The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Clondermott House

Provider: Apex Housing Association

Date of Inspection: 25 August 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:	Apex Housing Association
Responsible Individual/Responsible Person:	Ms Sheena McCallion
Registered Manager:	Mrs Bridgeen McCloskey
Service Profile: Clondermott House is a supported living type domiciliary care agency, which provides care and support services for up to 16 service users; this includes helping service users with tasks of everyday living, emotional support and assistance to access community services with the overall goal of promoting health and maximising quality of life. Service users have individual rooms and a range of shared facilities which includes a lounge, a number of bathrooms and a kitchen.	

2.0 Inspection summary

An unannounced inspection was undertaken on 25 August 2026, between 10.35 am and 5.15 pm by a care Inspector.

The last inspection of the agency was undertaken on 18 September 2025 by a care Inspector. No areas for improvement were identified. This inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; 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 competency assessments in respect of staff left in charge in the absence of the manager, supervision, service user records and restrictive practice.

It was establish that staff promoted the dignity and well-being of service users and that staff were knowledgeable and well trained to deliver safe and effective care.

Feedback from service users reflected their positive experience of the care and support provided by Clondermott House. Refer to Section 3.2 for more details.

As a result of this inspection one area for improvement previously identified was assessed as having been addressed by the provider. One previous area for improvement had not been satisfactorily addressed and therefore will be stated for a second time.

Three new areas for improvement were identified. Full details, including the new areas for improvement can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

Clondermott House uses the term 'tenants' to describe the people to whom they provide care and support. For the purposes of the inspection report, the term 'service user' is used, in keeping with the relevant regulations.

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 service 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 information held by RQIA about this service was reviewed. This included the previous QIP, registration information, and any other written or verbal information received from service users, their representatives, staff or the commissioning Trust.

Throughout the inspection process inspectors seek the views of those being supported by or working for 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, their representatives, 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.

Service users were complementary of the staff and the manager, describing a sense of security offered by the availability of staff. Service users stated that they were happy with the service provided to them by Clondermott House. Observation of engagement between service users and staff demonstrated that service users felt able to approach staff and seek support when required.

Staff spoken with expressed high levels of satisfaction in their employment working within Clondermott House. We were told about the supportive culture that exists amongst the staff team, shared values and collective commitment to assist and support service users in improving the quality of their day to day lives.

Staff described the positive outcomes achieved by service users, demonstrating an understanding of the impact of the support provided and the difference this made to the individual's quality of life. Staff spoke compassionately and respectfully about service users, demonstrating a clear understanding of individuals as people and the importance of providing support that was responsive to their needs, preferences and circumstances.

A HSC Trust representatives told us about the "good level of support" provided by Clondermott House. With regards to staff that stated, "Staff display a genuine interest in the welfare of the clients and support them to maintain independence as far as possible". They also described effective communication between themselves and the service.

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

Staff told us there was good teamwork and that they felt well supported in their role and that they were satisfied with the staffing levels. Staff were seen assisting service users in a caring and compassionate manner.

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. Review of employee's application forms and interview minutes illustrated that gaps in employment had been explored; as such, a previous area for improvement was assessed as having been addressed by the provider.

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. The induction programme was found to contain regular review points for which the new employee and line manager could examine professional development and, if necessary, agree upon additional supports.

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.

The majority of training elements had been undertaken and it was positive to note that compliance with training was monitored regularly by both the manager and as part of the quality monitoring process. Where training had expired there were plans in place to address this.

In addition to mandatory training such as Deprivation of Liberties Safeguards (DoLS) and adult safeguarding it was positive to observe staff had also undertaken mental health awareness training.

Discussion occurred with the manager and following the inspection, senior representatives of the organisation who agreed to consider provision of training in the management and response to self-injurious behaviours and the development of an associated policy and procedure. This will be reviewed at a future inspection.

Medicines Competency assessments were completed for all staff involved in the handling and administration of medicines.

It was positive to find the organisation had developed a person in charge handbook which contained essential information and guidance to support staff expected to undertake this role. Competency assessments for staff expected to act up in the absence of the manager were reviewed. Inconsistencies were identified in the quality of records, with elements of the template utilised by the organisation completed incorrectly, whilst other elements had not been populated. The previous area for improvement was not satisfactorily addressed and therefore will be stated for a second time.

The system utilised by the organisation to monitor compliance with supervision requirements was found to be ineffective. Review of records sampled identified that supervision was not consistently undertaken at the frequency stipulated within the organisation's own policies and procedures. An area for improvement was identified.

3.3.2 Care Delivery

There was a daily handover at the beginning of each shift, which included information about any changes to the service users' care, which the staff needed to assist them in their roles.

There was evidence of regular staff meetings, with minutes maintained to enable staff who were unable to attend to read for information sharing. It was positive to find evidence of discussions pertaining to changes in service users' needs and/or risks in addition to the sharing of organisation information, such as changes in policies and procedures which would impact staff practice.

Discussions with staff demonstrated knowledge held regarding individual service users' needs, their daily routine wishes and preferences. Observation of interactions between service user's and staff was found to be warm and supportive. Service users felt able to approach staff and seek support when needed, with staff prompt in responding.

The service was found to facilitate regular service user meetings, that records demonstrated were well attended. Service users were found to add to the set agenda, their opinions were recorded but moreover acted upon.

There was a system in place to ensure that the activities offered to service users were varied and geared towards their individual needs and preferences. It was positive to find that service users' individual interests were known by staff and that engagement in associated activities was encouraged. There was also evidence that staff readily shared information of local community events that service users could participate in.

3.3.3 Management of Care Records

Service users care records were held confidentially in line with data protection regulations.

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.

An area of good practice was recognised upon review of the agreements held between service users and the service. The agreements clearly established the respective expectations and responsibilities of both parties and provided a transparent account of the support to be delivered. The total hours of support to be provided were clearly detailed, with an accompanying breakdown of associated costs.

There was evidence service user's consent was sought in relation to information sharing, the management of medicines, support to maintain accommodation and the use of images. However, review of a sample of consent forms identified deficiencies in the recording and ongoing review of consent. Some records had not been signed by the service user and/or staff member, were incomplete whilst others had not been regularly reviewed. This led to concerns that the service could not provide consistent assurance that consent remained valid, current and could be appropriately evidenced.

Although aspects of the service users' care plans were person-centred, deficiencies were identified in the structure and content of the template used by the service. The template created ambiguity regarding actual assessed needs whilst one plan.

Risk management plans did not consistently reflect all current assessed risks. Review of service user records identified instances where risks known to the service had not been incorporated into the corresponding risk management plan. This created the potential for known risks to be insufficiently managed, inconsistencies in staff approach which could place service users, staff and others at risk of avoidable harm. Concerns were highlighted to the attention of the manager who agreed to take immediate action to address.

An area for improvement was identified in relation to service users' records.

There was a policy in place for the use of restrictive interventions. This included a tool to aid identification of any practices for which would be considered restrictive in nature. Observations made on the day of inspection identified restrictive practices deployed within the service, yet there was no associated documentation to evidence that the application of these interventions were assessed as necessary, just or proportionate nor was there reduction plans in place.

Discussion occurred with the manager and senior representatives of the organisation regarding the expectations outlined within the Regional Policy on the use of Restrictive Practices in Health and Social Care Settings. An area for improvement was identified.

3.3.4 Quality of Management Systems

There has been no change in the management of the service since the last inspection. Mrs Bridgeen McCloskey has been the manager in this service since 8 July 2025. Those consulted with described having good relationships with the manager and felt that she was approachable.

There was a policy and procedure in place to ensure any complaints received by the service were managed appropriately. In discussion with staff they advised that they were aware as to policies and procedures relating to the management of complaints. The manager also demonstrated awareness as to the Northern Ireland Public Services Ombudsman's (NIPSO) Model Complaints Handling Procedures.

Review of incident records identified that they were managed appropriately. There was system in place to ensure regular auditing of incidents and accidents, to establish any developing patterns/trends. It was highlighted to the attention of the manager that summarise pertaining to figures did not always appropriately correlate to the information available for the respective timeframe being reviewed. The manager agreed to take immediate action to address this and discuss means to avoid similar reoccurrences arising. This will be reviewed again 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 setting's adult safeguarding policy. A specific individual was identified as the agency's ASC. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm. The annual safeguarding position report had been reviewed and found to have been completed to a satisfactory standard.

The service 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, reviewing areas of practice such as staff training, staffing arrangements, service user records, complaints and safeguarding. It was also positive to find that additional financial audits were completed by another representative of the registered provider. The quality monitoring reports identified actions to drive service improvement and progression with these were appropriately monitored.

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	2*

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Bridgeen McCloskey, 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 15(2)(b)(c) **Stated:** First time **To be completed by:** Immediate and ongoing from date of inspection	The Registered Person shall ensure service user plans contain all necessary information to adequately and safely respond to identified needs and presenting risks. Ref: 3.3.3
	Response by registered person detailing the actions taken: All Care, Support and Risk Plans are being updated in full to ensure there is consistency in needs and risks being clearly identified.These will be updated before 24.11.2026 and reviewed weekly until complete.
Area for improvement 2 **Ref:** Regulation 15(5)(b), (10) **Stated:** First time **To be completed by:** 24 November 2026	The Registered Person shall ensure that all restrictive practices deployed within the service are necessary, proportionate and justified. Practice relating to restrictive practice must comply with expectations set out within the Regional Policy on the use of Restrictive Practices in Health and Social Care Settings. Ref: 3.3.3
	Response by registered person detailing the actions taken: A Restrictive Practice Register has now been implemented within the scheme 14.10.2026. This is reviewed annually and sooner if required. All risk assessments have now being reviewed and updated to include individualised restrictive practices in place for the required tenants.

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 12.4 **Stated:** Second time **To be completed by:** 24 November 2026	The Registered Person shall ensure that the training needs of individual staff for their roles and responsibilities are identified and arrangements are in place to meet them; this relates to the need for competency assessments to be undertaken for those who may be in charge of the service, in the absence of the manager. Ref: 3.3.1
	Response by registered person detailing the actions taken: All Competent Person in Charge assessments have been reviewed and are complete in full with detailed responses and signatures for staff and manager are in place and evidenced 07.10.2026
Area for improvement 1 **Ref:** Standard 13.3 **Stated:** First time **To be completed by:** 20 October 2026	The Registered Person shall ensure all employees receive appropriate and regular supervision associated with their role. Ref: 3.3.1
	Response by registered person detailing the actions taken: All staff have received supervision in line with the organisations policy, all dates and signatures are accurate and supervision tracker now reflects this. 07.10.2026

Please ensure this document is completed in full and returned via the Web Portal

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