

Inspection Report

Name of Service: Aldergrove House

Provider: Southern Health & Social Care Trust (SHSCT)

Date of Inspection: 30 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:	Southern Health & Social Care Trust
Responsible Person:	Mr. Steve Spoerry
Registered Manager:	Mrs. Rebecca Lee (Acting)
Service Profile – Aldergrove House is a domiciliary care agency, supported living type, which provides services for 11 service users, living in their own homes within the Southern Health and Social Care Trust (SHSCT) area. Service users require care and support with their enduring mental health disabilities. The building is owned by Radius Housing and the support is commissioned by The SHSCT.	

2.0 Inspection summary

A care Inspector completed an unannounced inspection on 30 July 2026 between 9.00 a.m. and 1.00 p.m.

The last care inspection of the agency was undertaken on 29 July 2025 by a care Inspector. No areas for improvement were identified.

This inspection was undertaken to evidence how Aldergrove House 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 managed.

To that end, the inspection examined the agency's governance and management arrangements, reviewing areas such as staff recruitment, professional registrations, staff induction and training and adult safeguarding. The Inspector also examined the processes for reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS), service user involvement, restrictive practices and dysphagia management.

The Inspector identified excellent practice in relation to induction, supervision and service user feedback. The Inspector noted good practice in monthly quality monitoring, incident management and care planning. There were good governance and management arrangements in place.

The Inspector did not identify any Areas for Improvement during 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 Aldergrove House 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.

Throughout the inspection process, inspectors seek the views of those working for or receiving support from 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 who spoke with the Inspector gave very positive feedback. One service user stated that 'I'm very happy here. I couldn't do without my place in Aldergrove House'. Another said that 'I couldn't be happier. The staff are lovely and do everything for me'.

Both staff on duty spoke with the Inspector and stated that they enjoyed working with the agency; they stated that the team are supportive. Both staff stated that the manager is supportive.

Relatives told the Inspector that they were happy with the care that their relatives received in Aldergrove House. One commented that 'my relative is very well looked after'.

One care manager who spoke with the Inspector commented that 'in two years working with Aldergrove House I have never had an issue. The team are great at working collaboratively with me. The staff have a good rapport with the Community Mental Health Team. Aldergrove House is well known for being a well settled and positive environment'. Another stated that 'I have no concerns at all with Aldergrove. The staff are professional and concerned with the wellbeing of the residents. I spoke to some of them recently due to concerns I had about a resident's mental health and I felt supported in creating a management plan for that resident. The staff are involved and know where the residents are on a daily basis'.

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 in the

agency. Consultation with staff, service users and their representatives established that there were no concerns regarding staffing levels.

A review of a sample of recruitment records indicated that the agency had completed pre-employment checks before staff commenced employment and had direct contact with service users. As a trust agency, recruitment is carried out regionally through Recruitment Shared Services (RSS) which is a division of the Business Services Organisation (BSO). Although the manager was not present for the inspection, she later provided evidence of a robust recruitment process via the Amicus recruitment portal. This demonstrated that the agency had completed pre-employment checks before staff commenced employment and had direct contact with service users. One member of staff had recently completed an internal transfer from another service. An Access NI check had been completed.

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. There was a robust, structured induction programme, which also included shadowing of a more experienced staff member.

The agency retained records of all staff training using a training matrix, and the Inspector noted that the majority of training was up to date. The agency had already booked updates where training was about to expire. Staff confirmed that received sufficient training for their roles.

Senior agency staff complete competency assessments on all staff, including night workers, to ensure that they were competent in their job role, as well as the supervision of service users administering their own medications.

The Inspector noted that the agency had procedures in place for appraising staff performance and senior staff completed a very comprehensive programme of supervision in keeping with the agency's policy and procedures.

3.3.2 Care Delivery

The agency held staff meetings every month and retained the minutes to share with staff who were unable to attend.

Staff were knowledgeable about individual service users' needs, their daily routine wishes and preferences.

The Inspector observed that staff interactions with service users were friendly and supportive. Staff were skilled in communicating with service users; they were respectful, understanding and sensitive to service users' needs.

Staff met the needs of service users' needs through a range of individual and group activities. It was reassuring to note that staff consulted service users about the activities they preferred, ensuring their views informed and shaped the day-to day activities. The Inspector viewed the Mindwise activity programme for service users.

The agency held service user meetings on a monthly basis. The Inspector viewed the minutes of these meetings.

3.3.3 Management of Care Records

The Inspector reviewed care records and support plans on the Epic system. The Inspector noted that these care plans were person centred, well maintained, regularly reviewed, and updated to ensure they continued to meet the service users' needs.

Discussion with the person in charge confirmed that none of the service users required a modified diet. She also confirmed that all service users were independently mobile

The person in charge confirmed that none of the service users was subject to Deprivation of Liberty Standards (DoLS). A resource file was available for staff reference if required.

There was a policy in place for the use of restrictive interventions and the agency maintained a register, which was reviewed and updated annually. The person in charge reported that all service users were subject to restrictive practices. She also confirmed that all restrictive practices concern medications.

3.3.4 Quality of Management Systems

The Inspector reviewed a sample of monthly quality monitoring reports, which evidenced that a robust system for reviewing the quality of care and staff practices was in place. The Inspector reviewed the reports and confirmed that these included engagement with service users, service users' relatives, staff and HSC Trust representatives. The reports included details of a review of the care records of service users; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

The Inspector reviewed the agency's process for the management of complaints and noted that the agency had not received any complaints since the last inspection. The agency provided generic complaints training to all staff, with senior staff undertaking further training.

Review of incident records via the Datix reporting system identified that the agency had managed these appropriately. There was evidence that the manager audited incidents on a regular basis using a Datix tracker system, to establish any patterns or trends. The agency also reviewed incidents as part of the monthly quality monitoring process

The Inspector viewed the agency's annual quality report, which included stakeholder feedback. This had been completed in April 2026.

The Inspector confirmed that effective systems and processes were in place to manage the safeguarding and protection of adults at risk of harm. The Inspector viewed the annual safeguarding position report. The agency had not made any safeguarding referrals since the last inspection. There was evidence that the agency responded to concerns raised with them and implemented measures to enhance both practice and the quality of service provided.

Fire risk assessments had been completed for the service user dwellings. There was evidence that staff completed fire safety checks as required. Staff had completed training fire safety and had participated in a fire evacuation drill on 16 May 2026.

4.0 Quality Improvement Plan/Areas for Improvement

The Inspector did not identify any Areas for Improvement during this inspection. The Inspector discussed the findings of the inspection with Mrs. Lisa McCrink (person in charge), Mrs. Kate Barr (senior support worker) and Mrs. Fiona Campbell (SHSCT Governance Manager) via Microsoft Teams as part of the inspection feedback process. These can be found in the main body of the report.



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