a care Inspector. No areas for improvement were identified. This inspection was undertaken to evidence how the agency 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 led.

The inspection found that safe, effective and compassionate care was delivered to service users and that the agency was well led. Details and examples of the inspection findings can be found in the main body of the report.

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 Bryansford Road was a positive experience. Refer to Section 3.2 for more details.

No areas for improvement were identified during this 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 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 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 the care and support provided by Bryansford Road was a positive experience. They described the staff as being 'nice' and how they 'like the company of the staff'. All service users said that they can tell the staff about their likes and dislikes and that they are supported to make their own choices about how to spend their days.

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.

The inspection found that there were no concerns regarding staffing levels.

There was a process in place to ensure that recruitment was managed appropriately; this ensured that all pre-employment checks, including criminal record checks (AccessNI), are completed and verified before staff members commenced employment and have direct engagement with service users.

Newly employed staff completed a structured induction at the commencement of their employment which included mandatory training.

A robust system was in place to ensure that all staff were compliant with pre-determined mandatory training requirements. It was good to note that there was 99 percent compliance with staff training; this is commended.

Competency assessments were undertaken on all staff to ensure that they were competent in their roles and responsibilities.

Procedures were in place for appraising the staffs' performance and supervisions were undertaken in keeping with the agency's policy and procedures.

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. It was good to note that any Speech and Language therapy (SALT) recommendations were included in the handover proforma; advice was given in relation to including a section whereby incidents could be similarly communicated to staff.

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. It was reassuring to note that service users were consulted about the activities they preferred, ensuring their views informed and shaped the day-to day activities. The activities the service users preferred to engage in were included in the 'About Me' document, which staff developed with the service users' input.

Service users were consulted with regularly in relation to their participation in various activities. Examples of the activities included going for drives, gardening or baking. Service users were supported to go for a pint if they wanted. It was also good to note that service users were involved in choosing a new paint colour for their bedrooms.

Service users' needs were assessed when they were first referred to the agency and before care delivery commenced. Following this initial assessment support plans were developed to direct staff on how to meet service users' needs and included any advice or recommendations made by other healthcare professionals. The details of support plans were signed by service users and/or their representatives as appropriate. Future goals and support goals were reviewed by staff on a monthly basis until achieved. A Service Summary was then completed within a number of months, to evaluate how the care delivery was matching up to the support plan.

Additional support protocols were developed for service users where they may need additional support with any behaviours that may be deemed as challenging or if they required any PRN medicine to manage this aspect of their care.

Service users had a health pathway and a health action plan in place to support their physical care needs.

Each service had a tenancy agreement in place.

A service user agreement was in place for each service user in keeping with the minimum standards and formed part of the Service Summary.

Service users had a Financial Agreement and a Budget Plan in place, as appropriate.

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 daily notes were recorded on an electronic records management system, which was designed to ensure the notes were detailed and meaningful. For example, the staff had to note what went well in the service users' day, if anything different happened or if anything did not go to plan. Staff recorded what the service user did for themselves and how they supported the service users to plan, organise and structure their day. The notes also showed that the staff considered the service users' choice in what they did and if they had control/ownership; and that their understanding was checked. The standard of the daily notes was excellent and is commended.

Review of records identified that the care plans were reflective of the recommendations outlined within the SALT Care Plan.

At times some service users may require the use of equipment that could be considered restrictive or they may live in a secure environment to keep them safe. It was established that safe systems were in place to safeguard service users and to manage this aspect of care. Any restrictive practices were reviewed alongside the support plan, care review and subject to multidisciplinary review. Advice was given in relation to increasing the frequency of reviews of the restrictive practice register.

Some service users were supported to self-administer their own medicines; this aspect of care delivery was included in the restraint reduction plan.

It was noted that service users' medicines were stored in a designated medication room rather than within their individual accommodation. These arrangements were discussed with the manager in the context of the ethos and principles of supported living, including the promotion of independence, choice and control. The manager provided assurance that the arrangements for the management and storage of service users' medicines would be reviewed on an individual basis, with decisions informed by a person-centred risk assessment to ensure that each arrangement reflects each service user's needs, preferences and assessed level of risk.

Records were held confidentially.

Specific areas of the communal environment 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.

Review of a sample of records evidenced that a robust system for reviewing the quality of care and staff practices was in place; it was good to note that the monthly quality monitoring arrangements included a focus of SALT diets.

There was a process in place to manage any complaints.

Review of incident records identified that they were managed appropriately. The electronic system used enabled live patterns or trends to be identified and the Trust's keyworkers had been informed of incidents in a timely manner.

RQIA had been notified appropriately of any incidents in line with requirements.

Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC); there was a system in place for professional registrations to be monitored by the manager.

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.

A specific individual was identified as the agency's ASC. The annual safeguarding position report had been completed.

It was established that effective systems and processes were in place to manage the safeguarding and protection of adults at risk of harm.

There was evidence that the manager responded to any concerns, raised with them and/or identified through the agency's internal quality assurance processes, and took appropriate measures to improve practice, and the quality of services provided by the agency.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Sinead Houston, Manager, as part of the inspection process and can be found in the main body of the report.



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