The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Threshold - Springfield Court

Provider: Threshold Services NI

Date of Inspection: 05 August 2025

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:	Threshold Services NI
Responsible Individual/Responsible Person:	Mrs Fiona McCabe
Registered Manager:	Mr Donal Quigley
Service Profile: Threshold -Springfield Court is a supported living type domiciliary care agency which provides domiciliary care services to ten service users with physical disabilities and/or sensory impairments. Service users live in their own bungalows and have the use of a number of shared areas.	

2.0 Inspection summary

An unannounced inspection was conducted on 5 August 2025 between 9.35 a.m. and 4.30 p.m. by a care Inspector.

The last care inspection of the agency was undertaken on 26 March 2025 by a finance 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; the inspection also sought to determine if the service 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 service user plans.

It was evident 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.

Service users said that the care and support provided by Threshold – Springfield Court was a good experience.

Threshold - Springfield Court 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.

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

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 Threshold - Springfield Court 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 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 using, working in and visiting the agency and examine a sample of records to evidence how the agency is performing in relation to the regulations and standards.

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

Service users spoke positively about the staff supporting, them advising that the staff "are very accessible", "very nice", with some describing them as "exceptional" and telling us they "couldn't ask for better staff".

It was reassuring to be told by service users that they felt respected and listened to as individuals, advising that staff regularly seek their opinions. They told us about flexibility in approach to the support that they receive, describing how this is tailored to them. One service user told us that, on occasion, they prefer to use allocated time to go out to local cafes or restaurants accompanied by staff.

Service users told us that they were happy within their own homes. One individual told us how lucky they feel as this has enabled them to have their own pets. With regard to maintenance issues, staff sought to resolve matters as soon as possible and kept service users informed on progress being made. Service users advised us that they were aware how to make a complaint, however stated they were happy at the moment.

In speaking with staff, they advised as to the impact of the recent change in provider. Some concerns centred on conditions of employee contracts, organisational communication and changes in systems. Staff stated that, in addition to the change in provider, there had also been a lot of change in the staff team, with six new employees having commenced within the service since March 2025. Feedback in relation to the newly formed team, however, was very positive with team members viewing one another as "reliable" and "very good". Observations on the day illustrated that support staff felt comfortable and at ease approaching both the Team Leader and Registered Manager for advice and/or guidance whenever needed.

In speaking with service users' representatives, it was positive to hear that they felt readily able to discuss any issues or concerns that they had directly with staff and/or the Registered Manager. They stated that they were aware as to the complaints procedures in place, however advised that they did not feel issues experienced to date warranted submission of a complaint. They described the staff team as highly responsive and were very complimentary of the staff. Service Users' representatives advised that communication was very good.

3.3 Inspection findings

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

Staff said there was good team work and that they felt well supported in their role. They did advise as to the impact of vacancies and sickness upon staffing levels, however felt that this was in the process of being resolved.

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. Checks were made to ensure that staff were appropriately registered with Northern Ireland Social Care Council (NISCC) or any other relevant regulatory body; there was a system in place for professional registrations to be monitored by the manager. The interview process was reviewed and written records were retained by the agency of the person's capability and competency in relation to their job role.

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. There was also evidence that the induction included shadowing of a more experienced staff member.

Training records of all staff are held electronically and, on review, it was evident that some staff training was outstanding or refresher training was required to be completed. Subsequent to the inspection, the Registered Manager provided assurances that action had been taken to address deficits identified and future training dates have been secured. A review of staff training and how it this is monitored will be reviewed at a future inspection.

Competency assessments were undertaken for staff to ensure that they were proficient in administration of medications.

It was apparent that staff received regular supervision. Procedures were in place for appraising staff performance and staff confirmed that annual appraisals had taken place.

3.3.2 Care Delivery

There was a daily handover at the beginning of each shift which included information about any changes to service user care needed by staff to assist them in their roles. Regular staff meetings were held and minutes retained of the meetings for staff who were unable to attend to read for information sharing.

Staff interactions with service users were observed to be friendly, with staff respecting service user privacy by contacting them prior to attending their home.

Good nutrition is important to the health of service users. Service users may need a range of support with meals; this may include simple encouragement through to full assistance from staff. Where service users required support with meal preparation, this was clearly stated within their plans and practice was found to be compliant with Speech and Language Therapy (SALT) recommendations.

Where service users required support with the management of medication, an assessment to determine the level of support required had been completed. For those service users who required medicine on an as needed basis, there were systems in place that enabled timely monitoring regarding frequency of administration.

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.

A review of records identified that service user consent was sought in relation to delivery of care and support, access to their home in the event of an emergency, and the staff contacting/requesting information from other healthcare professionals on their behalf. Service users were given the choice as to whether or not they wanted their photograph taken and used in any organisational promotional material or social media. Service users had tenancy agreements in place.

Service users' care records were stored securely and accessible to authorised personnel in accordance with data protection regulations.

Whilst each of the service users had a number of care, support and risk plans in place, improvements were required to ensure the accuracy of information included, for example, in one instance, a service user's assessment identified risks relating to social, leisure and community activities, yet there was no associated risk plan in place.

In the care plan of one service user, there were conflicting recommendations from two allied health professionals as to the staffing levels needed to safely complete moving and handling tasks, yet there was no evidence of the service following up on the matter to conclusively determine the level of support needed. Whilst the other service users' records contained differing directions relating to the level of support needed whilst the service user is using specialised mobility equipment.

Epilepsy Management plans for one service user stated a specific type of seizure activity, yet a seizure tracker used to record epileptic activity noted another type of epilepsy. There was no evidence of further consultation arising with the Epilepsy Specialist Nurse.

There were arrangements in place to ensure that service users, who required restriction had their capacity considered and, where appropriate, assessed. There was a policy in place for the use of restrictive interventions and a register was in place which was reviewed and updated regularly. Any restrictive practices were reviewed alongside the support plan and care review. Service user care, support and risk plans, however, detailed restrictive practices which were not featured in individuals' restrictive practice registers.

The need to ensure accurate and sufficient detail within care plans was discussed with the Registered Manager. This was identified as an area for improvement.

3.3.4 Adult Safeguarding and Incident Management

The agency's provision for the welfare, care and protection of service users was reviewed. The Department of Health's (DoH) regional policy 'Adult Safeguarding Prevention and Protection in Partnership' July 2015 was available and staff were aware as to the procedure for reporting concerns. The organisation had an identified Adult Safeguarding Champion (ASC). The safeguarding champion was known to the staff team.

Staff were required to complete adult safeguarding training during induction and every two years thereafter.

The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. Review of safeguarding records evidenced that these were managed appropriately.

The agency's governance arrangements for the management of accidents/incidents were reviewed and confirmed that an effective incident/accident reporting system was in place. Staff are required to record any incidents and accidents in a centralised electronic record which is then reviewed and audited by the manager and during monthly monitoring of the agency. A review of a sample of accident/incident records evidenced that these were managed appropriately.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies were appropriate.

3.3.5 Quality of Management Systems

There has been a change in the management of the agency since the last inspection. Mr Donal Quigley has been Acting Manager in this agency since 20 January 2025. Mr Donal Quigley's application for Registered Manager has been submitted and is pending.

The agency's registration certificate was up to date and displayed appropriately.

Those consulted with commented positively about the management team and described them as supportive, approachable and able to provide guidance.

There were monitoring arrangements in place in compliance with Regulations and Standards. The agency setting 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/day care setting. The reports of these visits were completed in detail also reviewing care records; accident/incidents; safeguarding matters; and training.

There was a system in place to ensure that complaints were managed appropriately.

There was evidence that the agency 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 by the agency.

4.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with the Regulations.

	Regulations	Standards
Total number of Areas for Improvement	1	0

The areas for improvement and details of the Quality Improvement Plan were discussed with Mr Donal Quigley, 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 Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** S Regulation 15 (2) (b) (c) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that all records relating to provision of care and management of risk are accurate, up to date and offer clear directions to staff. This is in particular reference to moving and handling, epilepsy management and restrictive practices. Ref: 3.3.3
	Response by registered person detailing the actions taken: All epilepsy, moving and handling and restrictive practise records have been fully reviewed and now reflect completely accurate information.

Please ensure this QIP is completed in full and uploaded via Web Portal

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