The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Granville

Provider: Southern HSC Trust

Date of Inspection: 5 August 2025

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:	Southern HSC Trust
Responsible Individual/Responsible Person:	Mr Steve Spoerry
Registered Manager:	Miss Dympna Casey (Acting)
Service Profile: Granville is a domiciliary care agency supported living service. The agency's staff provides care and support to service users living in shared accommodation; this includes assisting service users with personal care needs, meals, medication, housing support and assistance to access community services with the overall goal of promoting independence and maximising the quality of life.	

2.0 Inspection summary

An unannounced inspection took place on 5 August 2025, between 10.05 am and 5.15 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 13 February 2025; 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 recruitment practices, care records, staff induction, competency assessments, staff supervision, training and professional registrations.

As a result of this inspection one area for improvement previously identified was assessed as having been addressed by the provider and two areas for improvement have been stated for a second time. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

Good practice was identified in relation to the quality of the monthly quality monitoring reports and service user involvement.

We would like to thank the manager and staff team for their support and co-operation during the 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 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 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 and their quality of life

We spoke to staff to seek their views of working within the agency.

No service users took the opportunity to meet with the inspector.

The feedback staff provided indicated that staff felt supported by the manager, enjoyed working at the agency and they worked well together as part of a team. Staff told us that they were satisfied that the care and support was safe, effective, compassionate and well led. One told us that they have no concerns about the care of the service users, that the manager is supportive and approachable.

The information provided indicated that those who engaged with us had no concerns in relation to the agency.

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, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of service users.

It was identified that some staff currently employed within the agency had transferred internally without enhanced AccessNI checks having been completed. There was discussion with the manager about the need for the provider organisation to be fully assured they have a robust system for criminal checks to be completed for staff. RQIA is aware of ongoing discussion between the Department of Health and HSC Trusts in respect of this, and will keep this matter under review.

We reviewed two recently recruited care staff members' recruitment records. One record did not detail the reasons for leaving previous employment. An area for improvement has been identified.

The manager confirmed that checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC. However, review of the NISSC Matrix evidenced that a number of staffs' annual renewal dates were not accurately reflected. An area for improvement has been identified.

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

Discussion with the manager confirmed there was a robust, structured induction programme in place, which also included a period of shadowing of a more experienced staff member. Review identified one staff member had not completed an induction. An area for improvement made in the previous inspection report has been stated for a second time.

Discussion with the manager and review of competency assessments identified that not all staff left in charge of the agency in the absence of the manager had a competency assessment completed. An area for improvement made in the previous inspection report has been stated for a second time.

Records of all staff training were available and there were mechanisms in place to support oversight of the training matrix to ensure compliance. Generally, there was good compliance with mandatory training. Review identified that a small number of staff required update training in dysphagia awareness and food safety. A service user had a urinary catheter in place however; staff had not received training in catheter care. An area for improvement has been identified.

It was evident a number of staff had not completed learning disability training. This was discussed with the manager. They agreed to complete a scoping exercise to establish staffs' additional training needs to ensure they were trained to meet the specific needs of service users.

Staff consulted spoke positively about the training they receive and confirmed that they received sufficient training to enable them to fulfil the duties and responsibilities of their role and that training was of a good standard.

A review of staff supervision records evidenced that a number of staff had not had supervision in line with the agency's policies and procedures. An area for improvement has been identified.

There was evidence of effective systems in place to manage staffing. Staff said there was good teamwork and that they felt well supported in their role by the manager.

Staff said that there were sufficient staff to meet the needs of the service users. It was evident that staff had a good understanding of the needs, likes and dislikes 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.

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 that 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; this included going to the cinema, shopping, visiting restaurants and arts and crafts.

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

Service user meetings were held on a regular basis which enabled the staff to keep service users updated on any issues arising that may affect them. Some matters discussed included healthy eating and shared living arrangements. The meetings also enabled the service users to discuss any activities they would like to become involved in.

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.

Care records were generally person centred, regularly reviewed and updated to ensure they continued to meet the service users' needs. Discussion with the manager and review of care records confirmed that a service user recently had a urinary catheter inserted. A risk assessment and care plan on catheter care were not in place. An area for improvement has been identified.

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.

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

Records pertaining to consent were available.

3.3.4 Quality of Management Systems

We discussed the acting management arrangements, which have been ongoing since 7 April 2025; RQIA will keep this matter under review. Those consulted with commented positively about the manager and described her as supportive, empathetic and approachable.

There were monitoring arrangements in place in compliance with Regulations and Standards. A review of the reports of the agency's quality monitoring established that there was engagement with service users, service users' relatives, staff and 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.

A review of a sample of incidents confirmed these were managed appropriately and it was positive to note that any identified learning was shared with staff.

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.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Where complaints have been received since the last inspection, these were appropriately managed. There was evidence of a system to ensure oversight of complaints; this included a review of complaints during the monthly quality monitoring visits.

Discussion with staff confirmed that they knew how to receive and respond to complaints sensitively and were aware of their responsibility to report all complaints to the manager or the person in charge.

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.

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	2	5*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Dympna Casey, 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 13 (d) **Stated:** First time	The registered person shall ensure that no domiciliary care worker is supplied by the agency unless a written explanation of the reason for leaving previous employment has been obtained. Ref: 3.3.1
To be completed by: Immediate and ongoing from the date of inspection	**Response by registered person detailing the actions taken:** The SHCT utilise an interview checklist document that is completed at the point of interview and covers gaps in employment and reason for leaving previous post. This document in not held at service level. Regional work is being undertaken to try and incorporate these checks into our electronic pre-employment checks system (AMIQUS) to ensure gaps are escalated to managers. At service level, a New Start checklist has been developed to ensure this is checked and recorded by the registered manager until the regional process is agreed.This checklist will be kept in staff files.
Area for improvement 2 **Ref:** Regulation 15 (2) (a) (b) **Stated:** First time	The registered person shall ensure that robust and effective arrangements are in place in relation to catheter management; this includes but is not necessarily limited to a person centred and detailed care plan and risk assessment record. Ref: 3.3.3
To be completed by: Immediate and ongoing from the date of inspection	**Response by registered person detailing the actions taken**: Catheter care training and competencies have been completed, and a care plan and risk assessment is in place. This will be kept under review and training has been added to the training matrix.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 12.4 **Stated:** Second time **To be completed by:**	The registered person shall ensure that the training needs of individual staff for their roles and responsibilities are identified and arrangements are in place to meet them; this relates to the need for competency assessments to be undertaken for those who may be in charge of the service, in the absence of the manager.

Immediate and ongoing from the date of inspection	Ref: 3.3.1
	Response by registered person detailing the actions taken: A competency assessment is in place for all staff left in charge in the absence of the manager. This has now been completed by all relevant staff and has been added to the training matrix to enable robust oversite by the registered manager. Competencies will be completed on an annual basis.
Area for improvement 2 **Ref:** Standard 12.1 **Stated:** Second time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that newly appointed staff complete a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care, to ensure they are competent to carry out the duties of their job in line with the agency's policies and procedures. Ref: 3.3.1
	Response by registered person detailing the actions taken: A review of induction processes was undertaken following the previous inspection and robust inductions are being progressed for new staff. An audit of all staff files is being undertaken to identify gaps in inductions. Where no induction, or incomplete inductions, are held on file, a refresher induction is being completed to ensure that all staff have a fully completed induction on file to provide assurance that they are competent to carry out the duites of their job. The Registered Manager is aware of the induction process and recording requirements of same, and is adhering to this. Induction dates have been added to the training matrix to ensure 100% compliance in this area. An audit of inductions is planned by Head of service and Supported Living Co-ordinator in November to ensure compliance.
Area for improvement 3 **Ref:** Standard 12.3 and 12.4 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that staff complete update training in relation to dysphagia awareness and food safety, as appropriate, and training in catheter care. Ref: 3.3.1
	Response by registered person detailing the actions taken: All staff who required update/refresher training as identified during the inspection has now been completed. The training matrix is reviewed monthly by the Registered Manager and monthly monitoring officer, and minimum quarterly by the Head of Service.

	Completion of training has been flagged to all staff to ensure compliance with same. Some training dates are more infrequent resulting in challenges with getting dates booked. The Registered Manager has arranged in house training where possible to ensure training dates are maintained. Where it has not been possible to arrange training, a note is added to the matrix to provide rationale, and training booked as soon as it becomes available.
Area for improvement 4 **Ref:** Standard 12.6 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure that a robust system is implemented for the monitoring of staffs' professional registrations. Ref: 3.3.1
	Response by registered person detailing the actions taken: The matrix to record staff professional registrations has been reviewed and updated. This will be kept under review monthly by the Registered Manager. Monthly checks of the live register are undertaken to ensure continued registration by the registered manager. The SHSCT Social Work and Social Care Governance Team also oversee professional registrations and notify the Registered Manager of upcoming renewal dates and annual payment dates for action as required.
Area for improvement 5 **Ref:** Standard 13.3 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The registered person shall ensure staff have recorded formal supervision meetings in accordance with the agency's procedures. Ref: 3.3.1
	Response by registered person detailing the actions taken: Supervision is now being completed as per policy (bi-monthly) and a review of processes within the service has occurred. The matrix for recording supervision has been updated to reflect accurate dates and this is being monitored by the Registered Manager monthly. Supervision templates for recording supervision discussions have also been updated. Supervision resources (posters and leaflets)

	have been developed and shared at service level to support staff to have a better understanding of the expectations of supervision. Training has been specially developed and rolled out for supported living social care staff to reinforce the importance of supervision, offer clarity on the policy, and promote engagement in the process. This is available for both the supervisee and supervisor and has been arranged for Granville specifically in November 2025, with other dates available in Sept/Oct. An audit of supervision across supported living was conducted early 2025 and work commenced on an action plan in June 2025.Improvements in compliance and quality of supervision have been noted since commencement of the action plan. A review of the action plan will be conducted in December 2025, and a reaudit completed early 2026.

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