

Inspection Report

Name of Service: Ardavon

Provider: Apex Housing Association

Date of Inspection: 4 June 2026

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1.0 Service information

Organisation/Registered Provider:	Apex Housing Association
Responsible Individual/Responsible Person:	Ms Sheena McCallion
Registered Manager:	Ms Allison Foley
Service Profile – Ardavon is a supported living type of domiciliary care agency which provides care and support to up to 12 service users. The service users' care is commissioned by the Western Health and Social Care Trust (WHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 4 June 2026, between 10.35 am and 5.50 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 22 October 2024; and 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. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of service users.

Good practice was identified in relation to service user involvement and staff training. Feedback from a service user reflected their positive experience of the care and support provided. Refer to Section 3.2 for more details.

As a result of this inspection the areas for improvement previously identified were assessed as having been addressed by the provider. Full details, including new areas for improvement identified can be found in the main body of this report and the Quality Improvement Plan (QIP).

The Inspector would like to thank the person in charge, the service user 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 QIP 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

The Inspector spoke to a service user and staff to seek their views of living and working within the agency.

The service user indicated that they enjoyed their experience of living in Ardavon and they spoke highly of the staff and manager.

The service user told us that they were able to choose how they spend their day. The service user's comments included; "I like living here" and "Staff are brilliant and look after me well".

Staff told us that they were satisfied that the care and support was safe, effective, compassionate and well led. Staff spoke positively about the care delivery, training and management support in the agency. Staff comments included; "I get regular supervision and annual appraisal", "Excellent care and support provided" and "Service users are given choice in everything that they do".

Returned staff questionnaires confirmed that safe, effective and compassionate care was delivered to service users and the agency was well led. Comments included; "Ardavon is a great place to work in and tenants are at the forefront of all decisions in regards to their care and support and the running of their home".

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

Review of the agency's staff recruitment records confirmed that 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 provision of a bus escort alongside service users that attend day care settings. Review of a sample of staff duty rosters and discussion with the person in charge evidenced that a bus escort had been employed since the previous inspection. On this basis, the area for improvement was assessed as met.

Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC); there was a system in place for professional registrations, to be monitored by the manager and a record of checks retained. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

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

Staff were required to complete medication management training and a competency assessment was carried out with staff to ensure their competence before assisting with this task.

Staff provided positive feedback regarding the training they received and confirmed that it enabled them to fulfil the duties and responsibilities of their roles. Staff were provided with training appropriate to the requirements of their roles, which was recorded and monitored on a colour coded training matrix. The review concluded that staff had received mandatory and other role specific training since the last care inspection, including moving and handling, Dysphagia and medicines management. The agency had also provided training in regard to positive behaviour support awareness and learning disability, which strengthened staff competence in these areas.

A review of fire safety records identified that a number of staff had not completed a fire drill in line with the agency's fire safety policy and procedure. An area for improvement has been identified.

Staff confirmed that they were provided with opportunities to complete training commensurate with their role and are actively encouraged by the manager to develop new skills and knowledge.

An area for improvement identified during the previous inspection related to adult safeguarding training for transport staff. Review of the training records and discussion with the person in charge evidenced that transport staff had completed adult safeguarding training. On this basis, the area for improvement was assessed as met.

Review of a sample of staff duty rosters and discussion with the person in charge evidenced that recruitment agency staff were occasionally rostered on duty during night time hours. There was no evidence to determine the competency of these staff who were in charge in the absence of the registered manager. An area for improvement has been identified.

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.

Staff reported collaborative team working and confirmed that they felt well supported in their roles by the manager.

3.3.2 Care Delivery

There was a handover at the beginning of each shift, which all staff attended. These meetings focused on information about any changes in the service users' care needs.

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, arts and crafts, visiting restaurants and bowling.

Staff interactions with service users were observed to be polite, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual service users' needs, their daily routine, wishes and preferences.

It was positive to note that the agency had service users' meetings on a regular basis which enabled the service users to discuss the provisions of their care. Some matters discussed included: activities, the complaints process and ideas on how to improve the service.

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.

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.

On review of restrictive practices such as the use of an infrared movement monitor and an alarm mat it was identified that these arrangements were not fully detailed in the service users' care plans. An area for improvement has been identified.

Advice was given in relation to maintaining a restrictive practice register, which should improve manager oversight and regular review of any restrictions. This will be reviewed at a future inspection.

Discussion with the person in charge and review of arrangements concerning the storage of confidential records confirmed that service users' records were stored safely and securely in compliance with legislative. Staff recognised the importance of maintaining accurate and contemporaneous records to guide their practice and ensure that care provided was safe, effective and timely.

Staff recorded regular evaluations about the care and support provided.

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

Records relating to consent were signed by the service user, dated and their purpose was clear.

3.3.4 Quality of Management Systems

Ms Allison Foley has been the manager in this agency since 1 May 2019. Staff commented positively about the manager and described them as supportive, approachable and always available to provide guidance.

The agency was visited each month by a representative of the registered provider. A review of the reports of the agency's quality monitoring established that there was engagement with service users, service users' relatives, staff and Health and Social Care (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 reports of these visits were completed in detail.

The annual quality report was reviewed and noted to include stakeholder consultation.

The agency's governance arrangements for the management of accidents/incidents was reviewed and confirmed that an effective reporting policy and system was in place and that the agency had responded appropriately to the concerns raised. There was a monthly tracker for centrally recording accidents and incidents; this was reviewed regularly by senior management to ensure appropriate management and swift identification of any patterns or trends arising.

Agencies are required to have a person known as the 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 the process for reporting and managing adult safeguarding concerns and their responsibility in identifying and reporting any actual or suspected incidences of abuse 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 raising concerns in the public interest (Whistleblowing). The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any concerns. The agency's annual Adult Safeguarding Position report was reviewed and found to be satisfactory.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Review of a complaint received since the previous inspection evidenced this complaint was appropriately managed and was reviewed as part of the agency's quality monitoring process. Discussions 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.

Discussions with the person in charge and staff confirmed that systems were in place to monitor staff performance and ensure that staff received support and guidance. Staff received regular supervision and annual appraisals which supported their professional development and enabled them to discuss concerns and training needs.

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	1	2

Areas for improvement and details of the Quality Improvement Plan were discussed with the person in charge 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 15 (2) (b) (c) (11) Stated: First time To be completed by: Immediate from the date of inspection	The Registered Person shall ensure service user's care plans contain all necessary information to adequately and safely respond to identified needs and presenting risks inclusive of restrictive practices agreed. Systems must be in place to ensure multi disciplinary assessment/input, regular review and reflect the least restrictive approach for the least amount of time possible. Ref: 3.3.3
	Response by Registered Person detailing the actions taken: An organisational Restrictive Practice Register has been developed and will be fully implemented by 31/07/2026. The Register will be reviewed monthly by the Registered Manager to ensure that the least restrictive approach is applied and that all restrictive practices are regularly reviewed. In addition, all care plans and risk assessments are currently being reviewed to ensure that there is clear and comprehensive information regarding any restrictive practices in place for tenants. This review will be completed no later than 31/07/2026. Compliance with, and completion of, these actions will be closely monitored by the management team to ensure effective implementation and ongoing oversight.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 Ref: Standard 12.4 Stated: First time To be completed by: Immediate from the date of inspection	The Registered Person shall ensure that those staff who may be in charge of the agency in the absence of the registered manager are deemed competent to deliver safe and effective care. This relates specifically to recruitment agency staff. Ref: 3.3.1
	Response by Registered Person detailing the actions taken: Any agency staff who are deemed as competent and may be required to take charge of the service in the absence of a manager will be required to successfully complete a full Competent Person in Charge assessment. This process will ensure that staff have the necessary knowledge, skills, and competence to fulfil this responsibility. All required assessments will be completed by 15/07/2026.

Area for improvement 2 Ref: Standard 16.3 Stated: First time To be completed by: Immediate from the date of inspection	The Registered Person shall ensure all staff complete a fire drill in line with the agency's fire safety policy and procedure. Ref: 3.3.1
	Response by Registered Person detailing the actions taken: A fire drill was successfully completed on 04/06/2026, with all relevant records retained and uploaded to the organisation's internal training system. To ensure ongoing compliance, additional fire drills have been scheduled in line with organisational requirements. Compliance will be further strengthened through review and monitoring during monthly quality monitoring visits undertaken by a senior manager.

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