

Inspection Report

Name of Service: Greenisland House

Provider: Triangle Housing Association

Date of Inspection: 1 July 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:	Ms Deirdre Elizabeth McGuile
Service Profile: Triangle Housing Association is a domiciliary care agency, supported living type which provides housing support to service users living in self-contained apartments in a shared accommodation arrangement. The care is commissioned by the relevant Health and Social Care Trust (HSCT). Personal care is provided in conjunction with another registered domiciliary care agency.	

2.0 Inspection summary

An unannounced inspection took place on 1 July 2026, between 10.45am and 4.00pm by a care Inspector.

The last care inspection of the agency was undertaken on 24 June 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 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 care records.

Full details, including a new area for improvement identified, can be found 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.

3.0 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 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.

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

During the inspection, the inspector spoke with service users, staff, and visiting Health and Social Care (HSC) professionals.

Service users who spoke with the inspector stated that they enjoy living in Greenisland House and find the staff friendly. Comments included: "I enjoy living here. The staff support me. I have no concerns. The staff treat me well." and "The staff are friendly and good to me. I am happy with the service. I can go out with the staff. I attend the tenant meetings and I do the arts and crafts. I have no concerns about the staff."

Staff commented: "The service is well led by the manager; she is on the ball. I have a very good relationship with her. The training provided is excellent, and I enjoy the refresher training, especially the Respect training sessions. I ensure my NISCC registration remains up to date. The service users are offered a range of activities. The service provides person centred care."

HSC Trust representatives stated: "I cannot fault the service; the staff have gone above and beyond. They have met all necessary care needs without any issues. Communication has been excellent, and the staff consistently advocate for the service users. The staff have a thorough understanding of the service users, and I have no concerns regarding the care provided. The staff are fantastic. Service users consistently express satisfaction with the facility and never provide negative feedback. One service user described it as an excellent facility."

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 that systems are 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 staff recruitment records confirmed that pre-employment checks, including criminal record checks (AccessNI), were completed and verified prior to staff commencing employment and engaging directly with service users. The person in charge stated that no new staff members have been recruited since the previous inspection.

There was evidence that staff received a structured induction programme, which included shadowing a more experienced staff member. This programme provided a structured orientation and induction to ensure staff were competent to fulfil the roles and responsibilities of their job.

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.

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 staff had received mandatory training relevant to their roles and responsibilities. It is positive to note that the agency provides dementia awareness training.

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

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 activities offered to service users are varied and tailored to their individual needs and preferences. Service users are supported to access activities of their choice. Activities provided include both group and one to one sessions. Examples of activities include music evenings, bingo, and "tea at three".

It was positive to note that the agency held service users' meetings on a regular basis, enabling the service users to discuss any issues they may have and explore what activities they would like to become involved in.

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 and regularly reviewed. However, it was identified that, following a review of a service user's care file, the Trust care plan was not included in the service user's care records. Therefore, it was unclear whether the agency's own care plan aligned with the Trust care plan. This has been identified as an area for improvement.

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

There has been no change in the management of the agency since the last inspection Ms Deirdre Elizabeth McGuile has been the manager since 25 July 2024. 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.

One complaint has been received since the last inspection. A review of the complaint identified that it is being managed appropriately. It is positive to note that any identified learning is shared with staff.

There was evidence that the management team responded to any concerns raised with them or by their processes, and took measures to improve practice, the environment, 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 and Standards.

	Regulations	Standards
Total number of Areas for Improvement	1	0

Areas for improvement and details of the Quality Improvement Plan were discussed with the person in charge, 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: First time To be completed by: Immediate from the date of inspection	The Registered Person shall ensure that care plans align with the HSC Trust commissioned care plan. Ref: 3.3.3 Response by registered person detailing the actions taken: HSC care plan received on 03.08.26. I can confirm that Triangle's care plan for this individual aligns with the HSC Trust commissioned care plan.

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



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