

Inspection Report

Name of Service: Inspire Moylena Court

Provider: Inspire Wellbeing

Date of Inspection: 16 July 2026

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1.0 Service information

Organisation/Registered Provider:	Inspire Wellbeing
Responsible Individual/Responsible Person:	Ms Kerry Anthony
Registered Manager:	Mrs Sarah Taggart
Service Profile – Inspire Moylena Court is a supported living type domiciliary care agency based in Antrim. The agency provides support to up to 20 service users; the service users live on two separate sites. Service users have their care and support commissioned by the Northern Health and Social Care Trust (NHSCT) and Supporting People.	

2.0 Inspection summary

An unannounced inspection took place on 16 July 2026, between 9.45 am and 5.25 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 30 October 2025; 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.

There were effective governance and management arrangements in place. Feedback from a service user reflected their positive experience of the care and support provided. Refer to Section 3.2 for more details.

As a result of this inspection the four areas for improvement previously identified were assessed as having been addressed by the provider and two new areas for improvement were identified and 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 user, Health and Social Care (HSC) professional and staff team for their support and co-operation during and following this 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 a service user and staff to seek their views of living and working within the agency. The Inspector also spoke to a HSC professional following the inspection.

The service user told us that they were happy living in Inspire Moylena Court. They said they were supported well by staff and would make their own choices how they would spend their day. The service user's comments included; "I am happy here as this is the best supported living I have been in" and "Staff are helpful and supportive".

Staff spoke positively about the care delivery, training and management support in the agency. Staff comments included; "Independence and autonomy is promoted and service users are offered choice in all that they do", "Care and support plans are always updated as changes occur" and "Good training is provided and there is good communication within the agency".

A HSC professional who spoke with the Inspector said that the care and support given to service users was good and the management and care staff report any concerns in a timely manner.

Two staff returned questionnaires one staff member confirmed that safe, effective and compassionate care was delivered to service users and the agency was well led. One staff member's responses were shared with the manager, post inspection, for their review and consideration.

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 reasons for leaving previous employment as part of the recruitment process. Review of one staff recruitment record confirmed that reasons for leaving previous employment were recorded. Discussion with the manager confirmed that the agency's application form had been reviewed, following the previous inspection, to include reasons for leaving employment. On this basis, the area for improvement was assessed as met.

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 and a record of checks retained.

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.

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. 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 moving and handling, dysphagia and medicines management. The agency had also been provided training in regard to personality disorder and psychosis, which strengthened staff competence in these areas.

A review of fire safety records identified that a number of staff had not completed a fire drill in line with the agency's fire safety policy and procedure. An area for improvement has been identified.

There was evidence of effective systems in place to manage staffing. Service user consultation confirmed that in their experience staff were readily available as needed. Staff also told us that they were satisfied with the staffing levels in place. 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

There was a system in place to monitor appraisal and supervision compliance which evidenced that all staff had participated in supervision at a frequency aligned to that stipulated by the organisations policy and procedures. Records evidenced staff had also engaged in appraisals.

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. Staff support and facilitate these by researching and offering choices that may be of interest, using social stories and visual aids to support their understanding of new activities and choices, setting up activities so they are accessible to the service user. Activities included going to the cinema, bowling, crazy golf, shopping and visiting restaurants.

Staff were observed communicating respectfully and sensitively with a service user. 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.

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

There has been no change in the management of the agency since the last inspection. Mrs Sarah Taggart has been the registered manager in this agency since 14 November 2019. Those consulted described the manager as approachable 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 ensuring monthly monitoring visits are completed on a monthly basis. Review evidenced the agency was visited each month by a representative of the registered provider. On this basis, the area for improvement was assessed as met.

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.

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

Discussion with the manager illustrated knowledge and understanding regarding the statutory notification requirements. The agency had a system in place to ensure that all accidents and incidents were managed appropriately. It was also positive to note that these were reviewed as part of the monthly quality monitoring process.

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.

An area for improvement stated for a second time during the previous inspection related to complaints management where it was identified that complaints records did not contain the results of any investigation, the action taken and the outcome of the complaint in relation to the complainant's satisfaction. Review evidenced that there was a process in place to ensure any complaints received by the agency were appropriately managed in line with the agency's policies and procedures. A record of complaints received since the previous inspection was maintained. On this basis, the area for improvement was assessed as met.

It was positive to note the complaints procedure had been reviewed to include compliance with the Northern Ireland Public Services Ombudsman's (NISPO) Health and Social Care Model Complaints Handling Procedure.

A review identified staff required training in the management of complaints commensurate to their role. An area for improvement has been identified.

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.

An area for improvement stated for a second time during the previous inspection related to a written protocol being developed to support staff of what actions to take where there is a suspected overdose of prescription or non-prescription medication. Discussion with the manager and review of the medication policy and procedure evidenced that a protocol for suspected overdose of prescription or non-prescription medication had been included. On this basis, the area for improvement was assessed as met.

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

Areas for improvement have been identified where action is required to ensure compliance with Minimum Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Sarah Taggart, 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 Minimum Standards, revised 2021	
Area for improvement 1 Ref: Standard 16.3 Stated: First time To be completed by: Immediate from the date of inspection	The Registered Person shall ensure all staff complete a fire drill in line with the agency's fire safety policy and procedure. Ref: 3.3.1
	Response by Registered Person detailing the actions taken: The Registered person will ensure by checking all the agency's fire compliance records regularly, to identify if any staff have not attended a fire drill. This will ensure that any staff who have not done so will be scheduled to attend and participate in the next planned fire drill.
Area for improvement 2 Ref: Standard 12.4 Stated: First time To be completed by: Immediate from the date of inspection	The Registered Person shall ensure all staff undertake complaints training commensurate to their role. Ref: 3.3.4
	Response by Registered Person detailing the actions taken: All staff that support in the service as part of their Induction with the organisation complete a module how to handle complaint management training as part of day three topics. The Registered Manager regularly ensure such practice is embedded by including complaints management as an agenda item in team meetings, reflective practice and in one to one supervision.

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