The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Manor Healthcare**

Provider: **Manor Healthcare Ltd**

Date of Inspection: **20 January 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:	Manor Healthcare Ltd
Responsible Individual/Responsible Person:	Mr Eoghain King
Registered Manager:	Ms. Lauren McFerran
Service Profile: Manor Healthcare is a domiciliary care agency, support living type, which provides care and support to adults with a learning disability. Care and support is provided on a 24 hour basis, to 12 service users living in the Templepatrick area. The service users live in seven separate bungalows/houses.	

2.0 Inspection summary

An unannounced inspection took place on 20 January 2026, between 9.15 am and 4.30 pm by a care Inspector.

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 16 December 2024; 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 implementing systems for good communication; care records and auditing processes; and the recording of explanations of gaps in employment.

Service users said that the care and support provided by Manor Healthcare was a good experience. Refer to Section 3.2 for more details.

As a result of this inspection 12 of the 13 areas for improvement previously identified were assessed as having been addressed by the provider. One area for improvement has been carried forward for review at the next inspection. 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.

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 Quality Improvement Plan 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/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 told us that the staff are 'friendly' and that they like how they help them 'to be independent'. They said that they 'enjoy their (own) space' and that they like how they are able to relax in their own house. One respondent stated that 'the staff are good at looking after me and they keep making nice meals and keep the place tidy'. It was good to note that service users said they could go to a church of their choice.

One relative spoken with said that they felt that their loved one was not brought out of their bungalow often enough and that they lacked fresh air and stimulus; they agreed to raise this with the manager.

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.

Review of the agency's staff recruitment records confirmed that all pre-employment checks, including criminal record checks (AccessNI), were generally completed and verified before staff members commenced employment and had direct engagement with service users. Improvements were required, however, in relation to the managerial oversight of recruitment

records; this relates specifically to gaps in employment that were discussed during the interview process, but not followed up or recorded. An area for improvement has been identified.

Newly appointed staff had completed a structured orientation and induction, to ensure they were competent to carry out the duties of their job.

There are a number of service users being supported by Manor Healthcare who present with complex behaviours which are, at times, challenging. The staff were provided with face to face, online and e-learning, to support them in their roles. Positive Behaviour Support (PBS) training involves learning person-centred, proactive strategies to understand and address behaviours which staff may find challenging, focusing on the service users' needs, teaching new skills, and creating supportive environments. Trauma-informed care training equips staff to recognise, respond to and support service users who are affected by trauma focusing on safety, trust and empowerment. Staff were provided with these training elements, in addition to their mandatory training requirements.

Sometimes service users who have epilepsy may be prescribed an emergency medication that can be used to stop seizures that last too long. Staff had received specific training in this regard.

Competency assessments were undertaken on all staff to ensure that they were competent in their roles and responsibilities; this included medicines and finance competency assessments.

Procedures were in place for appraising the staffs' performance and supervisions were undertaken in keeping with the agency's policy and procedures.

There were good systems in place to manage staffing. There were enough staff on duty to help the service users. Staff said they felt well supported in their role and that they were satisfied with the staffing levels.

3.3.2 Care Delivery

Effective communication across shifts is essential for ensuring consistent, safe and effective care to service users.

A number of service users had Positive Behaviour Support (PBS) plans in place. The manager advised that these are in the process of being reviewed and that they are waiting on an updated PBS plans being finalised. A number of service users had weekly/biweekly meetings with the multidisciplinary team (MDT), to support their transition from another healthcare setting into Manor Healthcare. These meetings included the review of all incidents, including those where physical intervention was required. Where service users displayed behaviours which may be considered challenging, staff completed a record to identify the trigger that occurred just before the behaviour, a description of the behaviour itself and the consequence or the outcome that followed the behaviour (ABC charts). These records were subject to regular review as part of the MDT meetings.

There was a verbal handover in each bungalow at the start of every shift; and that there was a communication book in place which staff were required to read every day.

Whilst the communication book included information about the service users, which the staff needed to assist them in their roles, the manager was advised to develop a written handover system, which would ensure that they were appropriately informed of any changes in the service users' needs. This would provide staff with a structured system to ensure that they are informed of the outcomes of the MDT meetings. An area for improvement has been identified.

Staff interactions with service users were observed to be friendly and supportive. Service users were supported to participate in a range of activities, in accordance with their needs / preferences. Review of care records identified that the care plans relating to activities were sufficiently detailed regarding the service users' wishes, preferences or daily routines. Review of the activities folder identified that there was evidence of varied activities provided; and review of the care records audits identified that the care plans for activities had been audited. Activities had been discussed at staff supervisions, team meetings and they were also reviewed as part of the care record audits and in the monthly quality monitoring process. Four areas for improvement previously identified in relation to the provision of activities had been addressed by the provider.

3.3.3 Management of Care Records

Service users' needs should be assessed within two days of moving to the service. Review of records identified that an Assessment of Need had been completed. An area for improvement previously identified in this regard had been addressed.

Service User Agreements were signed by service users or their representatives within five days of the service users moving to the service; and these are reviewed on an annual basis or if there are any changes required. Further detail regarding the Service User Agreements is detailed in section 3.3.4.

Promoting Quality Care (PQC) is regional guidance on the assessment and management of risk in mental health and learning disability services. A core function of mental health and learning disability services is to assess the treatment and care needs of people presenting to them. An integral part of such an assessment is the consideration of risks posed by some people with a mental disorder to either themselves or others. Understanding the level of risk that a service user may present forms part of the service users' overall assessment, nevertheless it is an integral part of formulating an appropriate care package.

Where service users were under PQC, a Comprehensive Risk and Management Plan should be updated in a six monthly basis, in keeping with good practice guidance. Whilst it is the responsibility of the Trust to ensure that multidisciplinary reviews are undertaken on a six monthly basis, advice was given to the manager, in relation to tracking the dates of these meetings, to ensure that no risks are missed.

The Trust care plans were was in place. Risk and management plans were also in place and thee were updated on a monthly basis, or as the service users' needs changed.

A number of service users require specific medicine to be given to them on an 'as needed' or 'when required basis'; this is referred to as 'PRN'. There are times medical practitioners will prescribe these medications on a phased basis, where it is clearly indicated which medication should be administered first (first line), before administering the next medicine (second line) or a different medicine (third line). These instructions are recorded on a PRN Protocol.

Review of records identified that these were reviewed regularly and clearly communicated to staff. Where this was not adhered to, appropriate action was taken to prevent recurrence; thus reducing the risk of these medicines being given unnecessarily.

The daily notes completed by staff within the service users' homes were returned to the registered office on a regular basis; an area for improvement previously identified in this regard had been addressed. The manager was advised, however, that the notes returned should be filed along with the rest of the service user's notes, and not filed with those notes belonging to other service users in the same bungalow. Advice was also given that ABC charts and Physical Intervention charts should similarly not be retained in each of the bungalows and that a system should similarly be put in place to ensure they are returned to the registered office in a timely manner. RQIA acknowledges that plans are in place to introduce an electronic records management system, which should address these matters going forward.

Where service users required hourly checks at night, to ensure their safety, there were no records retained in relation to these. An area for improvement has been identified.

Care record audits were undertaken and there was evidence that follow up action had been taken in relation to any issues identified; the manager was advised to increase the frequency of audits, to ensure that any deficits identified could be actioned in a timely manner. This will be reviewed at a future inspection.

There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had their capacity considered and, where appropriate, assessed. Where a service user was experiencing a deprivation of liberty, the care records contained the relevant authorisation documents. The manager was advised to liaise with the Trust where authorisation extensions were pending.

A restrictive practice register was maintained and included a number of restrictions. The manager was advised to increase the frequency of reviewing this to monthly, to evidence meaningful reduction in such practices. An area for improvement has been identified.

The manager was advised to develop a missing persons' proforma in keeping with good practice. The manager welcomed this advice and agreed to implement this going forward.

3.3.4 Quality of Management Systems

Ms Lauren McFerran has been the Registered Manager since 6 November 2019.

Review of a sample of records evidenced that a robust system for reviewing the quality of care and staff practices was in place. The agency was visited each month by a representative of the registered provider to consult with service users, their relatives and staff and to examine all areas of the running of the agency. The reports of these visits were completed in detail. It was good to note that the status of each of the areas for improvement identified on the last QIP, were commented on each month; this is good practice.

An area for improvement had previously been identified in relation to the need for the Service User Agreements to provide a detailed breakdown of the care, support and utility charges for each service user.

This related to the charges for single occupancy bungalows which did not provide a breakdown of the utility costs and discrepancies identified between the utility charges for similar sized bungalows. RQIA is aware that the Northern Health and Social Care Trust (NHSCT) had previously been involved in agreeing the care, support and utility charge for service users and that the utility bills for the previous year were used to create a charge for utilities which was split evenly among the service users within each dwelling. RQIA acknowledges that the provider has been engaging with the Trust in this regard, however, we were unable to verify any changes made to the Service User Agreements. The area for improvement previously identified in this regard has been carried forward for review at the next inspection.

The incident/accident reporting system had recently been developed, to ensure that there is a record of timely follow up with multidisciplinary professionals and that that incidents are reported to the Trust keyworkers in keeping with the Trust requirements. An area for improvement previously identified in this regard had been addressed. Improvements were required, however, in relation to the need for regular audits of incidents, in order to identify patterns or trends. Whilst we were assured that the incidents were reviewed in detail in the monthly quality monitoring processes, implementing a formal audit of incidents on a monthly basis, will improve manager oversight of accidents/incidents and behavioural incidents. An area for improvement has been identified.

Given that there were a small number of staff from an acute hospital setting included in the staffing requirements, the manager was advised to ensure their names were recorded on the staffing roster. Following the inspection, assurances were provided that this will be implemented; this will be reviewed at a future inspection.

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. The responsible individual was identified as the appointed ASC for the agency. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm. Safeguarding referrals and associated reports were retained in a centralised folder; an area for improvement previously identified in this regard had been addressed.

The annual safeguarding position report had been completed.

Whilst complaints were managed appropriately, advice was given in relation to refraining from using a complaints book in each of the seven bungalows. One centralised system for recording complaints should be retained in the registered office; this should enhance the manager's oversight of any complaints received. This will be reviewed at a future inspection.

The annual quality report was in the process of being completed. Based on the information viewed, we were satisfied that the area for improvement previously identified in this regard had been addressed.

It was good to note that the service users had signed Tenancy Agreements and these were available for inspection. The area for improvement previously identified in this regard had been addressed.

Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC) and the Nursing and Midwifery Council (NMC); there was a system in place for professional registrations to be monitored by the manager.

Staff meetings were held on a regular basis and minutes retained for any staff who were not able to attend. Advice was given in relation to implementing a system of 'house' meetings, where possible, to ensure that service users' views on the service can be ascertained.

There was a policy and procedure in place in relation to the use of overt closed circuit television (CCTV) in an identified bungalow; and it was identified that the service user's consent had been obtained in this regard.

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	1*	5*

* the total number of areas for improvement includes one that has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Lauren McFerran, 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 16 (1)(b) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that a structured written system of communication is developed and implemented, to ensure that any updates in relation to service users' needs are clearly communicated to staff; and to ensure that staff are informed of the outcomes of any MDT meetings. Ref: 3.3.2
	Response by registered person detailing the actions taken: A weekly communication meeting has been implemented between the service manager and the senior of each service. Senior staff meetings, chaired by the manager will occur bi-monthly (6 times per year) or as and when necessary. Senior staff have a streamlined reporting system directly to the manager regarding changes and updates of each service user and of the service as they happen. The manager will oversee, and monitor this process closely and hold documentation in the office.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 4.3 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Service User Agreements should be reviewed to include a detailed breakdown of the care, support and utility charges for each service user; and confirmation should be sought from the NHSCT to ascertain if the same charging system is in place since 2018 and that the charges have been agreed with the Trust. Ref: 3.3.4
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref:** Standard 11.2 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that gaps in employment are recorded. Ref: 3.3.1
	Response by registered person detailing the actions taken: The manager will oversee this as part of the onboarding process and will ensure that gaps in employment are captured during the interview process moving forward and documented accordingly.

Area for improvement 3 **Ref:** Standard 10.4 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that where service users require hourly checks at night, to ensure their safety, there are records retained in relation to these. Ref: 3.3.3 **Response by registered person detailing the actions taken:** An hourly checklist has been developed and implemented into each service. The manager will audit this regularly.
Area for improvement 4 **Ref:** Standard 9 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the restrictive practice register is reviewed on a monthly basis, to evidence meaningful reduction in such practices. Ref: 3.3.3 **Response by registered person detailing the actions taken:** The restrictive practice register shall be reviewed on a monthly basis to evidence where possible, evidence of meaningful reduction in such practices.
Area for improvement 5 **Ref:** Standard 8.10 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall develop and implement a formal audit of incidents which should be used on a monthly basis, to identify any patterns or trends. Ref: 3.3.4 **Response by registered person detailing the actions taken:** All accidents and incidents are now sent directly to the manager as and when they arise. The manager will collate and audit the information for patterns and trends and have readily available for inspection.

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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