The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Dumbarton House**

Provider: **Threshold (Richmond Fellowship NI Ltd)**

Date of Inspection: **11 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:	Dumbarton House Threshold
Responsible Individual/Responsible Person:	Mrs Fiona McCabe
Registered Manager:	Mr Stewart Lecky
Service Profile – Dumbarton House, located in Belfast and is a supported living type domiciliary care agency provided by Threshold. The agency's aim is to provide care and support to meet the individual assessed needs of up to 12 people who experience enduring mental ill-health issues. Under the direction of the manager, staff are available to provide care and support to service users 24 hours a day with tasks of everyday living, emotional support and assistance to access community services, with the overall goal of promoting health and maximising quality of life.	

2.0 Inspection summary

An unannounced inspection took place on 11 November 2025 between 10.30 am and 5.25 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 assess progress with the area for improvement identified, by RQIA, during the last care inspection on 6 January 2025; and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that care delivery was safe, compassionate and that effective care was delivered to service users. However, improvements were required to ensure the effectiveness and oversight of certain aspects of the agency, such as recruitment practices, staff training and accident/incident recording. This is discussed in more detail in sections 4.1 and 4.2.

As a result of this inspection an area of improvement identified in the previous inspection relating to the adult safeguarding policy was assessed as having been addressed by the provider. This is discussed in more detail in sections 4.2. Full details, including 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 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.

To prepare for this inspection we reviewed information held by RQIA about this agency. This included the previous area 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 those being supported by and working for the agency; and examine a sample of records to evidence how the service 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 active listening, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

We spoke with service users, relatives and staff to seek their views of living, visiting and working within Dumbarton House.

Service users who spoke with the inspector had mixed views about their experience of living within Dumbarton House. One comment made to the inspector included the following statement: "I am happy here". Another service user advised that it could be noisy at times and that they were dissatisfied with the complaints process. This was discussed with the manager who evidenced the efforts to try to resolve issues raised and agreed to ensure all information regarding the complaints process and other avenues for redress and support is made clear to service users. Further discussion on the complaints procedure and process is outlined in section 4.5.

Service users who completed the electronic survey reported mixed views about the care and support provided in Dumbarton House. One response indicated dissatisfaction with staff approach towards residents; another stated that there were fewer activities available. These comments were relayed to the manager to action as necessary. This is discussed in more detail in section 4.4. The remaining responses indicated service users were satisfied or very satisfied with the care and support provided by staff in Dumbarton house.

Relatives who provided feedback on Dumbarton House indicated that they were satisfied with the care and support provided to their loved ones.

Staff who spoke with the inspector spoke positively about the approachability and support of management and said that they felt the service was well- led. Staff said the care provided to service users was safe, effective and compassionate and that there was good training opportunities and good teamwork among staff.

A professional who provided feedback on the service made the following comments: "Dumbarton House is a well-run supported living environment with a staff team who consistently demonstrate professionalism, courtesy and a strong knowledge base. I have found the manager and senior support staff to be thoughtful, compassionate and genuinely invested in the well-being of individuals they support".

4.0 Inspection findings

4.1 Staff Recruitment, Induction and Training Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction and completion of regular staff training to ensure the agency safely and continually meets the needs of service users.

A review of a sample of the agency's staff recruitment records confirmed that criminal record checks (AccessNI) were completed and verified before staff members commenced employment and had direct engagement with service users. There was limited detail readily available regarding the most recently recruited employees to evidence that robust checks had been undertaken by the manager before employees commenced direct work with service users. The manager advised that they did not have direct access to recruitment records at the time of the inspection as these were kept by another department.

On review of the information provided after the inspection regarding the most recently recruited staff, it was confirmed that full employment histories, gaps in employment and reasons for leaving care positions had not been obtained prior to their employment in the agency. To ensure compliance with regulations a full employment history of all potential employees must be obtained prior to commencing work with service users. 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), the Nursing and Midwifery Council (NMC) or any other relevant regulatory body; 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.

A review of a sample of the most recently appointed staff, evidenced that staff had completed a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care. There was a robust, structured, induction programme which included shadowing of a more experienced staff member. This was reviewed periodically and signed off by the manager to ensure the competence of staff in carrying out the duties of their job in line with the agency's policies and procedures.

Staff spoke positively about the training they receive and confirmed that they received sufficient training and support from the manager to enable them to fulfil the duties and responsibilities of their role. The agency maintained an electronic record of all staff training; however, a review of this record indicated that refresher training was required for some staff in mandatory areas such as, Adult Safeguarding Champion Training, Fire Safety, Manual Handling, Infection Protection and Control (IPC) and Medicines Management. It was also noted that training did not cover dysphagia and this was not included within the training matrix. An area for improvement has been identified.

All staff were provided with training in relation to medicines management. Competency assessments were undertaken with staff to ensure that they were proficient in the administration of medications and these were refreshed annually. A review of medication errors which occurred since the last inspection, evidenced that these had been actioned appropriately.

4.2 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 had an identified Adult Safeguarding Champion (ASC). The Adult Safeguarding policy also reflected and referenced the Department of Health's (DoH) regional policy. An area for improvement identified during the previous inspection related to information contained within the Adult Safeguarding Policy. On review of the organisation's current Adult Safeguarding policy and procedures, it was evident that recommendations identified as part of the Quality Improvement Plan had been implemented and on this basis the area for improvement was assessed as met by the provider.

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.

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.

The agency's governance arrangements for the management of accidents/incidents was examined and confirmed that there was an incident/accident reporting policy and system in place. 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. A review of accidents/ incidents that occurred since the last inspection confirmed that these had been managed appropriately.

It was positive to note that the manager was in the process of developing an electronic matrix to record incidents/ accidents and Adult Safeguarding concerns. Due to this system not being fully developed, it was not possible to ascertain at ease, the number of incidents since the last inspection. Medication incidents which occurred since the last inspection were recorded and stored in hard copy in a separate file. As these were not stored in date order, it was difficult to establish how many medication incidents had occurred and if there were any trends arising. It

was evident that the ability to review and track incidents and accidents was impacted by the differing methods of recording. An area for improvement has been identified.

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

RQIA reviewed a Serious Adverse Incident (SAI) report completed by the Belfast HSC Trust since the previous inspection. RQIA is satisfied that measures have been implemented to reduce the risk of recurrence and that any recommendations are embedded into practice.

4.3 Mental Capacity Act / Deprivation of Liberty Safeguards (DoLS) and Restrictive Practice

The Mental Capacity Act (Northern Ireland) 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 were required to complete Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The manager reported that none of the service users were subject to DoLS. There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had had their capacity considered and, where appropriate, assessed. The registered manager confirmed that no service users are subjected to restrictive practices within the service.

There was a policy in place for the use of restrictive interventions and any restrictive interventions applied such as locked safes for medication were applied with the express consent of the service users, reviewed regularly alongside the support plan and included multidisciplinary input for the safety and well-being of the individual.

4.4 Management of Care Records and Care delivery

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 person centred, regularly reviewed and updated to ensure they continued to meet the service users' needs. The service users' care plans contained details about their likes and dislikes and the level of support they may require. The details of care plans were shared and signed by service users and/or their representatives as appropriate.

There was a daily handover at the beginning of each shift and staff recorded regular evaluations about the care and support provided. This included information about any changes to the service users' care needs so that staff could assist them as needed accordingly.

It was good to note that the agency had service user meetings on a regular basis which enabled the service users to discuss the provisions of their care and to make suggestions regarding any activities they would like to avail of. Some matters discussed included: exercise activities, film night, room support, grocery arrangements, menu preparations, seasonal activities and games. Comments noted within the service user survey indicated that there had been a reduction in activities provision. This was discussed with the manager who advised that service users are encouraged to participate in activities that are available in the local community as part of social inclusion ethos. It was felt that the reduction in activities engagement was due to individual choice however, it was agreed that all service users would continue to be updated of any activities or events arising and staff would encourage and support service users to engage in any events of their interest.

The manager reported that none of the service users currently required the use of specialised equipment. They were aware of how to source such training should it be required in the future. Care records identified that moving and handling risk assessments and care plans were up to date.

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.

4.5 Managerial Oversight and Governance

There has been no change in the management of the service since the last inspection. Staff commented positively about the manager and described them as supportive, approachable and able to provide guidance. There were procedures in place for staff supervisions to take place on a monthly basis and to appraise staff performance annually.

The agency was visited each month by a representative of the registered provider to consult with service users, their relatives and staff and to examine all areas of the running of the service in compliance with Regulations and Standards. The reports included details of a review of service user care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

The Annual Quality Report was reviewed and was satisfactory.

There was a range of policies available to direct staff in care delivery and support planning based on individual risk assessments.

An application has been submitted to RQIA for registration of a new Responsible Person; this is currently under review. The agency's registration certificate is pending and will be updated in due course.

The current certificates of public and employers' liability insurance were viewed and were 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 the complaints policy, complaints leaflet for service users and Service User Guide identified that these documents required amendments to reflect the correct address for RQIA and to ensure that other avenues for redress when service users

feel dissatisfied with the response by the agency are clearly set out. The manager has since shared the revised complaints policy and procedure which was satisfactory and could be made available in other suitable formats.

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	2

The areas for improvement and details of the Quality Improvement Plan were discussed with Mr Stewart Lecky, 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 (d) **Stated:** First time **To be completed by:** Immediately from the date of inspection and ongoing	The Registered Person shall ensure that no domiciliary care worker is supplied by the agency unless full and satisfactory information is made available in respect of matters set out in Schedule 3. This relates to the need to ensure that a full work history is provided of potential employees from the age of 18, any gaps in employment are explored and any reasons for leaving care positioned are provided as part of the pre-employment checks process. Ref: 4.1
	Response by registered person detailing the actions taken: The current system of recruitment in Threshold Services NI ensures that all work histories, gaps in employment and reasons for leaving care roles are detailed. The organisation is also ensuring that all records are available to managers and available for inspection rather than having any items being held by another department.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards 2021	
Area for improvement 1 **Ref:** Standard 12.4 **Stated:** First time **To be completed by:** Immediately from the date of inspection and ongoing.	The Registered Person shall ensure that the training needs of individual staff for their roles and responsibilities are identified and arrangements are in place to meet them. This includes the need to ensure the training matrix is kept up to date and reviewed regularly. **Ref: Section 4.1**
	Response by registered person detailing the actions taken: Dysphagia and Food Essentials training is now available for all staff and the second half of this staff team will complete it by 04.02.26. The Training Matrix is updated and reviewed on a monthly basis as a minimum and compliance with Mandatory trainings compiamnce is above our organizational target of 90%.

Area for improvement 2 **Ref:** Standard 10 **Stated:** First time **To be completed by:** Immediately and ongoing	The Registered Person shall ensure that there are clear and documented systems are in place for the management of records in accordance with legislative requirements. This relates to the need to ensure that there is a consistent approach to incident/ accident recording and reporting to include Adult Safeguarding concerns and medication errors. **Ref: 4.2**
	Response by registered person detailing the actions taken: The organisation moved to digitised recording systems, with Dumbarton migrating to SharePoint in June 2025. These systems are fully in place for Safeguarding and Incident recording, including medication errors. Dated records of all Incidents were available on the day of inspection digitally (with a parallel paper-based system just being archived). The service ensures that digital documents are completed in a timely manner following incidents of any nature. At inpsection, an incident tracking spreadsheet was also in place detailing every incident from August 2025. This will be fully backed to Jan 2025 within 7 days and a new Excel book added for Accidents.

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