The Regulation and Quality Improvement Authority

# Inspection Report

**Name of Service:** Rodgers Community Care

**Provider:** Rodgers Community Care Ltd

**Date of Inspection:** 8 July 2025

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

## 1.0 Service information

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| **Organisation/Registered Provider:** | Rodgers Community Care Ltd |
| **Responsible Person:** | Mr Michael Rodgers |
| **Registered Manager:** | Mrs Isobel Janene Swain |
| **Service Profile –** Rodgers Community Care is a domiciliary care agency based in Lisburn which provides a range of personal care, social support and sitting services to adults and children living in their own homes. Service users have a range of needs including dementia, mental health, learning disability and physical disability. These services are commissioned by the South Eastern Health and Social Care Trust (SEHSCT) and the Belfast Health and Social Care Trust (BHSCT). | |

## 2.0 Inspection summary

An unannounced inspection was undertaken on 8 July 2025 between 10.25 am and 4.50 pm by a care Inspector.

The last care inspection of the agency was undertaken on 26 January 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.

The inspection established that care delivery was well led, 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. Two areas for improvement were identified during this inspection. These relate to staff training and policy and procedure documents. Full details of these new areas for improvement identified can be found in the main body of this report and in the quality improvement plan (QIP) in Section 5.

## 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 agency and review a sample of records to evidence how it 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 approached service users, relatives, care staff and HSC professionals to seek their views of Rodgers Community Care. The information provided indicated that there were no concerns in relation to the care and support provided to service users.

Service users and relatives who provided feedback on the service indicated that they were satisfied with the care and support provided by the agency.

One service user who spoke with the inspector said: "They treat me well – they are great".

Relatives who spoke with the inspector advised that they were happy with the carers and that the office could be contacted easily if needed. Some comments received by those who completed the service user/relatives questionnaire included the following statements: "Could not do without them" and; "we are very happy with the service we get – all the carers are brilliant".

Staff who spoke with the inspector indicated that the service users get good care and support from the agency; that the training was good and that management were approachable and good to work for.

HSC professionals who spoke with the inspector advised that communication from the agency is good and that there is good collaboration with the agency where any issues arise.

## 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 16 January 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 required amendments to ensure it was reflective of the Department of Health's (DoH) regional Guidelines for Adult Safeguarding. It was suggested the policy should include a clear outline of the procedure to follow in the event of any concerns being raised. The manager followed this advice, amended the policy and this has since been shared with the inspector. 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. It was recommended to the manager that a log of all safeguarding concerns should be created for tracking purposes which should include details of any follow up actions, protection plans or information that should be shared with care staff for the prevention and protection of harm of service users. The manager welcomed this advice. This will be reviewed at a future inspection.

Staff were required to complete adult safeguarding training during induction. A review of training records highlighted that there were staff who needed to refresh this training. This is discussed in more detail in Section 4.4.

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 agency also retained records of all accidents and incidents that had occurred. A review of these records indicated that all of those recorded had been managed appropriately. Advice was given to the manager in respect of creating a tracking record so that any trends arising from accidents and incidents can be easily identified. The manager confirmed that this has since been implemented. This will be reviewed at a future inspection.

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.

On review of training records there were a number of new staff that had not completed Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. This was discussed with the manager who has since confirmed that training dates have been set for all staff identified.

The manager reported that one service user had been subject to DoLS however there was no documentation held within the care records and clarity was therefore needed to ascertain if DoLS was still in place for the service user. The manager acted on this immediately and later confirmed that DoLS was no longer applicable and that care records had been updated to reflect this.

There was a restrictive practice policy in place and whilst there was evidence of use of bed rails on a service user's care records, this was not recorded as a restrictive practice. A discussion took place with the manager on the need to review all care records to identify what, if any, other restrictive practices are implemented for service users' safety. It was recommended that a register be compiled to identify restrictive interventions and to review these regularly to ensure they are proportionate to the aim sought; and used for no longer than is necessary in line with the assessed need of the individual. This will be reviewed at a future 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 as part of induction to the agency. The agency held an electronic record of all training undertaken by staff which on review, indicated that several staff were outstanding refresher training in a number of mandatory training areas including, Adult Safeguarding, Child Protection, Medication training, Infection Control, Dysphagia and DoLS. An area for improvement has been identified. The manager explained that staff are updating the electronic training matrix and provided assurances that all staff identified with outstanding training have since arranged to complete their refresher training and that the training needs of staff are reviewed on a monthly basis to ensure compliance. Staff who spoke with the inspector advised that they found the training was useful and that they were aware of the need to keep their mandatory training up to date.

The manager reported that a number of service users required the use of specialised equipment to assist them with moving and that this was included within the agency's mandatory training programme. Where service users required assistance in the use of other specialised equipment; bespoke training from HSC professionals was arranged and competency assessed before care delivery commenced. This was then reviewed and refreshed annually. Care records evidenced that the agency proactively and collaboratively worked alongside the HSC Trust to ensure the appropriate training was provided and competency assessed before delivery.

All staff had been provided with training in relation to medicines management and were required to complete competency assessment prior to undertaking this task.

## 4.5 Care Records and Service User Input

A sample of service users' care records were 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. 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. There was evidence that staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate.

A number of service users were assessed by SALT with recommendations provided and some required their food and fluids to be of a specific consistency. Staff demonstrated a good knowledge of service users' wishes, preferences and assessed needs. These were recorded within care plans along with associated SALT dietary requirements. Staff were familiar with how food and fluids should be modified and implemented the specific recommendations of the SALT to ensure the care received in the setting was safe and effective.

## 4.6 Governance and Managerial Oversight

A review of a selection of policies and procedures indicated that some documents including the Complaints Policy, Adult Safeguarding Policy and use of Social Media policy were not ratified and did not have a set review date. This is identified as an area for improvement.

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.

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 which also required review. On examination of the complaints received since the last inspection, it was confirmed that they had been appropriately managed and were reviewed as part of the agency's quality monitoring process.

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 |
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| **Total number of Areas for Improvement** | 1 | 1 |

Areas for improvement and details of the Quality Improvement Plan were discussed with Janene Swain, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

## Quality Improvement Plan

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| **Action required to ensure compliance with The Domiciliary Care Agency Regulations (Northern Ireland) 2007** | |
| **Area for improvement 1**<br><br>**Ref:** Regulation 16 (2) (a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate and ongoing from date of inspection | The registered person shall ensure each employee of the agency receives training and appraisal which are appropriate to the work he is to perform.<br><br>This relates to the need to ensure staff training is kept up to date and under regular review.<br><br>Ref: 4.4 |
| | **Response by registered person detailing the actions taken:**<br>Staff had been enrolled on to training couses identified as outstanding. Training was completed and updated by 31.08.25. Training is ongoing and reviewed on a fortnightly basis. |
| **Action required to ensure compliance with Domiciliary Care Agencies Minimum Standards (revised) 2021** | |
| **Area for improvement 1**<br><br>**Ref:** Standard 9.5<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediately and ongoing Standard | 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**.**<br><br>Ref: 4.6 |
| | **Response by registered person detailing the actions taken:**<br>Policies are reviewed and revised as needed on an annual basis. The company policies are due to be reviewed week commencing 01.09.2025, reviesed accordngly and signed off by Senior Management. |

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