The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: L&B Care Services

Provider: Bettys Care 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:	Bettys Care Ltd
Responsible Individual/Responsible Person:	Mrs Mary Elizabeth 'Betty' Fitzpatrick
Registered Manager:	Miss Melissa Fitzpatrick
Service Profile – L & B Care Service is a domiciliary care agency based in Bessbrook, Co. Down which provides a range of personal care and social support to 43 adults 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 Southern Health and Social Care Trust (SHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 25 November 2025, between 9.45 am and 2.40 pm by 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, compassionate care was delivered to service users.

Four areas for improvement were identified in relation to policies and procedures; recruitment; induction records; and supervision and appraisals.

Good practice was identified in relation to service user feedback and person centred care records.

L&B Care Services uses the term clients 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 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.

Service users spoke in positive terms about the care workers. They stated communication was good and the staff responded positively to requests made in relation to care delivery. They commented that staff were well trained, courteous and treated them with dignity and respect.

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.

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. Whilst these reports provided evidence of engagement with Trust representatives, they did not include their views on the quality of service provided. The manager had completed some of the monitoring reports; this is not in accordance with the

legislation. The manager was informed that a suitably experienced person who is not involved with the day-to-day operation of the service must complete these reports. They agreed to action these matters moving forward and compliance will be assessed at the next inspection.

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 an incident log, containing brief details of the 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 Complaints policy required updating to include the contact details of the Trust's complaints department and the Northern Ireland Public Sector Ombudsman (NIPSO).

The service has an operational policy, procedure or protocol that 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 requires updating to ensure it is specific to the agency and contains information on what to do if an emergency is suspected or evident. A number of policies required updating to ensure they are relevant to the agency's organisational structure and operations and reflect regional guidance. The Untoward Incident Policy did not relate to the agency's organisational structure, systems and processes. In addition, the Whistleblowing Policy did not reflect current regional guidance. An area for improvement has been identified.

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 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 pre-employment checks, including criminal record checks (AccessNI), were completed and verified before staff members commenced employment and had direct engagement with service users. Concerns were noted in relation to employment history, some gaps in employment had not been explored and references were received by text messages and/or from individuals who did not have direct management responsibility for the applicant. An area for improvement has been identified.

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.

The interview process was reviewed and written records were not consistently retained by the agency of the person's/nurses' capability and competency in relation to their job role. Interview records were detailed but did not contain a scoring system. The manager was advised to keep written records of all interviews and may wish to consider using a scoring system to support the interview outcome. This will be reviewed at the next inspection.

There was a process in place to ensure that newly appointed staff completed a structured orientation and induction, to ensure they were competent to carry out the duties of their job; however, completed induction records were not consistently retained. Therefore, we were not assured that the induction had been provided in keeping with the agency's policies and procedures. An area for improvement has been identified.

Training records were not readily available during the inspection. These records were shared with the inspector following the inspection. The 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.

Supervision is an important part in staff development. Records of regular supervisions and appraisals were not available during the inspection. An area for improvement has been identified.

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. Staff stated that service users 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. 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.

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.

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.

It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm.

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 no service users were subject to DoLS.

A number of restrictive practices were employed. The agency did maintained a restrictive practices register. The manager was advised to consider maintaining a register of restrictive practices as this would supported robust governance and oversight.

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	1	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Melissa Fitzpatrick, 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 **Stated:** First time **To be completed by:** Immediate from the date of inspection	The Registered Person shall ensure that no domiciliary care worker is supplied by the agency unless: (d) full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 3. This refers to ensuring all employments are evident, gaps explored and references are obtained from appropriate individuals, in a format that allows verification prior to any offer of employment. Ref: 3.3.2
	Response by registered person detailing the actions taken: our recruitment program will be updated to include on the application form gaps in employment. If the applicant does not give a reason for the gap in employment on the application form, then this will be discussed during the interview process and recorded in the interview notes. All recruitment records including induction process and interview notes will be securely stored and audited as part of our monthly monitoring.p

Action required to ensure compliance with the Domiciliary Care Agencies Minimum Standards. Version 1.1: August 2021	
Area for improvement 1 **Ref:** Standard 9 **Stated:** First time **To be completed by:** Immediate from date of inspection	The Registered Person shall ensure there are policies and procedures in place that direct the quality of care and services. This relates to ensuring all policies are relevant to the agency's organisational structure and processes and reflect regional guidance. Ref: 3.3.1
	Response by registered person detailing the actions taken: complaints policy has been updated to add the new address for complaints procedure. Whistleblowing policy has been updated to reflect the latest guidelines. Policies will be updated every three years to reflect legislation or sooner if required t
Area for improvement 2 **Ref:** Standard 12.7 **Stated:** First time **To be completed by:** Immediate from the date of inspection	The Registered Person shall ensure a record is maintained for each member of staff induction. These records should include the content of the programme and dates these activities were undertaken. Ref: 3.3.2
	Response by registered person detailing the actions taken: our induction process will be signed off by the new employee and the staff member. Will continue to take place over three days. All records will be securely stored and audited as part of our meeting nthly monitoring.
Area for improvement 2 **Ref:** Standard 13 **Stated:** First time **To be completed by:** Immediate from the date of inspection	The Registered Person shall ensure staff have received supervisions and performance appraisal in accordance with the agency's procedures. A record of these meetings should be maintained for each staff member. Ref: 3.3.2
	Response by registered person detailing the actions taken: our staff appraisals will take place annually. Our staff supervisions will take place every three months. These records will be securely stored and will be audited as part of our monthly monitoring. Our policy on appraisals will be updated this year.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews