The Regulation and Quality Improvement Authority

# Inspection Report

**Name of Service:** Jaz Care Ltd

**Provider:** Jaz Care Ltd

**Date of Inspection:** 23 April 2026

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

## 1.0 Service information

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| **Organisation/Registered Provider:** | Jaz Care Ltd |
| **Responsible Individual/Responsible Person:** | Mr Zia Nazar |
| **Registered Manager:** | Miss Natasha Kerr (Acting) |
| **Service Profile -**<br>Jaz Care Ltd is a domiciliary care agency based in Lurgan. The agency provides a range of personal care services to people living in their own homes. Jaz Care Ltd currently provides care to 100 service users. Services are commissioned by the Northern Health and Social Care Trust (NHSCT) and the Southern Health and Social Care Trust (SHSCT). | |

## 2.0 Inspection summary

An unannounced inspection was undertaken on 23 April 2026 between 10.00am and 4.45pm by a care Inspector.

The last care inspection undertaken on 20 May 2025 identified five areas for improvement. These related to recruitment practice, record keeping, monthly monitoring reports, complaints management and the review of agencys policies. This inspection was undertaken to evidence the progress with respect to the areas for improvement identified at the last inspection and to determine how the agency is performing in relation to the regulations and standards. It also sought to establish if it is delivering safe, effective and compassionate care and if the service is well-led.

The inspection established that the service was well-led, that care delivery was safe and that effective and compassionate care was delivered to service users. Four out of the five areas for improvement identified at the previous inspection were assessed as having been addressed by the provider. One area for improvement relating to agency policies was assessed as not met and is stated for a second time. One new area for improvement was identified during this inspection relating to safeguarding procedures and is discussed in section 3.3.1. The remaining findings of this inspection are outlined 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 identified, 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 the service users/relatives who are in receipt of care and support; the care workers who work for the agency and Health and Social Care staff. A review of a sample of records is also undertaken 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 survey.

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

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

Service users who were contacted for feedback said that they were happy with the standard of care provided by the agency. Comments received included the following statements: "the care is going well and nothing could be better" and "the carers are doing what I need, are respectful and I have no complaints".

Relatives who spoke with the inspector advised that they were very satisfied with the care and support provided to their loved ones by the care staff of the agency. One relative made the following comment: "Without the carers, my relative would not be able to live at home. The Team Leader is really on top of things and knows what my relative needs".

Staff who spoke with the inspector said that they enjoyed working for the agency and that the training and managerial support provided was of a good standard and included both face to face and on line training. Staff said they felt that the service users receive a good service.

Healthcare professionals who provided feedback on the agency during the inspection said that there had been improvements with the agency's recruitment processes and that the agency is good at reporting any concerns.

## 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. Although recommended changes had been made to the policy since the last inspection, the policy did not have an issue or review date assigned, the signature of the person who ratified changes to the policy was not legible and some terminology required to be updated in keeping person centred language and Adult Safeguarding best practice. This area for improvement is stated for a second time and has been included within the systematic review of all policies and procedures referenced in section 3.3.5.

The agency's annual Adult Safeguarding Position report was reviewed and it was positive to note that information for this was collated on a quarterly basis.

The organisation had an identified Adult Safeguarding Champion (ASC). 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. The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

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. 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 retained records of any referrals made to the HSC Trust in relation to adult safeguarding. The manager advised that three adult safeguarding referrals had been made since the last inspection. A review of these records confirmed that the agency had responded appropriately to the concerns raised in line with the Adult Safeguarding Policy and procedures. However, on review of records relating to accidents and incidents, it was identified that some reports of unexplained bruising reported to the Commissioning Trust were not considered under Adult Safeguarding Policy and procedures. There was no evidence of consultation with relevant healthcare professionals to establish how bruising may have occurred and if there were potential safeguarding concerns. Furthermore, it was identified that body maps had not been completed and there was no evidence of a robust or effective system in place to record any related investigations, actions or outcomes. In response the manager agreed to review all identified records immediately and in consultation with relevant professionals, consider if retrospective referrals should be completed. An area for improvement has been identified.

It was evident from a review of the accident and incident records that each of the Commissioning Trusts had established different systems for recording and reporting accidents/incidents. The manager confirmed that all recorded accidents/incidents were reviewed on a monthly basis in line with the Trusts' reporting requirements. Medication

incidents were recorded separately and on examination of a sample of records relating to medication incidents, it was established that appropriate actions had been taken to ensure service user safety and staff competence in the administration of medication.
It was recommended that a centralised record for all accidents and incidents arising should be implemented for review on a monthly basis to enable the swift identification of any patterns or trends. This advice was welcomed by the manager who agreed to implement these recommended changes. This will be reviewed at a future inspection.

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

### 3.3.2 Mental Capacity Act and Restrictive Practice

The Mental Capacity (Northern Ireland) Act 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 are required to complete Deprivation of Liberty Safeguards (DoLS) training as appropriate to their job roles. The manager confirmed that there were no service users subject to DoLS within the agency.

A review of restrictive practices such as the use of bed rails evidenced that whilst these were applied only under the direction of the multidisciplinary team, these were not recorded on a central register to facilitate regular review and to ensure proportionality and necessity for the safety and well-being of the service users concerned. From discussion with the manager and from review of the quality monitoring reports, it was positive to note that the recording and review of restrictive practices had been identified as an area to progress within the agency. RQIA will review progress with respect to the recording and review of restrictive practices at a future inspection.

### 3.3.3 Staff Recruitment, Induction and Training 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.

An area for improvement identified at the previous inspection related to recruitment practices. To ensure compliance with regulations a full employment history together with any gaps of employment of all potential employees must be obtained for each prospective employee. A review of the agency's most recently recruited staff's records confirmed that pre-employment checks, including employment history, gaps in employment and criminal record checks (AccessNI), were completed and verified before staff members commenced employment and had direct engagement with service users. On this basis the area for improvement was deemed to have been addressed by the provider.

A review of the records of a staff member recruited since the previous inspection identified that no explanation had been recorded where an employee had left a caring position. This was discussed with the manager who took immediate steps to address this during the inspection. The manager gave assurances that more robust scrutiny around all future employee's work history will ensue to ensure compliance with the Regulations and Standards. This will be reviewed at a future inspection.

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

A review of induction and training records confirmed that staff had completed training in Dysphagia and in relation to responding to choking incidents. Other mandatory training elements included Moving and Handling, Medication Administration, Infection Control, Basic First Aid, Dementia and Fire Safety.

### 3.3.4 Care Records and Service User Input

A sample of service users' care records examined confirmed that these contained sufficient information about the level of support required and that moving and handling risk assessments and care plans were up to date. 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.

### 3.3.5 Governance and Managerial Oversight

An area for improvement identified at the previous inspection related to Quality Monitoring reports. A review of records confirmed monitoring arrangements had been completed 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 the previous areas for improvement identified and a review of service user care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements. The manager was advised to remove any duplicated sections of the report template and to include unique identifier codes when reporting for accuracy when reviewing for trending and tracking purposes. The manager agreed to implement this advice in future monitoring reports. On this basis the area for improvement was deemed to have been addressed by the provider.

The Annual Quality Report was reviewed and it was noted that there were no actions arising in response to any suggestions made by service users/relatives for improving the service. This was discussed with the manager who agreed to review the report and ascertain what if

any actions should be taken in response to any recommendations made. This will be reviewed at a future inspection.

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

An area for improvement identified at the previous inspection related to record keeping and organisation of the agency's documentation. A range of agency records was examined and provided evidence of organised and secure record- keeping. On this basis the area for improvement was deemed to have been addressed by the provider.

An examination of all complaints received since the last inspection evidenced that complaints were managed in accordance with the agency's policy and procedure and a centralised tracker document recorded the actions taken in response to complaints. It was evident that complaints received since the last inspection were appropriately managed and reviewed as part of the agency's quality monitoring process. Advice was given to the manager around recording the outcome of each complaint received, whether or not it was substantiated and what learning arose as a consequence of the complaint. The manager welcomed this advice and agreed to action this. On this basis the area for improvement was deemed to have been addressed.

The inspector examined a wide range of policies in response to the previous area for improvement identified. Whilst the majority of the policies evidenced review dates thereon, some policies required additional and updated information and the signature of the person who ratified changes to the policies was not legible. This area for improvement is therefore stated for a second time.

There was a system in place that ensures that the service has an operational policy where staff are unable to gain access to a service user's home.

## 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 |
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| **Total number of Areas for Improvement** | 1 | 1* |

* the total number of areas for improvement includes one that has been stated for a second time and which is carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Natasha Kerr, Position (Acting 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**

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| **Area for improvement 1**<br><br>**Ref:** Regulation 15 (6) (a)<br><br>**Stated: First** time<br><br>**To be completed by:** | The Registered Person shall ensure that where the agency arranges the provision of prescribed services to the service user, the arrangements shall specify the procedure to be followed after an allegation of abuse, neglect or other harm has been made e.g. unexplained bruising which should include completion of body maps.<br><br>Ref: 3.3.1 |
| | **Response by registered person detailing the actions taken:**<br><br>As part of our ongoing review of policies and procedures. Our Safeguarding policy will be updated to reflect a flow chart detailing the procedures staff are to follow if they suspect any form of abuse or harm. This will be completed by 3.7.2026<br><br>Relating to the two particular cases identified during the inspection contact was made to both service users keyworkers to ascertain if any of the adverse incidents triggered a concern under safeguarding procedures. Confirmation has been obtained from both keyworks that following review of the adverse incidents and recent review meetings, no areas of concern have been noted.<br><br>As part of implementing a monthly tracker of incidents this will form part of the safeguarding procedure when tracking incidents, trends and patterns to follow up with named keyworkers to provide further assurance if at any point a safeguarding referral has been made or needs to be made.<br><br>Following implementation of the revised policy and procedure this will be discussed at team meetings with staff and care co-ordinators will be provided with further training.<br><br>Body maps are being used and completed by care staff if they identify any unexplained bruising or marks on a service users skin notifying the care co-ordinator who reports to the named keyworker. This was discussed in detail at the last team meeting on 21.5.2026<br><br>Safeguarding practices will be an ongoing agenda item at all team meetings. |

| **Action required to ensure compliance with Domiciliary Care Agencies Minimum Standards (revised) 2021** | |
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| **Area for improvement 1**<br><br>**Ref:** Standard 9.5<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>Immediately and ongoing | The Registered Person shall ensure that all policies and procedures are subject to a systematic 3 yearly review; any revision to or introduction of new policies and procedures are to be ratified by the registered person**.**<br><br>Ref: 3.3.1 |
| | 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. |

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