The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Care Plus (N.I) Limited

Provider: Care Plus (N.I) Ltd

Date of Inspection: 25 November 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:	Care Plus (N.I) Limited
Responsible Individual/Responsible Person:	Mrs Jacquline Mary Maguire
Registered Manager:	Mrs Janette Rolston
Service Profile – Care Plus (N.I) Ltd is a domiciliary care agency which is based in Castlederg. 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 25 November 2025 between 10 .10 am and 4.15 pm by a care Inspector.

The last care inspection of the agency undertaken on 19 November 2024 identified one area for improvement relating to recruitment practices. This inspection was undertaken to assess the progress with respect to the area 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.

An area for improvement identified at the previous inspection was assessed as met by the provider. Two new areas for improvement were identified during this inspection relating to recruitment practices and quality 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 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 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 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. Comments received included the following statements: "they are all wonderful – I don't know what I would do without them" and "there's not a thing that they could do better for me".

One relative who spoke with the inspector spoke in positive terms about the care workers.

Staff who provided feedback on the agency stated that they were satisfied with the training and support they received and that they felt service users received good care.

Trust representatives stated they were very satisfied with the communication between themselves and the agency and that the carers went above and beyond for service users.

4.0 Inspection findings

4.1 What are the systems in place for identifying and addressing risks?

The provision for the welfare, care and protection of service users was reviewed. The organisation's policy and procedures reflected information contained within the Department of

Health's (DoH) regional policy 'Adult Safeguarding Prevention and Protection in Partnership' July 2015 and outlined the procedure for staff in reporting concerns. The organisation had an identified Adult Safeguarding Champion (ASC). A review of the annual Adult Safeguarding Position report highlighted that it was missing the date in which it was completed. The manager addressed this immediately. The contents of the report were 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 agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. A review of records confirmed that these had been managed appropriately. Safeguarding concerns were recorded on a centralised record. Advice was given to the manager that to aid in identifying any trends / patterns in relation safeguarding concerns, the type of safeguarding concern should be highlighted alongside any follow up actions taken and protection plans that were implemented for the prevention and protection of harm of service users. The manager welcomed this advice and revised the safeguarding recording document.

Staff were required to complete adult safeguarding training during induction and every two years thereafter. A review of the training records confirmed compliance with all staff training requirements. 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 day care setting's policy and procedure with regard to raising concerns in the public interest (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).

The agency's accident/incident policy was reviewed and amended at the Inspector's request to ensure it provides staff with clear guidance on how to report concerns outside normal working hours and to stipulate the policy review date.

The agency retained records of all accidents/incidents and a review of these records indicated that they had been managed appropriately. 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 were notified in addition to Trust representatives. This will be reviewed at a future inspection.

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

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

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 one service user was subject to DoLS and this was recorded on a register which is reviewed regularly to ensure that the correct documentation is place. On examining the care records of a service user where DoLS were in place it was identified that an update from the Trust representative was required in respect of an extension which had lapsed in recent months. The manager evidenced that that this had been requested from Trust representatives and gave assurances of continued efforts to ensure that all documentation pertaining to the DoLS remains up to date. This will be reviewed at a future inspection.

There was a policy in place for the use of restrictive interventions however the manager advised that there were no other restrictive practices in place for any of the service users within the service.

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.

An area for improvement identified during the previous inspection related to recruitment practices where it was identified that robust checks had not been undertaken in relation to one employee's work history. On review of this staff member's recruitment records, it was evidenced that staff had reviewed and documented the employee's work history as appropriate. On this basis the area for improvement was deemed to have been addressed by the provider.

Examination of the agency's most recently employed care staff during this inspection confirmed that criminal record checks (AccessNI), were completed and verified before staff members commenced employment and had direct engagement with service users. On review of other pre-employment checks such as gaps in employment and reasons for leaving caring roles, it was identified that the reasons for the dismissal of one employee from a previous caring role were not investigated thoroughly to provide assurances that there were no concerns about the character or integrity of the employee. This oversight was addressed immediately and it was confirmed that there were no concerns in regards to the employee's character or conduct within their previous role. The need to ensure that employees are of integrity and good character as part of robust pre-employment checks is outlined in the regulations and standards. An area for improvement has been identified.

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 was evidence that all newly appointed staff had completed a structured orientation and induction which incorporated NISCC's Induction Standards for new workers in social care; this helps to ensure staff are 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 which also included 'shadowing' of a more experienced staff member. Written records were retained by the agency of all training, including induction and professional development activities undertaken.

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 for training in- person. 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. A review of the policy relating to medicines management identified that it included direction for staff in relation to administering liquid medicines. It was positive to note that a demonstration of this task was also provided to staff alongside any shared learning to ensure that any changes in procedure are embedded into practice.

A review of the training records identified that two staff were outstanding DoLS training. The manager confirmed after the inspection that both staff have since completed this training in line with the regulations and standards and MCA legislative requirements.

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. 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 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.

4.5 Governance and Managerial Oversight

The agency maintained a monthly monitoring system for evaluating the quality of the services provided. On examination of a sample of the reports of the agency's quality monitoring it was established that there was engagement with service users, relatives and HSC Trust representatives. However, review 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 actions to be progressed in the following month. This includes reference to the previous quality improvement plan arising from the most recent inspection and any progress made.

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.

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 raised under the complaints process since the last inspection evidenced that these were appropriately managed however some sections of the complaints template were not fully completed. This was addressed by the manager immediately. Advice was also given to the manager around the need to review service user/ relative's feedback from quality monitoring calls to ensure that any issues raised are clarified and addressed as appropriate in line with the agency's complaints policy and quality monitoring processes. This will be reviewed at a future inspection. 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. This highlights a clear protocol that directs staff from the agency 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	2	0

Areas 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

Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007

Area for improvement 1 **Ref:** Regulation 13 (a) **Stated:** First time **To be completed by:** Immediately and ongoing from the date of inspection	The Registered Person shall ensure that no domiciliary care worker is supplied by the agency unless he is of integrity and good character. This relates to the need for robust recruitment checks and evidence of same to ensure the integrity and good character of any care staff prior to commencing work with service users Ref:4.3
	Response by registered person detailing the actions taken: This has been adhered to and all staff members who under take interviews have been made aware of the importance of robust recruitment check.
Area for improvement 2 **Ref:** Regulation 23 (1)(2)(3)(4)(5) **Stated:** First time **To be completed by:** Immediately and ongoing from the date of inspection	The Registered Person shall ensure that monthly quality monitoring reports are robustly and comprehensively completed in keeping with Regulation; the reports must ensure they respond precisely to items outlined in the template and utilise reference unique identifiers for accuracy when recording and reporting. The reports should contain an 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. Ref: 4.5
	Response by registered person detailing the actions taken: This has been adhered to and new template has been implemented.

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