

Inspection Report

Name of Service: Link Community Care

Provider: Link Community Care Ltd

Date of Inspection: 9 June 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:	Link Community Care Ltd
Responsible Persons:	Mrs Beverley Loney Mr Henry (Harry) Loney
Registered Manager:	Mrs Beverley Loney
Service Profile – Link Community Care is a domiciliary care agency which provides a range of personal care and support to service users living in their own home. Services are commissioned by the South Eastern Health and Social Care Trust (SEHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 9 June 2026 between 10.30am and 4.00pm by a care Inspector.

The last care inspection undertaken on 18 August 2025 identified four areas for improvement. These related to staff training, monthly monitoring reports, medicines management and review of policies and procedures. 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 the agency 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. Two out of four areas for improvement identified at the previous inspection were assessed as having been addressed by the provider. These relate to staff training and quality monitoring reports. Two areas for improvement relating to medicines management and review of policies and procedures were assessed as not met and were stated for a second time. One new area for improvement was identified during this inspection relating to the management of adult safeguarding concerns. This is outlined in section 3.3.1. Details of the areas for improvement and 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

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: "They are fantastic and my relative loves to see them coming".

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. Staff said they felt that the service users receive a good service.

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 had been reviewed and was reflective of the Department of Health's (DoH) regional policy and outlined the procedure for staff for reporting concerns. 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. A review of documents related to adult safeguarding concerns that arose since the previous inspection evidenced that these were not kept separately from the accidents/incidents records and it was therefore difficult to identify and review this documentation at ease. Advice was given to the manager around the need for a separate centralised record keeping system for all adult safeguarding concerns and it was recommended that a tracker document be implemented to aid in the swift identification of trends or patterns that may arise. The manager agreed to action this advice which will be reviewed at a future inspection.

The manager advised that there had been one adult safeguarding concern raised since the last inspection relating to unexplained bruising which had been reported by a healthcare professional. A review of records pertaining to this concern identified that follow up in respect any identified training needs for carers had not been documented by the agency and there was no evidence of any shared learning having been embedded into practice. An area for improvement was identified.

Staff were required to complete adult safeguarding training during induction and every two years thereafter. A review of the training matrix evidenced that all staff were up to date with this mandatory training requirement. 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 raising concerns in the public interest (Whistleblowing).

The agency's annual Adult Safeguarding Position report was reviewed and it was satisfactory.

The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

The agency retained records of all accidents and incidents that had occurred and it was positive to note that these were also recorded on an electronic database which was regularly reviewed to ensure they were managed appropriately. A review of the documentation relating to accidents and incidents found that older records had not been archived. Advice was given to the manager around the need for archiving to avoid any confusion when reviewing these. RQIA will review this at a future inspection.

An area for improvement identified at the previous inspection related to the management of medication errors. On review of records relating to medication errors arising since the last inspection, it was identified that documentation completed by staff in response to a medication error had not been fully completed and the signature of the reviewer was missing on one document. There was therefore insufficient evidence of robust review of the incident so as to ensure staff competency around administration of medication. This area improvement has been restated for a second time.

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 was one service user subject to DoLS within the agency. This was recorded on a register which was reviewed regularly to ensure that all pertaining documentation was kept up to date within the service user's care records in line with the legislation.

A review of restrictive practices such as locked medication boxes, 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 by the manager and to ensure proportionality and necessity for the safety and well-being of the service users concerned. Advice was given to the manager in respect of the recording and review of restrictive practices. This will be reviewed 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.

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.

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.

An area for improvement identified at the previous inspection related to staff training. A review of induction and training records evidenced that a new electronic system had been developed to record all staff training. Whilst a number of staff required to complete their refresher training in a several mandatory training areas including Fire Safety, Moving and Handling, Medication Administration and Infection Control, the manager had made

arrangements for all identified staff to complete this training and confirmed after the inspection that staff were now compliant. On this basis the area for improvement identified at the previous inspection was assessed as met.

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. On this basis the area for improvement was assessed as met. Advice was given to the manager in respect of ensuring that reports include a review of the areas for improvement arising from the last inspection and more detail and accuracy when responding to the information required as per the template. It was further recommended that reports evidence that appropriate actions have been taken in response to medication errors and complaints received by the agency. 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 examination of all complaints received since the last inspection evidenced that complaints were managed in accordance with the agency's policy and procedure.

An area for improvement identified at the previous inspection related to policies and procedures which not been reviewed within three years in line with the domiciliary care agency minimum standards. On examining the policies and procedures, there was evidence that a review had commenced, however, the complaints policy required additional information to include contact details of other avenues for complaints redress. The manager advised that the majority of policies had been reviewed however this work remains ongoing. This area for improvement will be carried forward to the next inspection and 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
Total number of Areas for Improvement	1	2*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Beverly Loney, 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	
Area for improvement 1 Ref: Regulation 15 (6) (9) Stated: First time To be completed by:	The Registered Person shall ensure that the agency shall specify the procedure to be followed after an allegation of abuse, neglect or other harm has been made and shall make arrangements by training or other measures to prevent service users being harmed or placed at risk of harm, abuse or neglect. Ref: 3.3.1
	Response by registered person detailing the actions taken: The agency has a robust policy and procedure in place to manage any allegation of abuse, neglect or harm. The agency will carry out an investigation, the commissioning Trust will be made aware, and any preventative measures will be carried out. This may involve further training to alleviate neglect, risk and harm.
Action required to ensure compliance with Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 Ref: Standard 7.14 Stated: Second time To be completed by: Immediately and ongoing	The registered person shall ensure that the management of medicines is systematically audited to ensure they are consistent with the agency's policy and procedures and action is taken when necessary to ensure medication is administered safely as required. 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.

Area for improvement 2 Ref: Standard 9.5 Stated: Second time To be completed by: 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.
	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.

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



The Regulation and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority

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