The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Complete Homecare 24

Provider: Complete Home Care 24 Ltd

Date of Inspection: 18 September 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:	Complete Home Care 24 Ltd
Responsible Individual/Responsible Person:	Miss Roisin Austin
Registered Manager:	Mrs Ciara Austin (Acting Manager)
Service Profile: Complete Homecare 24 is a Domiciliary Care Agency which provides a range of personal care and support to service users living in their own homes. The majority of the Agency's service users have care commissioned on their behalf by the Northern Health and Social Care Trust (NHSCT) while other service users purchase their care privately from the Agency.	

2.0 Inspection summary

An unannounced inspection was undertaken 18 September 2025, between 9.50 a.m. and 5.20 p.m. by a care Inspector.

The last care inspection of the agency was undertaken on 8 November 2024. No areas for improvement were identified during the last inspection. 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 service user plans, quality monitoring reports, policy and procedures, competency assessments, staff inductions, staff training and complaints management.

Service users said that the care and support provided by Complete Homecare 24 was a good experience.

Identified areas for improvement can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.0.

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 Complete Homecare 24. 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 those receiving the service, their representatives and those working in 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' feedback was complimentary about the staff delivering care, who they described as "very, very good and very understanding". Service users told us that they felt staff listened to them and that they felt safe with staff. One service user advised that the staff "couldn't be any better to me … they go above and beyond, doing extra and they don't seem to worry about time. I couldn't ask for better".

One Service user's representative told us that they found the staff "easy to work with" and advised they were all "very accommodating" and "responsive". They advised that staff were respectful and delivered "very good care" to their loved ones. One representative told us that the staff "clearly know their jobs"; they described how staff quickly and appropriately responded to an emergency situation, acting to protect their loved one from risk of further harm.

Some service users' representatives consulted, advised that, on occasion, care calls had unexpectedly been delayed. On such occasions, some service users and/or their representatives had been advised as to the delay, however this practice was not consistent. Overall, service user's representative told us that communication from staff was good, and that office based staff have been accessible when needed.

Service users' representatives spoke positively about the Manager and one of the locality managers who we were told was "very accommodating". Those service users' representatives consulted illustrated an awareness as to the complaints procedures, although they stated they had no present concerns.

The majority of staff consulted were confident in the quality of care delivered to service users. One staff member stated these assurances were provided through receipt of positive feedback from the service user they support as well as from their family. Another member of staff told us they felt the "care out on the floor is amazing".

Discussion with staff and review of records evidenced that safeguarding concerns were managed in keeping with Regulation and best practice guidance.

Commissioners told us that they had no concerns regarding the quality of care provided by Complete Homecare 24. They advised they found management staff to be "very helpful, polite and professional" whilst care staff were described as "conscientious", "caring" and diligent in recognising changes in service users' presentation. One commissioner felt concerns were brought to their attention in a timely manner.

One commissioner advised that a service user they support had made a complaint to the agency regarding a lack of consistency in staffing. The commissioner stated that the agency responded appropriately to the complaint and described how a visit completed by the deputy manager to collaboratively agree a way forward with the service user had been greatly appreciated. A commissioner stated that "it would be great in the future if this service could expand into other geographical areas".

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular training and continued supervision and support.

Service user and service user representative feedback retained by the agency indicated that "times are an issue sometimes" referring to receipt of calls with some service users feeling that "staff are always rushing and don't have enough time". Staff also indicated that due to staffing shortages, either as a result of vacancies and/or unforeseen circumstances such as sickness, they had been expected to complete additional care visits, which unfortunately had negatively impacted times of scheduled visits.

Concerns were also communicated by staff to the inspector regarding duration of shifts and/or adequate break periods. This was discussed with the Manager following the inspection and the Inspector asked that a review current call scheduling be undertaken so as to ensure that they positively promote staff wellbeing and the provision of quality care to service users. This aspect of service delivery will be reviewed at a future care inspection.

A review of a sample of staff recruitment records confirmed that all pre-employment checks, including enhanced criminal record checks (AccessNI), were completed and verified before staff 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 in relation to their job role. It was positive to note that at the point of interview, gaps in employment history were actively explored.

he Manager advised that there was a process in place to ensure that newly appointed staff completed a structured orientation and induction, to ensure they were competent to carry out the duties of their job. However, review of associated induction records evidenced insufficient detail and did not provide assurance that the induction was sufficiently robust, this was discussed with the Manager during feedback. An area for improvement has been identified.

Records of all staff training were retained and the Manager maintained oversight of the training matrix to ensure compliance. This training included Deprivation of Liberties Safeguards (DoLS), adult safeguarding, Dysphagia, at a level appropriate to their job roles. It was also positive to note that additional training had also been provided such as oral hygiene, continence care and autism.

It was noted that mandatory training did not include specific elements such as Stoma care. In discussion with the Manager, they advised that a course in stoma care was currently being considered. In addition, there was no evidence that complaints management training had been undertaken by appropriate personnel within the agency. It was also found that medicines competency assessments were not completed on an annual basis in line with the agency's policies and procedures. An area for improvement was made.

There was no policy in place relating to the potential absence of the Manager. As such, there were no competency assessments in place for individuals expected to oversee the day to day management of the agency when the Manager is not available. An area for improvement has been identified.

Staff confirmed they received regular supervision. Procedures were in place for appraising staff performance and there was evidence of completion of appraisals on an annual basis.

3.3.2 Care Delivery and Care Records

It was positive to note that the service user agreement and service user guide contained detailed information to ensure informed decisions could be made by service users. This document promoted choice, advising service users that they could state their preference regarding the gender of carers who would deliver their care and/or support. The agreement also sought individuals' consent regarding staff entry to their home in response to emergency situations.

Empowerment of individuals' and promotion of their autonomy was evident within care plans that contained a section titled "Service user views of own needs/ Right to decline and refuse elements of care". This demonstrated a commitment to ensuring individuals understood risks and were able to make informed decisions regarding their care and support.

There was a system in place for identifying any missed visits by staff into service users' homes; this included spot checks on staff practice, regular contact with service users and their relatives; and regular auditing of the daily notes completed by the care workers. The agency also utilised a live check-in/check-out system, for staff to use on arrival and on leaving service users' homes.

The agency completed an initial assessment of needs when service users' 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.

Whilst care plans were in place to direct staff on how to meet service users' needs, it was found that these did not always contain up-to-date and/or accurate information. For example, one service user's plans contained contradictory information relating to assessed level of diet prescribed within their Speech and Language Therapy (SALT) Care Plan. This was highlighted to the Manager in order for immediate action to be taken.

Recommendations for use of visual aids to promote communication detailed within a service users' SALT Care Plan had not been incorporated within the service user's plan which was created by the agency. Furthermore, in the risk assessment completed for the same service user, it was identified that a number of known risks were not recorded. Issues identified were brought to the attention of the Manager to immediately address; advice was also provided to consult with the Speech and Language Therapist and Behavioural Therapist involved in the care of this individual.

An examination of service users' care records also identified that these were not being updated on a regular basis. One example of this related to a service user being prescribed bed rest until completion of an occupational therapist assessment. Although the required assessment had been completed, the care plan had not been updated to reflect the change in directions. An area for improvement was made.

The service was unable to produce relevant documentation associated with Deprivation of Liberty Safeguards (DoLs). Whilst there was evidence that the agency sought to identify restrictive practices being utilised by staff, not all restrictions were appropriately detailed within care records, and the agency did not retain a register of any restrictions used. An area for improvement was made.

3.3.3 Quality of Management Systems

There has been no change in the management of the agency since the last inspection. Mrs Ciara Austin has been the Acting Manager in this agency since 29 August 2023.

Service users, service user representatives and staff consulted with commented positively about the Manager describing her as friendly, approachable and "lovely". All other feedback received by RQIA was shared with the Responsible Person for consideration and action, as appropriate.

The agency's annual report was in the process of being finalised. Review of service users' survey responses were positive with carers described as "friendly", "reliable" and "excellent". The annual quality report will be reviewed at a future care inspection.

Review of incident records identified that they were managed appropriately. There was evidence that incidents were audited on a regular basis, to establish any patterns/trends.

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 setting's adult safeguarding policy. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm.

The agency is required to have a robust system in place for evaluating the quality of the services which the agency arranges to be provided.

It was disappointing to note that the deficits highlighted in this report had not been identified within the monthly monitoring reports which were reviewed.

In addition, there were some inconsistencies with regard to the accuracy of information contained within the monthly monitoring reports sampled; for example, information contained within the agency's incident tracker was not accurately reflected in the quality monitoring reports.

Other sections within these reports contained generic statements detailing actions taken, such as the number of staff files reviewed; however, there was no overview of findings or the corresponding actions being taken to address identified shortfalls.

Although it was positive to note that the agency frequently sought and included feedback from service users, their representatives and staff, stakeholder feedback was not included. No actions were included within the reports in relation to negative feedback received.

The Inspector was therefore not assured that a robust quality monitoring system was in place so as to identify shortfalls, and drive improvements in an effective and sustained manner. An area for improvement was identified.

The management of complaints was also considered. It was noted that no complaints had been recorded since the date of the previous inspection despite monthly monitoring reports detailing expressions of dissatisfaction which should have been managed in line with the agency's complaints procedures. This was discussed with the Manager and examples provided. Although the Manager provided verbal assurances of actions taken in response to concerns raised, there was no written evidence to validate this. An area for improvement has been identified.

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	4	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Ciara Austin, 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(2) (b) (c) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure service user plans contain accurate and all necessary information to adequately and safely respond to identified needs and presenting risks. Ref: 3.3.2
	Response by registered person detailing the actions taken: A monthly audit and quality review of care plans will be carried out, with a minimum of 20 checks completed and fully documented at the end of each month. The audit will confirm whether assessments are complete, care plans are personalised and consistent, daily notes align with the care plan, and whether risk assessments have been appropriately completed and updated. All findings will be included in the monthly monitoring report.
Area for improvement 2 **Ref:** Regulation 15(10) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure restrictive practices are appropriately detailed within service user plans. Ref: 3.3.2
	Response by registered person detailing the actions taken: A monthly audit and quality review of care plans will be conducted, with at least 20 checks completed and fully documented at the end of each month. The audit will also ensure that all restrictive practices are clearly and appropriately detailed and dated within each service user's plan. The restrictive practice matrix will remain in place and continue to be updated and reviewed on a monthly basis.
Area for improvement 3 **Ref:** Regulation 23(1), (4) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that monthly monitoring reports are completed in a comprehensive and robust manner at all times in keeping with Regulation. Ref: 3.3.4
	Response by registered person detailing the actions taken: Enhancements to the monthly monitoring reports have been implemented, including updated templates and checklists. Greater emphasis will be placed on identifying trends, risks, and gaps in care provision, with clear deadlines set for responsible staff to follow up. A compliance checklist has also been developed to ensure that the system in place is robust and effective.

Area for improvement 4 **Ref:** Regulation 22(6), (8) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that all complaints received are responded to according to the agency's policy and procedure and appropriate records are retained to enable analysis of any developing patterns and/or trends so as to drive necessary improvements. Ref: 3.3.4
	Response by registered person detailing the actions taken: In accordance with the complaints policy and procedure, a new complaints form has been developed, and a comprehensive complaints matrix has been introduced. This will ensure that all complaints are accurately logged, appropriately responded to, and records are maintained in line with the policy and procedure, as well as included in the monthly monitoring reports.

<table>
<tr><th colspan="2">Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, Version 1.1: August 2021</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 12.1

Stated: First time

To be completed by:
18 October 2025</td><td>The Registered Person shall ensure that a robust system is in place which ensures that all care staff are provided with an appropriately structured induction with records of the induction retained.

Ref: 3.3.1</td></tr>
<tr><td>Response by registered person detailing the actions taken:
A new structured induction programme has been developed, incorporating the full induction process along with competency assessments. Records will be easily accessible within staff files, and the induction programme will be regularly reviewed to ensure the system remains robust and effective. This will also be checked each month.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 12

Stated: First time

To be completed by:
Immediate from the date of the inspection</td><td>The Registered Person shall ensure that a robust system is in place which ensures that all staff receive mandatory training in a timely and effective manner.
In addition, bespoke training should also be provided to staff, as needed, in response to identified needs and/or risks of service users to whom they are delivering care.

Ref: 3.3.1</td></tr>
<tr><td>Response by registered person detailing the actions taken:
All staff are required to complete their full e-learning training via the Evolve platform. Currently, there are 24 essential courses available, with the flexibility to add bespoke training to address any additional identified needs or risks of service users. The essential courses currently include:
• Safeguarding
• COSHH
• Continence Care
• Dementia Awareness
• DOLS
• Dysphagia Awareness
• Fire Awareness
• First Aid
• Manual Handling
• Food Hygiene
• GDPR
• Health & Safety
• Human Rights
• Infection Control
• Medication
• Record Keeping
• Personal Care
• Professional Boundaries
• Aphasia Awareness</td></tr>
</table>

	• Catheter Care • Lone Working • Oral Care • Restraint • Stoma Care This platform will also create the training matrix with live information, it will also send out reminders to all staff when their training is to be renewd and automatically reset it for them.
Area for improvement 3 **Ref:** Standard 9.1 **Stated:** First time **To be completed by:** 18 October 2025	The Registered Person shall ensure that a Policy and Procedure is in place in regard to the Absence of the Manager; evidence should also be retained that this Policy and Procedure has been read and understood by all relevant staff. Ref: 3.3.1
	Response by registered person detailing the actions taken: .A policy and procedure regarding manager absence has now been implemented (Policy 57) Manager competency assessments have been completed, and all staff at CH24 have read and acknowledged their understanding of these. Manager rotas are now also published weekly for all staff to view.

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

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