The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Ardmonagh Family and Community Group**

Provider: **Belfast HSC Trust**

Date of Inspection: **19 February 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:	Belfast HSC Trust
Responsible Individual/Responsible Person: -	Dr Michelle Templeton
Registered Manager:	Miss Elaine McGreevy
Service Profile – Ardmonagh Family and Community Group is a domiciliary care agency delivering care in the community to adults and children with a range of disabilities living within the Belfast Health and Social Care Trust (BHSCT). The agency provides a range of personal care services and social support to 40 service users living in their own homes.	

2.0 Inspection summary

An unannounced inspection was undertaken on 19 February 2026, between 10.00am and 3.45pm. by a care Inspector.

The last care inspection undertaken on 5 December 2024 by a care inspector identified three areas for improvement relating to monthly monitoring reports, recruitment practices and safeguarding records. This inspection was undertaken to evidence the agency's progress with respect to the areas for improvement identified and to ascertain how the service is performing in relation to the regulations and standards. The inspection also sought to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

The inspection found that safe, effective and compassionate care was delivered to service users and that the agency was well led.

As a result of this inspection, the previous areas for improvement identified at the previous inspection were assessed as having been addressed by the provider. No new areas for improvement were identified.

Details of the findings of this inspection can be found in the main body of the 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, 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 trusts.

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

Throughout the inspection process inspectors seek the views of the service users/relatives who are in receipt of care and support; the home care workers who work for the agency and health care professionals who have knowledge of working with the agency.

Comments from staff, service users and their relatives were very positive. Service users said that staff were pleasant and that they treated them very well. Comments received included the following statements "they are brilliant and go above and beyond" and "I think they are great and wait over their time they are so kind and thoughtful".

Staff spoken with were very happy in their roles and felt training was useful and that management was supportive. They confirmed that they would have no hesitation in reporting poor practice.

One professional who spoke with the inspector said that they had no concerns in relation to the agency and that they had good systems in place to manage risks. Another professional who spoke with the inspector said they found the agency to be "absolutely fantastic" and that they are very good at communicating with the community teams and that the staff are very accommodating and pleasant.

The information provided indicated that there were no concerns in relation to the agency.

3.3 Inspection findings

3.3.1 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 identified three Adult Safeguarding Champions (ASC) within the service. The agency's annual Adult Safeguarding Position report was reviewed and found to be satisfactory.

An area for improvement identified during the previous inspection related to the recording and review of adult safeguarding referrals and investigations that had arisen within the service. The manager advised that although no adult safeguarding concerns had been raised in the agency since the last inspection, a tracker document had been developed to enable the manager to record succinctly the actions taken in response to any safeguarding concerns and confirmed that this would be kept under regular review for tracking and trending purposes. On this basis the area for improvement was assessed as met by the provider.

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.

RQIA had been notified appropriately of any incidents that had been reported to the Police Service of Northern Ireland (PSNI) in keeping with the regulations. Incidents had been managed appropriately.

The governance arrangements for the management of accidents/incidents was reviewed and confirmed that an effective incident/accident reporting policy and system was in place. A matrix was developed to keep track of incidents / accidents arising and this was reviewed regularly to ensure appropriate management of same. There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

3.3.2 Mental Capacity Act and Restrictive Practice

The Mental Capacity Act (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 who spoke with the Inspector demonstrated their understanding that service users who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the MCA.

Staff had completed MCA training appropriate to their job roles. The manager reported that one service user was subject to Deprivation of Liberty Safeguards (DoLS). On examination of the pertaining DoLS documentation, it was identified that this required review by the commissioning Trust. The manager confirmed after the inspection that they had requested a review of the DoLS from the Trust and that this was expected imminently. RQIA will keep this matter under review to ensure compliance with MCA legislation.

The manager confirmed that there were no other restrictive practices employed within the service.

3.3.3 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. There was evidence of robust systems in place to manage staffing.

An area for improvement identified at the previous inspection related to recruitment records where gaps in one employee's employment history had not been recorded. On review of this staff member's recruitment records there was evidence that all gaps in employment history had been retrospectively obtained and satisfactory explanations recorded within their recruitment records. In addition, the manager had developed a template to record any gaps in employment and explanations for same for all potential employees. On this basis the area for improvement was deemed to have been addressed.

A review of the agency's staff recruitment records of staff employed since the last inspection 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. Checks were made to ensure that staff were appropriately registered with Northern Ireland Social Care Council (NISCC) and there was a system in place for professional registrations to be monitored by the manager. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

The interview process was reviewed and written records were retained by the agency of the person's capability and competency in relation to their job role.

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

Review of training records identified that all mandatory training elements had been provided to staff and that where specific training was required such as epilepsy training, the agency made arrangements for this training to be delivered to those identified staff members.

3.3.4 Care Delivery and 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.

Discussions with staff and review of service users' care records reflected the multi-disciplinary input and the collaborative working undertaken to ensure service users' health and social care needs were met within the agency. There was evidence that staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate. Staff also implemented the specific recommendations of the SALT to ensure the care received in the setting was safe and effective.

Care records were well maintained, 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. The details of care plans were shared and signed by service users and/or their representatives as appropriate.

There was a system in place for identifying any missed calls; this included spot checks on staff practice, regular contact with service users and their relatives; and regular auditing of the daily notes completed by the care workers.

3.3.5 Governance and Managerial Oversight

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

There were monitoring arrangements in place in compliance with regulations and standards. An area for improvement stated for the second time at the previous inspection related to deficits in information recorded in the monthly monitoring reports including the identification of the monitoring officer, incomplete sections and inclusion of non- contemporaneous information within reports. A review of the agency's quality monitoring reports established that the monitoring officer was clearly identified at the front of the report and included details of a review of accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements. Advice was given to the manager around ensuring that the template includes appropriately sized text box for each section to help ensure that all relevant information is clearly recorded in future reports. This advice was welcomed by the manager and will be reviewed at a future inspection. On this basis the area for improvement was deemed to have been addressed by the provider.

There was a system in place to ensure that complaints are managed in accordance with the agency's policy and procedure. The manager advised that no complaints had been received since the last inspection.

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

The service has an operational policy, procedure or protocol that clearly directs staff from the agency as to what actions they should take if they are unable to gain access to a service user's home. This policy includes information on how to manage and report such situations in a timely manner.

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 Ms Elaine McGreevy, Manager, as part of the inspection process and can be found in the main body of the report.

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