The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Rutledge Recruitment and Training

Provider: Rutledge Recruitment and Training Ltd

Date of Inspection: 26 June 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:	Rutledge Recruitment and Training Ltd
Responsible Person:	Mr Jonathan Doherty
Registered Manager:	Mrs Dominika Kulis
Service Profile – Rutledge Recruitment & Training is a domiciliary care agency based in Portadown. The service provides care and support to individuals living in their own homes. Services provided include personal care, medication support, meal provision and a sitting service. These services are commissioned by the Southern and Northern Health and Social Care Trusts.	

2.0 Inspection summary

An unannounced inspection was undertaken 26 June 2025 between 9.50am and 4.15pm by a care Inspector.

The last care inspection of the agency was undertaken on 29 February 2024 by a care 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; and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

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 examined.

Two areas for improvement were identified during this inspection. These relate to staff supervision and Quality Monitoring reports.

Good practice was identified in relation to recruitment practice and staff induction and training.

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 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 service. This included any previous areas for improvement issued, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors will seek the views of those receiving support, as well as those working within the service and review 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 actively listening to a range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans. We contacted a service user, relatives, care staff and HSC professionals to seek their views of Rutledge Recruitment and Training Ltd. The information provided indicated that there were no concerns in relation to the service provided to service users.

One service user and two relatives who were contacted for feedback indicated that they were satisfied with the care and support provided by the agency.

Staff who spoke with the inspector indicated that the service users get good support and a good service from the agency and that training for all staff was good.

One HSC professional who provided feedback advised that the agency has been very accommodating and positive to work with and that communication is good and responsive.

3.3 What has this service done to meet any areas for improvement identified at or since the last inspection?

The last care inspection of the agency was undertaken on 11 April 2024 by a care inspector. No areas for improvement were identified.

4.0 Inspection findings

4.1 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 was reflective of the Department of Health's (DoH) regional Guidelines for Adult Safeguarding. 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 agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. A review of safeguarding records evidenced that these were managed appropriately. Advice was given to the manager with regards creating a log of all safeguarding concerns raised for tracking purposes to include consideration of any protection plans that may be implemented for the prevention and protection of harm of service users.

Staff were required to complete adult safeguarding training during induction and it was positive to note that this was refreshed every year 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 procedures with regard to whistleblowing.

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

4.2 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 had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The manager reported that none of the service users were subject to DoLS or restrictive practices as part of their care and support plans however it was later identified that one service user was subject to DoLS under Emergency Provisions but no update had been received in respect of the Trust Panel DoLS authorisation. In response to this, the manager made contact with the relevant department to establish the position and agreed to update the care plan accordingly. It was recommended that a review take place of all service users to establish if DoLS apply and to compile a register to ensure these are reviewed regularly and not applied disproportionately or for longer that is necessary in line with the legislation. This will be reviewed at a later inspection.

4.3 Staff Selection, Recruitment and Induction

A 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 the Northern Ireland Social Care Council (NISCC). There was a system in place for professional registrations to be monitored by the manager. Staff were aware of their responsibilities to keep their registrations up to date. There were no volunteers deployed within the agency.

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 for new staff which included shadowing of an experienced staff member. Written records retained by the agency of the person's capability and competency in relation to their job role were signed off by the manager at the end of the induction period.

4.4 Staff Training and Development

Staff were provided with training appropriate to the requirements of their role. The agency maintained an electronic record of all training undertaken by staff which was regularly reviewed to ensure compliance. Staff who spoke with the inspector advised that they were happy that the training provided equipped them for their caring role and were aware of the need to keep their mandatory training up to date.

The manager reported that none of the service users currently required assistance of specialised equipment however manual handling training was included within the service's mandatory training programme which included both face to face and online manual handling training.

All staff had been provided with training in relation to medicines management and staff were also required to complete competency assessment which was refreshed on a yearly basis.

A review of training records confirmed that staff had completed training in dysphagia and in relation to responding to choking incidents.

Supervision is an important part in professional development and staff should complete supervision in line with their professional bodies' guidance and retain a written record as evidence for inspection purposes. On review of supervision practices, it was highlighted that staff supervision and annual appraisal take place annually. The agency's supervision policy was reviewed and whilst it highlighted that staff are supervised and that audits and spot checks are undertaken, the supervision arrangements were not clearly specified with regards the format, frequency and how formal supervision meetings are recorded. Furthermore it did not outline the arrangements for staff should they require supervision outside the set arrangements. This has been identified as an area for improvement.

4.5 Care Records and Service User Input

A sample of service users' care records was examined and contained detailed information about the level of support required and it was good to note that service users had an input into devising their own plan of care. Care plans reflected the multi-disciplinary input and collaborative working undertaken to ensure service users' health and social care needs were met within the agency.

There was evidence of regular contact with service users and their representatives in line with the commissioning trust's requirements however a review of a sample of care plans identified that these had been signed only by the manager and not by the service users or their next of kin. Advice was given to the manager around how care and support plans can evidence that a consultation has taken place with the service user or next of kin as appropriate in respect of how identified care needs are to be met by the agency. This will be reviewed at a future inspection.

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.

4.6 Governance and Managerial Oversight

There were monitoring arrangements in place in compliance with the 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. These did not provide a summary of the comments made by those consulted and did not use a unique identifier to enable any specific service user's issues to be followed up appropriately. One report examined inaccurately reported the number of incidents/accidents recorded for the month. This has been identified as an area for improvement. Advice was given to the manager around accuracy of information included in the quality monitoring reports to include a breakdown of specific comments made by stakeholders and use of unique identifier numbers. This will enable the identification and tracking of any trends as well as assessing what if any, actions have been taken by the agency towards improvement between each monitoring visit.

The agency's registration certificate was up to date and displayed appropriately along with current certificates of public and employers' liability insurance. The Annual Quality Report was reviewed and was satisfactory.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. A review of complaints received since the last inspection confirmed they had been appropriately managed and were reviewed as part of the agency's quality monitoring process.

There was a system in place to ensure that records were retrieved from discontinued packages of care in keeping with the agency's policies and procedures.

Where staff are unable to gain access to a service user's home, the service had an operational policy, procedure or protocol that clearly directs staff as to what actions they should take to manage and report such situations in a timely manner.

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

5.0 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	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Nicola Murray, 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 23(1) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided. The report shall summarise the views of stakeholders consulted and provide an accurate report of aspects evaluated This relates to information included in Quality Monitoring reports. Ref:4.6
	Response by registered person detailing the actions taken: The agency has revised its view towards the Quality Monitoring reporting template to ensure all stakeholder feedback is recorded in detail, including a summary of comments received from service users, relatives, staff, and HSC Trust representatives. A unique identifier system has been introduced to allow for individual issues to be tracked and followed up appropriately. Reports are now subject to internal review by the several managers to ensure accuracy of data regarding incidents, accidents, and complaints. This revised system is being implemented immediately and will be reviewed at each monitoring visit to ensure ongoing compliance.
Action required to ensure compliance with Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standards 13 **Stated:** First time **To be completed by** Immediately and ongoing	The Registered Person shall ensure that each employee of the agency details the arrangements and frequency of supervision procedures. Staff should receive appropriate and recorded formal supervision meetings and recorded appraisal. Ref: 4.4
	Response by registered person detailing the actions taken: The agency's supervision policy has been updated to clearly specify the format, frequency, and recording requirements for supervision and appraisal. Formal supervision will continue to take place on a yearly basis, with annual appraisals completed for all staff. Records of supervision meetings and appraisals will be maintained and available for inspection. Staff will also have the option to request additional supervision outside scheduled meetings should the need arise. A more stringent audit system,

	building on the existing arrangements, has been implemented to monitor compliance with supervision and appraisal requirements. The manager will review supervision records monthly to ensure standards are consistently met.

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