The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Gnangara

Provider: Radius Housing Association

Date of Inspection: 19 December 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:	Radius Housing Association
Responsible Individual/Responsible Person:	Mrs Fiona McAnespie
Registered Manager:	Ms Margaret Irwin
Service Profile – Gnangara is a supported living type domiciliary care agency which supports service users who require assistance with tasks of everyday living, emotional support and assistance with accessing community services. Services are commissioned by the Western Health and Social Care Trust (WHSCT).	

2.0 Inspection summary

An unannounced inspection was undertaken on 19 December 2025, between 10.10 am and 5.pm by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 7 January 2025; and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

As a result of this inspection two areas of improvement identified in the previous inspection relating to medication recording and monitoring of staff's professional registrations were assessed as having been addressed by the provider. This is discussed in more detail in section 3.3.1.

The inspection established that care delivery was safe, compassionate and that effective care was delivered to service users. It also determined that the service was well led.

There were no areas for improvement identified during this inspection. Full details can be found in the main body of this report.

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 the previous area 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 being supported by and working for the agency; and examine a sample of records to evidence how the service 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 survey.

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

Through active listening, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

We spoke with service users, relatives, staff and HSC professionals to seek their views of living, visiting and working within Gnangara.

Service users who spoke with the inspector expressed positive views about their experience of living in Gnangara and of the support provided by staff. One comment made to the inspector included the following statement: "They are all great here – the staff are so supportive and helpful". One returned service user questionnaire indicated that the service user felt very satisfied with the care and support provided by staff however, they felt that some improvements could be made around ensuring the correct meal is received from the kitchen. This was relayed to the manager to action as appropriate.

Relatives who provided feedback on the service said that they felt their loved ones received good support from staff whom they felt were caring and attentive.

Staff who spoke with the inspector spoke positively about the approachability and support of management and said that they felt the service was well- led. Staff said the care provided to service users was safe, effective and compassionate and that the training was good.

Professional Healthcare staff who provided feedback on the service said that the communication with staff is of a high standard and that staff are friendly and approachable with good support provided to service users from staff and management.

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 completion of regular staff training to ensure the agency safely and continually meets the needs of service users. 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.

An area for improvement identified during the previous inspection related to the monitoring of agency staff's professional registrations. The manager advised that there were no agency staff enlisted to work in Gnangara. A matrix was maintained of all staff's NISCC registrations which was regularly checked by the manager to ensure that all staff were appropriately registered with the Northern Ireland Social Care Council (NISCC). On this basis the previous area for improvement was deemed to have been addressed by the provider. Staff who spoke with the inspector confirmed that they were aware of their responsibilities to keep their registrations up to date.

A review of a sample of the most recently appointed staff, evidenced that staff had completed a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care. There was a robust, structured, induction programme which included shadowing of a more experienced staff member. This was reviewed periodically and signed off by the manager to ensure the staff were competent in carrying out the duties of their job in line with the agency's policies and procedures.

Staff spoke positively about the training they receive and confirmed that they received sufficient training and support from the manager to enable them to fulfil the duties and responsibilities of their role. The agency maintained a matrix of all staff training and a review of this confirmed that all staff received mandatory training and other training relevant to their roles and responsibilities.

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.

All staff were provided with training in relation to medicines management. Competency assessments were undertaken with staff to ensure that they were proficient in the administration of medications.

An area for improvement identified at the previous inspection related to medication record keeping. A review of the practice of medication administration confirmed that changes had been implemented to practice to ensure that it is in keeping with good practice guidelines. On this basis the area for improvement was assessed as met.

Regular staff meetings were held and minutes maintained of the meetings for staff unable to attend, to read for information sharing.

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). The agency's annual Adult Safeguarding Position report was reviewed and 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 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. The manager confirmed that there had been no adult safeguarding concerns raised since the last inspection.

Service users said they had no concerns regarding their safety; they described how they could speak to staff if they had any concerns about safety or the care provided to them.

The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

The agency's governance arrangements for the management of accidents/incidents was examined and confirmed that there was an incident/accident reporting policy and system in place. All accidents/ incidents that occurred were recorded by staff on a reporting template. On review of accidents/incidents that occurred since the last inspection, it was evident that these had been managed appropriately. A review of the accident/incident reporting template, evidenced that staff had completed a template for falls incidents when reporting some on falls-related incidents. This was discussed with the manager who confirmed plans to address this with all staff to ensure that the correct template is completed for all incidents arising. This will be reviewed at a later inspection. It was positive to note that all incidents/accidents are also recorded on an electronic matrix which is regularly reviewed by the manager and corporate governance staff to ensure robust oversight of incidents management and timely identification of any trends arising.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

3.3.3 Mental Capacity Act / Deprivation of Liberty Safeguards (DoLS) and Restrictive Practice.

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 were required to complete Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The manager reported that none of the service users were subject to DoLS. 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. The registered manager confirmed that no service users are subjected to restrictive practices within the service.

3.3.4 Management of Care Records and Care delivery

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 person centred, regularly reviewed and updated to ensure they continued to meet the service users' needs. 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 user's preferences and choices around how their support was provided. Care reviews had been undertaken in keeping with the agency's policies and procedures. There was also evidence of regular contact with service users and their representatives, in line with the commissioning trust's requirements.

There was a daily handover at the beginning of each shift and staff recorded regular evaluations about the care and support provided. This included information about any changes to the service users' care needs so that staff could assist them as needed accordingly.

3.3.5 Managerial Oversight and Governance

There has been no change in the management of the service since the last inspection. Staff commented positively about the manager and described them as supportive, approachable and able to provide guidance. There were procedures in place for staff supervisions to take place on a monthly basis and to appraise staff performance annually.

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.

The Annual Quality Report was reviewed and was satisfactory.

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

There was a range of policies available to direct staff in care delivery and support planning based on individual risk assessments.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. The manager confirmed that there had been no complaints received since the previous inspection. 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. Discussions with service users concluded that they were aware of the agency's complaints process and how to make a complaint to staff or the manager.

The agency's registration certificate was up to date and displayed appropriately along with current certificates of public and employer's liability insurance.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Margaret Irwin (Manager), as part of the inspection process and can be found in the main body of the report.

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James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews