The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Lydian Care Ltd

Provider: Lydian Care Ltd

Date of Inspection: 28 October 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:	Lydian Care Ltd
Responsible Individual/Responsible Person:	Mr Pierre Gerard Burns
Registered Manager:	Mrs Fiona Theresa Kane
Service Profile – Lydian Care Ltd is a domiciliary care agency located in Newcastle. The agency provides domiciliary care and support to service users in their own homes. The agency currently supplies staff to service users who have care commissioned by the South Eastern and Belfast Health and Social Care Trust (SEHSCT) and Belfast Health and Social Care Trust. (BHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 28 October 2025, from 9.30 am and 4.00 pm by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; and to determine if the agency delivering safe, effective and compassionate care and if the service is well led.

The inspection found that safe, effective and compassionate care was delivered to service users and that the agency was well led.

An area for improvement was identified in relation to care records.

Good practice was identified in relation to training compliance; incident management; staff recruitment processes; and the agency's Service Users' Newsletter, which included falls prevention information. Details are contained in the main body of this report.

Lydian Care Ltd uses the term 'people who we support' to describe the people to whom they provide care and support. For the purposes of the inspection report, the term 'service user' is used, in keeping with the relevant regulations.

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 registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning trusts.

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

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 review/examine a sample of records to evidence how the agency is performing in relation to the regulations and standards.

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.

Trust representatives stated they were generally satisfied with the communication between themselves and the agency. They noted the agency had responded positively to requests in relation to urgent communication processes. They also confirmed the agency completed regular reviews of service users' needs. Service users indicated they were very satisfied with the care they received.

Service users and their representatives spoke in positive terms about the care workers. They stated communication was good and the staff responded to requests made in relation to care delivery. It was evident from speaking with the service users' representatives that they were aware of the complaints procedure. Feedback received was discussed with the manager and assurances were provided in relation to the actions taken to resolve the issues raised.

3.3 Inspection findings

3.3.1 Governance and Managerial Oversight

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

There were monitoring arrangements in place in compliance with 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, and staff and HSC Trust representatives. The reports included details of a review of a sample of service user' care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

There were processes in place to review the quality of the service on an annual basis. The Annual Quality Report was reviewed and was satisfactory.

There was a system in place to ensure that complaints and incidents are managed in accordance with the agency's policy and procedure. Staff demonstrated a good awareness of both the complaints procedure and whistleblowing policy. There was evidence of a system to ensure oversight of complaints and incidents; this included a review of complaints and incidents during the monthly quality monitoring visits. The manager was advised to consider further strengthening of the oversight process by maintaining complaints and incident logs, which contained brief details of the complaint/incident, timeline and outcome.

There was a selection of policies available to direct staff in care delivery and support planning based on individual risk assessments. Staff confirmed they had access to policies.

The service has an operational policy, procedure or protocol that clearly directs staff from the agency as to what actions they should take if they are unable to gain access to a service user's home. This policy includes information on how to manage and report such situations in a timely manner.

There was evidence of monthly team meetings following which information was cascaded to staff unable to attend. The manager confirmed staff were provided with updates on policies and additional training requirements. Staff stated they could add to the meeting agenda if there were items they wished to discuss.

3.3.2 Staffing Arrangements (recruitment and selection, induction and training)

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. There was evidence of robust systems in place to manage staffing.

There were good systems in place to manage staffing. Consultation with service users and their representatives established there were no concerns regarding service users receiving their calls in keeping with the care plan.

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 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.

The interview process was reviewed and written records were retained by the agency of the person's capability and competency in relation to their job role. Interview records were detailed and contained a scoring system. The agency maintains records which evidence they seek the applicant's full employment history and explores gaps in employment.

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to the Northern Ireland Social Care Council's (NISCC) 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. Written records were retained by the agency of the person's capability and competency in relation to their job role.

Review of training records identified that staff were provided with training appropriate to the requirements of their role. Where service users required the use of specialised equipment to assist them with moving, this was included within the agency's mandatory training programme.

3.3.3 Care Delivery and Care Records

Service users' needs were assessed when they 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 and included any advice or recommendations made by other healthcare professionals.

Care records were generally person centred and regularly reviewed. A review of a sample of care records evidenced that service users, where possible, were involved in planning their own care and efforts had been made to ascertain service users' preferences and choices around how their support was provided. Staff recorded regular evaluations about the care and support provided. On occasion staff were noted to use abbreviations and a small number of records did not accurately reflect the service users' current care needs. The service user and/or their representatives as appropriate had not signed a number of records; it was therefore difficult to determine if they had been in agreement with the care plan. The manager provided assurances they would strengthen the agencies care record audits to ensure all the relevant information was recorded; up-to-date and available in the service users care records. An area for improvement has been identified in relation to care records.

Staff recorded regular evaluations about the care and support provided. Service users and/or their representatives had access to their care records.

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.

Care reviews had been undertaken in keeping with the agency's policies and procedures. There was also evidence of regular contact with service users and their representatives, in line with the commissioning trust's requirements.

It was good to note the agency produced a newsletter for service users, which contained general information relating to the agency and health promotion information.

There was a system in place for identifying any missed calls; 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.

3.3.4 Safeguarding

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.

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 whistleblowing.

Service users said they had no concerns regarding their safety; they described how they could speak to staff if they had any concerns about safety or the care being provided. The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any 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.

RQIA had been notified appropriately of any incidents that had been reported to the Police Service of Northern Ireland (PSNI) in keeping with the regulations. Incidents had been managed appropriately.

3.3.5 Deprivation of Liberty Safeguards (DoLs)

The Mental Capacity Act (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 who spoke with the Inspector demonstrated their understanding that service users who lack capacity to make decisions about aspects of their care and treatment have rights as outlined in the MCA.

Staff had completed appropriate DoLS training appropriate to their job roles. The manager reported that a number of the service users were subject to DoLS, and the agency maintained a register. Where a service user was experiencing a deprivation of liberty, the care records did not contain full details of assessments completed and agreed outcomes developed by the HSC Trust representative. Following the inspection the manager confirmed they had received all the relevant forms from the Trust and provided assurances that a review of the DoLS register and relevant information would be completed monthly.

A number of restrictive practices were employed. The agency maintained a restrictive practices register; this supported robust governance and oversight of restrictive practices.

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	0	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Fiona Kane, 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 Minimum Standards. Version 1.1: August 2021

Area for improvement 1 **Ref:** Standard 10.4 **Stated:** First time **To be completed by:** Immediate from the date of inspection	The Registered Person shall ensure there are robust governance and oversight systems in place to review care records. The care records must be accurate, up-to-date, contain all the necessary assessments and plans in relation to the care delivered. They must also contain evidence that the service user and/or their representative have been involved with the care planning. Ref: 3.3.3
	Response by registered person detailing the actions taken: We have taken immediate steps post inspection to ensure that service user/representative agreement and involvement with care planning is clearly shown and recorded clearly. We have reaffirmed the audit process to the Quality team, Administrative team and Management team. To ensure care records are audited and reviewed on a weekly basis and we have taken steps to ensure that all required assessments and plans specific to each service user is requested according to the specific requirements and needs of each.We have reaffirmed with our teams our ongoing monthly audits of service user files within each geographical area, escalating and prioritising next steps and actions to management and HSC as needed.

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

The Regulation and Quality Improvement Authority

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