

Inspection Report

Name of Service: Garryduff Supported Living Service

Provider: Triangle Housing Association

Date of Inspection: 18 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:	Triangle Housing Association
Responsible Individual/Responsible Person:	Mr Christopher Harold Alexander
Registered Manager:	Mrs Kelly McKay
Service Profile: Garryduff Supported Living Service is a Domiciliary Care Agency, supported living type. The agency provides 24 hour personal care and housing support to service users who live in shared accommodation. Service users have individual rooms and a range of shared areas. The service users care is commissioned by the Northern Health and Social Care Trust (NHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 18 June 2026, between 10.30 am and 5.30 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 5 June 2025; and to determine if the agency is delivering safe, effective and compassionate care, and if the service is well led.

As a result of this inspection, one of the two areas for improvement was assessed as having been addressed by the provider. However, the area for improvement relating to care records has been restated. Full details, including the restated area for improvement, are available in the main body of this report and in the Quality Improvement Plan (QIP) in Section 4.

It was evident that staff were knowledgeable and trained to deliver safe and effective care.

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 areas for improvement 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 staff survey.

3.2 What people told us about the service

As part of the inspection process, staff members were consulted regarding their views on the care and support provided by the agency. No service users were available to speak with the inspector, but positive interactions between a service user and staff were observed.

Staff spoke positively about the manager, staff training and the care and support delivered to the service users. Comments included: "The service is well managed and the manager has an open door policy. Training is effective, and the trainer is enthusiastic, delivering excellent training. I enjoy working with the service users, who are provided with choices about their day. Some service users are non-verbal; however, we understand their gestures and needs. We have a stable staff team, and I enjoy my job" and "We work well as a team. The training is really good, with plenty to learn, and I receive sufficient training to perform my role effectively. Service users are given choices where possible, and we get to understand their needs. Care plans are in place to direct their care. I love my job."

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through staff induction, regular staff training, and ensuring that the number and skill level of staff on duty each day meet the needs of service users.

There was evidence of robust systems in place to manage staffing; it was noted that there were enough staff on duty to meet the needs of the service users.

A review of the staff recruitment records confirmed that pre-employment checks, including criminal record checks (AccessNI), were completed and verified before staff members commenced employment and had direct engagement with service users.

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. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

There was a robust, structured induction programme that included shadowing a more experienced staff member. Records reviewed confirmed that staff had completed a structured orientation and induction to ensure they were competent to fulfil the roles and responsibilities of their job.

The agency has maintained a record for each member of staff, documenting all training, including induction and professional development activities undertaken. A review of a sample of staff training records established that the majority of staff had received mandatory training relevant to their roles and responsibilities. A number of staff required refresher training in Moving and Handling; dates for staff to attend this training had been identified and recorded in the training records. It was positive to note that the training records were up to date, reflecting the dates training was completed and the dates booked for staff to attend mandatory training. The area for improvement relating to training records has been met.

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

3.3.2 Care Delivery

There was a daily handover at the beginning of each shift, which included information about any changes to the service users' care, which the staff needed to assist them in their roles.

There was a system in place to ensure that the activities offered to service users were varied and tailored towards their individual needs and preferences. Service users are supported to access activities of their own choice. Activities for service users were provided which involved both group and one to one activity. Examples of activities include attending day care, trips, out and gardening.

It was observed that staff responded to service users' requests for assistance promptly and in a caring and compassionate manner.

3.3.3 Management of Care Records

The service users' care plans contained details of their likes, dislikes, preferences, and the level of care and support they may require. 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 regarding how their support was provided. The details of care plans were shared with and signed by service users and/or their representatives as appropriate.

Care records were person centred, regularly reviewed, and updated to ensure they continued to meet the service users' needs. However, it was identified that a service user's Speech and Language Therapist (SALT) assessment was not accurately reflected in their care plan. An area for improvement has been stated for a second time.

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

Staff recorded regular evaluations about the care and support provided. A review of a sample of these records evidenced that they were legible, up to date and signed by the person making the entry.

Service users' care records were held confidentially.

3.3.4 Quality of Management Systems

Since the last inspection, there has been an acting manager in place. The inspector will keep this under review. Staff spoke positively about the management team.

Monitoring arrangements were in place in compliance with regulations and standards. A review of the agency's quality monitoring reports 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, accidents/incidents, safeguarding matters, staff recruitment and training, and staffing arrangements.

Review of incident records identified that they were managed appropriately. There was evidence that incidents were audited on a regular basis, to establish any patterns/trends. It was positive to note that these were reviewed in detail as part of the monthly quality monitoring process.

The annual quality report was reviewed, and it was noted that stakeholder feedback was included.

Agencies are required to have a person known as the Adult Safeguarding Champion (ASC), who is responsible for implementing the regional protocol and the agency's adult safeguarding policy. There was an appointed ASC for the agency. It was established that effective systems and processes were in place to manage the safeguarding and protection of adults at risk of harm. It was positive to note that staff had completed adult safeguarding training, and those spoken with demonstrated a clear understanding of their responsibility in identifying and responding to any actual or suspected incidences of abuse, as well as the process for reporting concerns.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. The manager advised that no complaints have been received since the last inspection.

There was evidence that the management team responded to any concerns raised with them or by their processes, and took measures to improve practice and/or the quality of services provided by the agency.

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

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Kelly McKay, Registered 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 15 (1)(2)(a)(b)(c) Stated: Second time To be completed by: Immediately from the date of inspection	The Registered Person shall ensure that the care plans are kept up to date and reflect the service users' assessed needs. Ref: 3.3.3 Response by registered person detailing the actions taken: The registered manager has raised the discrepancy in the commissioner's care plan and requested this be amended to reflect the care needs accurately. The registered manager has reviewed all care plans provided by named workers to ensure accuracy and that our own plans are reflective of these.

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



The Regulation and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority

James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA



Tel: 028 9536 1111



Email: info@rqia.org.uk



Web: www.rqia.org.uk



Twitter: @RQIANews