The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Ardaveen Manor**

Provider: **Southern HSC Trust**

Date of Inspection: **4 March 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 Health & Social Care Trust
Responsible Individual/Responsible Person:	Mr Colm McCafferty
Manager:	Mr Patrick Murtagh (Acting)
Service Profile – Ardaveen Manor is a supported living type domiciliary care agency, located within a residential area of Bessbrook. The agency offers domiciliary care and housing support to 11 adults; the care and support is provided by Southern Health and Social Care Trust (SHSCT) staff.	

2.0 Inspection summary

An unannounced inspection took place on 4 March 2025, between 8.30 a.m. and 1:30 p.m. This was conducted by a care Inspector.

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 reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS), service user involvement, restrictive practices and Dysphagia management were also reviewed.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards.

Two areas for improvement were identified. These were related to risk assessments and validation of staff from recruitment agencies.

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.

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.

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 survey.

3.2 What people told us about the service and their quality of life

We spoke to service users, a relative and a member of staff to seek their views of the agency.

One of the service users told us that they liked it here and their house is good, while another smiled and nodded in response to my questions about living in Ardaveen Manor and the staff who care for them.

A relative spoke very positively about the agency, they had no concerns about the staff, who keep them informed of anything they need to know and are easy to contact. The relative told us that they were aware of how to raise any concerns or make a complaint.

A staff member spoke highly of the support they receive in their role and shared that they felt empowered to raise any concerns and confident that they would be listened to.

There were no responses to the electronic survey. The responses to the questionnaires did not indicate any concerns in relation to the care delivered to the service users.

3.3 Inspection findings

3.3.1 Staffing Arrangements

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

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 induction programme which also included shadowing of a more experienced staff member.

A review of the records relating to staff that were provided from a recruitment agency did not evidence that an acceptable profile was available for staff. The profile shared did not contain essential information such as criminal record checks and confirmation of trainings to include Mental Capacity Act training. An area for improvement has been identified.

The agency has maintained a record for each member of staff of all training, including induction and professional development activities undertaken.

3.3.2 What are the systems in place for identifying and addressing risks?

The agency's provision for the welfare, care and protection of service users was reviewed. The organisation's adult safeguarding policy and procedures were reflective of the Department of Health's (DoH) regional policy and clearly outlined the procedure for staff in reporting concerns. The organisation had an identified Adult Safeguarding Champion (ASC).

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 in normal business hours and out of hours. 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. The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding.

All staff had been provided with training in relation to medicines management. A review of medication errors found that appropriate action was taken.

The Mental Capacity Act (Northern Ireland) 2016 (MCA) provides a legal framework for making decisions on behalf of service users who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, service users make their own decisions and are helped to do so when needed. When service users lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had had their capacity considered and, where appropriate, assessed. Where a service user was experiencing a deprivation of liberty, the care records contained details of assessments completed and agreed outcomes developed in conjunction with the HSC Trust representative.

Although care and support plans are kept under regular review, two care files required a review of the risk assessments. The manager confirmed that these has been requested but not received. An area for improvement has been identified.

3.3.3 What are the arrangements for promoting service user involvement?

From reviewing service users' care records, it was good to note that service users had an input into devising their own plan of care. The service users' care plans contained details about their likes and dislikes and the level of support they may require. Person centred support plans were reviewed and found to involve the service user.

The agency had undertaken an evaluation of the service to include feedback from service users. A review of the minutes of the monthly tenants' meeting found that the service user feedback report was shared.

3.3.4 What are the arrangements to ensure robust managerial oversight and governance?

There were monitoring arrangements in place. A review of the reports of the agency's quality monitoring established that there was engagement with service users, staff and HSC Trust representatives. The reports included details of a review of accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

There is an established system of recording used within the service which enables the manager to easily view, action and record any training, registration, incidents or supervision needs.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. No complaints were received since the last inspection.

The agency's registration certificate was up to date and displayed appropriately.

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	0

Areas for improvement and details of the Quality Improvement Plan were discussed with the 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 Domiciliary Care Agencies Regulations (Northern Ireland) 2007

Area for improvement 1 **Ref:** Regulation 13 (schedule 3) **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure that no domiciliary care worker is supplied by the agency without full and satisfactory information available in relation to him in respect of each of the matters specified in Schedule 3. This relates specifically to the documentation in relation to workers from the recruitment agency. Ref: 3.3.1
	Response by registered person detailing the actions taken: Currently, the SHSCT Human Resources team ensure that all checks are complete for agency staff. Human Resources then liaise with Ardaveen Management to agree suitable agency staff for the service. A new agency checklist has been devised and implemented at service level to ensure that all necessary documents have been received including staff profile with a current photo, staff training, Access NI and NISCC registration. The registered manager is responsible for ensuring all necessary checks are completed and that the record is maintained on file.
Area for improvement 2 **Ref:** Regulation 15 (3) (b) **Stated:** First time **To be completed by:** Immediately from the date of inspection	The Registered Person shall ensure service users' care records are kept under review; this relates specifically to the review of risk assessments. Ref: 3.3.2
	Response by registered person detailing the actions taken: The two risk assessments identified during the insepction that required review and update have now been completed with input from the Community keyworker and Ardaveen staff. Monthly audits of tenant files are completed by Management which includes the care plan and risk assessments for tenants. Any documents that require review are highlighted and communicated to the relevant keyworkers. A record of all attempts to have documentation updated is held on each tenant's file. Tenant documents are also checked prior to annual review meetings and any changes to care plans and risk assessments are then discussed and/or agreed by the MDT at the annual review.

	The Monthly monitoring officer's complete checks on tenant's files and any outstanding or outdated documents are added to the monitoring report action plan. The registered manager is responsible for ensuring the completion of these actions, and this is overseen by the Supported Living Co-ordinator. There is a clear standard operating guide for staff to follow regarding the escalation of concerns relating to documents not being reviewed/ updated when asked. This has recently been updated and ensures clear escalations up to Assistant Director and Social Work Lead level if required. A similar escalation process has also been agreed for issues picked up at service level/ local audits.

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