

Inspection Report

Name of Service: Kingdom Healthcare Limited

Provider: Kingdom Healthcare Limited

Date of Inspection: 21 July 2026

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1.0 Service information

Organisation/Registered Provider:	Kingdom Healthcare Limited
Responsible Person:	Mr Ciaran Patrick Maynes (registration pending)
Registered Manager:	Mrs Tracey McLaughlin
Service Profile – Kingdom Healthcare Ltd is a domiciliary care agency which provides a range of personal care and social support services to service users living in their own home. The service users care is commissioned by the South Eastern Health and Social Care Trust (SEHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 21 July 2026, between 8.50 a.m. and 3:50 p.m. This was conducted by a care Inspector.

The inspection examined the agency's governance and management arrangements, reviewing areas such as staff recruitment, professional registrations, staff induction and training and adult safeguarding. The reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS), service user involvement, restrictive practices and Dysphagia management were also reviewed.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards, and to assess progress with the area for improvement identified during the last care inspection on 12 May 2025.

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.

As a result of this inspection, the area for improvement previously identified was assessed as having been addressed by the provider. Three new areas for improvement were identified, these related to training, risk assessments and policy review.

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 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 home care workers who work for the agency; and review/examine 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 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 shared that they felt respected by the carers, they looked forward to the arrival of the carers and had no concerns about their care. One response received following the inspection was discussed with the Responsible Individual.

Staff told us that they had no concerns about the quality of care and support being provided to service users, and that they found the manager approachable.

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.

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. This review provide evidence that the provider had addressed the area for improvement identified during the inspection on 12 May 2025.

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.

Checks were made to ensure that staff were appropriately registered with 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.

The agency has maintained a record for each member of staff of all training, including induction and professional development activities undertaken.

Procedures were in place for supervision and for appraising staff performance.

3.3.2 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.

Staff were required to complete adult safeguarding training during induction with annual updates 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.

All staff had been provided with training in relation to medicines management.

During inspection a concern was raised in relation to the number of training topics completed on a single day by staff attending update training. The Responsible Individual advised that in addition to the seventeen training topics that a workbook was also completed by the trainee on the same day. An area for improvement has been identified.

The Mental Capacity Act (Northern Ireland) 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 had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles.

On inspection a risk assessment was not reflective following a significant change in relation to recommendations outlined by Speech and Language Therapy (SALT) some months previously. An area for improvement has been identified.

3.3.3 What are the arrangements for promoting service user involvement?

From reviewing service users' care records, it was good to note that service users had an input into devising their own plan of care. The service users' care plans contained details about their likes and dislikes and the level of support they may require.

3.3.4 Care Delivery

Staff were knowledgeable of individual service users' needs; their daily routine wishes and preferences.

Records reviewed evidenced that staff were prompt in recognising service users' needs and any early signs of distress or illness.

Staff meetings were not held regularly and the staff meeting policy did not stipulate how frequently the meetings would be held. The Responsible Individual has agreed to review the staff meeting frequency. This will be reviewed at future inspection.

3.3.5 What are the arrangements to ensure robust managerial oversight and governance?

Mrs Tracey McLaughlin has been the registered manager in this agency since 19 January 2023. Staff spoken with commented positively about the manager, describing her as knowledgeable and approachable.

A number of policies were noted to require review. An area for improvement has been identified.

There were monitoring arrangements in place. A review of the reports of the agency's quality monitoring established that there was engagement with service users, staff and HSC Trust representatives. The reports included details of a review of accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements. Advice for further improving these monitoring reports was shared with the Responsible Individual such as; the use of unique identifiers, inclusion of identified areas for improvement and increasing the number of feedback comments. This will be reviewed at future inspections.

There was a process in place to manage any complaints.

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

Domiciliary care 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 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 was viewed.

There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided within the agency.

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

Changes to the agency's registration certificate are anticipated and the new certificate will be issued in due course.

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	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Ciaran Patrick Maynes Responsible Individual, 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)(a) Stated: First time To be completed by: Immediately from the date of inspection	The Registered Person shall ensure that risk assessments are accurate, this relates specifically to risk assessments being reflective of the recommendations outlined by Speech and Language Therapy (SALT) Ref: 3.3.2 Response by registered person detailing the actions taken: As identified on the day of the inspection, that although the management team and staff were fully aware of the updated SALT recommendations for the identified service user, and were being followed correctly by all staff caring for this particular service user, the risk assessment had not been updated accordingly. This has now been amended and all service users with SALT recommendations in place have had their risk assessments reviewed to ensure they are up to date and accurate.

Area for improvement 2 Ref: Regulation 16 (2)(a) Stated: First time To be completed by: Immediately from the date of inspection	The Registered Person shall ensure that each employee of the agency receives appropriate training Ref: 3.3.2 Response by registered person detailing the actions taken: On reflection and discussion with my colleagues, we as a team feel that this area of improvement could have been been a point made for discussion and review as opposed to an official area for improvement as we feel that all our staff do receive "appropriate training". The delivery and content of our training has always been at a high level and has never been questioned before. The only point raised in relation to training by the inspector was a query in relation to the volume and timeframe in which our training has been delivered and consequently how effective the training then becomes. That said, we have listened and discussed same as a team and our training schedule has been thoroughly reviewed and structured to lend more time to each training module with the aim of ensuring that retention of information from training is maximised for staff which in turn should lead to a higher level off care delivery for our end service users.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 Ref: Standard 9 Stated: First time To be completed by: Immediately from the date of inspection	The Registered Person shall ensure that Policies and procedures are subject to a systematic 3 yearly review, and the registered person ratifies any revision to or the introduction of new policies and procedures. Ref: 3.3.3 Response by registered person detailing the actions taken: All policies and procedures are in the process of being reviewed to ensure they are up to date and accurate so that they comply with the standard and are fit for purpose.



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