The Regulation and Quality Improvement Authority

# Inspection Report

**Name of Service:** Care Plus (N.I.) Ltd

**Provider:** Care Plus (N.I.) Ltd

**Date of Inspection:** 2 December 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:** | Care Plus (N.I) Limited |
| **Responsible Individual** | Mrs Jacquline Mary Maguire |
| **Registered Manager:** | Mrs Janette Rolston |
| **Service Profile –**<br>Care Plus (N.I) Ltd is a domiciliary care agency which is based in the Omagh, County Tyrone. Service Users have a range of needs including, dementia, learning disability and frailty relating to old age. The services are commissioned by the Western Health and Social Care Trust (WHSCT). | |

## 2.0 Inspection summary

An unannounced inspection was undertaken on 2 December 2025 between 10.10 am and 4.05 pm by a care Inspector.

The last care inspection of the agency undertaken on 05 December 2024 identified four areas for improvement relating to Adult Safeguarding practice, complaints, record keeping, and quality monitoring reports. This inspection was undertaken to assess the progress with respect to the areas of improvement identified and to evidence how the agency is performing in relation to the regulations and standards. It also sought to determine if it is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that the service was well- led, that care delivery was safe and that effective and compassionate care was delivered to service users.

All areas for improvement identified at the previous inspection were assessed as met by the provider. One new area for improvement was identified during this inspection. This relates to the completion of monthly monitoring reports. This area for improvement is discussed within the 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 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 the 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 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 HSC staff. A review of a sample of records is also undertaken 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 broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

Service users who spoke with the inspector advised that they were very satisfied with the care and support provided by the agency.

Relatives who spoke with the inspector said that they were very happy with the standard of care provided to their loved ones.

Staff who spoke with the inspector felt satisfied with the training and managerial support provided and that the service users receive a good service.

## 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 were reflective of the Department of Health's (DoH) regional policy and clearly outlined the procedure for staff in reporting concerns.

The organisation had an identified Adult Safeguarding Champion (ASC). The agency's annual Adult Safeguarding Position report was reviewed and found to be satisfactory.

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 manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI). The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. An area for improvement identified during the previous inspection related to the management of an adult safeguarding concern that arose within the service. A review of records confirmed that it had been managed appropriately. On this basis the area for improvement was deemed to have been addressed by the provider. The manager advised that no adult safeguarding concerns had been raised since the last inspection.

Staff were required to complete adult safeguarding training during induction and every two years 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 raising concerns in the public interest (Whistleblowing).

The agency's accident/incident policy was examined and did not clearly specify the out of hours arrangements for staff to report any accident/incident arising outside normal working hours and did not have a policy review date noted thereon. The manager acted on this immediately and has since provided an amended and ratified accident/incident policy with these details included.

The agency retained records of all accidents/incidents and a review of these records indicated that they had been managed appropriately. Medication errors arising within the service led to a performance evaluation of the staff member involved and further training and assessment to ensure competency in completing medication tasks was completed. A review of records relating to medication errors noted that not all sections of the performance template were completed and it was recommended that the error type is clearly identified and actions taken in response. The manager welcomed this advice and amended the records and template immediately.

It was positive to note that a tracking system was in place to record all the accidents/incidents arising which was reviewed on a monthly basis. It was recommended that the actions and outcomes relating to each incident are also added as well as highlighting if relatives/ representatives were notified in addition to Trust representatives. This advice was welcomed by the manager and recommended changes have been implemented.

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

## 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 are required to complete Deprivation of Liberty Safeguards (DoLS) training as appropriate to their job roles. The manager confirmed that there were no service users subject to DoLS within the agency.

There was evidence that restrictive practices such as the use of bed rails were applied only under the direction of the multidisciplinary team and that documentation pertaining to such practices were held within care records and subject to regular review. Discussion took place with the manager around ensuring that any restrictive interventions are recorded on a central register to ensure such practices remain subject to multi-disciplinary assessment, that they are proportionate, necessary and regularly reviewed for the safety and well-being of individual service users. This will be reviewed at a future inspection.

## 4.3 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.

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 spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

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, three-day induction programme which also included shadowing of a more experienced staff member.

Staff were provided with training appropriate to the requirements of their role as part of induction to the agency. This included training for staff in the use of specialised equipment for service users who required equipment to assist them with mobility/ transfers. This was refreshed yearly thereafter with all staff attending in- person refresher training which outlined the procedure for staff to follow in the event of deterioration in a service user's ability to weight bear.

A review of training records confirmed that staff had completed training in dysphagia and in relation to responding to choking incidents. All staff had been provided with training in relation to medicines management and were required to complete a competency assessment prior to undertaking this task. One staff member required refresher training in Adult Safeguarding and the manager advised that this was due to long term absence. Assurances were given that this would be arranged with the staff member on their return to work. This will be reviewed at a future inspection.

## 4.4 Care Records and Service User Input

A sample of service users' care records examined confirmed that these contained sufficient information about the level of support required and that moving and handling risk assessments and care plans were up to date. 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.

A number of service users were assessed by Speech and Language Therapist (SALT) with recommendations provided and some required their food and fluids to be of a specific consistency. A review of a sample of care records evidenced that staff were given clear indications where SALT recommendations were in place and this was recorded within the service user's care records. Staff who spoke with the inspector indicated that they were familiar with how food and fluids should be modified and that they implemented the specific recommendations of the SALT to ensure the care received in the setting was safe and effective.

## 4.5 Governance and Managerial Oversight

An area for improvement identified during the last inspection related to review of complaints as part of quality monitoring processes. A review of a sample of the reports of the agency's quality monitoring established that a review of complaints was now included within the monthly monitoring report template. All reports were signed and dated by the manager. This area for improvement was assessed as met by the provider.

The reports completed as part of quality monitoring processes evidenced that there was engagement with service users, relatives and HSC Trust representatives. The agency's staff were not consulted as part of quality monitoring visits. Reports included a review of accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements. An examination of a sample of these reports highlighted the need for further improvement; the manager was advised that additional detail should be included within these reports so as to enable the manager to quality assure care delivery, identify deficits and identify actions to be progressed in the following month.

In addition, person/s completing monthly monitoring reports should use person centred language in keeping with Adult Safeguarding best practice and employ the use of unique identifier references to allow for traceability by the manager when reviewing and/or auditing this information. An area for improvement has been identified.

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

Two areas for improvement identified during the previous inspection related to complaints management and recording. A review of the complaints processes evidenced that there was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. On review of complaints raised within the agency since the last inspection, it was evidenced that these were recorded on a template which were dated and signed. There was also a centralised recording system which outlined any investigations undertaken in response to a complaint. Outcomes were reviewed and signed off by the manager once the complaint had reached a conclusion.

The complaints policy included a flow chart to outline the process for managing complaints as well as other areas for redress should a complaint not be resolved satisfactorily. On this basis both areas for improvement were deemed to have been addressed.

The Annual Quality Report was reviewed and was satisfactory.

There was a system in place that ensures that the service has an operational policy where staff are unable to gain access to a service user's home.

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

## 5.0 Quality Improvement Plan/Areas for Improvement

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

| | Regulations | Standards |
|---|---|---|
| **Total number of Areas for Improvement** | 1 | 0 |

An area for improvement and details of the Quality Improvement Plan were discussed with Mrs Janette Rolston (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 Agencies Regulations (Northern Ireland) 2007** | |
| **Area for improvement 1**<br><br>**Ref:** Regulation 23<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediately and ongoing from the date of inspection | The Registered Person shall ensure that quality monitoring reports are robustly and comprehensively completed in keeping with Regulation; the reports must respond to items outlined in the template and utilise reference unique identifiers for accuracy when recording and reporting. The reports should contain a time bound action plan which must be reviewed at the outset of each new monitoring visit to chart progress and evidence meaningful and timely review by the manager.<br><br>Ref: 4.5 |
| | **Response by registered person detailing the actions taken:**<br>This has been adhered to and new template has been implemented. |

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