

Inspection Report

Name of Service: Potens Domiciliary Care

Provider: Potensial Limited

Date of Inspection: 6 May 2026

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:	Potensial Limited
Responsible Person:	Miss Nicki Stadames
Registered Manager:	Mr Mike Barton
Service Profile: Potens Domiciliary Care Agency provides care and support to service users who have a learning difficulty. Service users are living in their own homes or with their families in County Fermanagh and Derry/Londonderry localities.	

2.0 Inspection summary

An unannounced inspection took place on 6 May 2026 between 11.00 am and 5.00 pm by a care Inspector.

The last care inspection of the service undertaken on 2nd May 2025 identified no areas for improvement. This inspection was undertaken by a care inspector to evidence how the service is performing in relation to the regulations and standards; and to determine if the service is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that care delivery was safe and that effective and compassionate care was delivered to service users. However, improvements were required to ensure the effectiveness and oversight of certain aspects of the agency. One area for improvement was identified during this inspection relating to monthly monitoring reports.

Staff were observed to be respectful and promoted the dignity and well-being of service users. Staff spoken with were knowledgeable and well trained to deliver safe and effective care.

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 service 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 any 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 will seek the views of those living, working and visiting the service; and review/examine a sample of records 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

We spoke to a range of service users, relatives and staff to seek their views of living within, visiting and working in Potens.

The information provided by service users, relatives and staff whom we spoke with indicated that the care and support provided by Potens was of a good standard. One service user told the inspector that the staff treated them well but they felt dissatisfied with how the rotas were arranged. These comments were relayed to the manager to action as appropriate.

One relative of a service user described Potens as “a really brilliant service”.

Staff spoke positively in regard to the care delivery. One staff member commented that “staff know 100% what they are doing and are all very client focused and go out of their way for the service users”. Training was described as “excellent” and another staff member said they felt well supported in their role by management.

Several staff members responded to the electronic survey. The majority of respondents indicated that they were ‘very satisfied’ or ‘satisfied’ that the care provided was safe, effective and compassionate and that the service was well led. One staff member’s response had indicated ‘very dissatisfied’ in their response to all of the questions however no further information or comments were given to explain reasons for these views. This was discussed with the manager to review and action as necessary.

A visiting professional also responded to the electronic survey. Comments expressed concerns in respect of the choice and range of activities offered during the day to service users. Improvements were recommended around staff’s communication and how they can best motivate service users. These comments were discussed with the manager who agreed to review and action as appropriate. Further details on this can be found in section 3.3.2.

3.3 Inspection findings

3.3.1 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).

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 during 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 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 governance arrangements for the management of accidents/incidents were reviewed and confirmed that an effective incident/accident reporting policy and system was in place. Any incidents and accidents that occurred were recorded on a centralised electronic record, which is then reviewed and audited monthly by senior management. A review of a sample of accident/incident records evidenced that these were managed appropriately.

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

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 no evidence of any dissatisfaction in relation to the staffing levels. Staff said that there had been a reduction in the use of agency staff and a relative advised that the use of agency staff had reduced.

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 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. Staff spoke positively about the induction process describing it as very detailed and thorough with good managerial support provided throughout.

Staff were provided with training appropriate to the requirements of their role. A review of training records evidenced that these are held digitally on the organisation's learning management system and that all staff were up to date with all mandatory training requirements.

All staff had been provided with training in relation to medicines management and all staff were required to complete a competency assessment requiring sign-off by the manager before staff are deemed competent to assist with this task.

Procedures were in place for appraising staff performance and all staff received regular supervision.

3.3.2 Care Delivery

There was a daily handover at the beginning of each shift, which included information about any changes to the service users' care needs to enable staff to safely assist them in their roles. The daily handover was also used to assist staff in relation to planned appointments/activities for the day.

Both service users' and relatives who spoke with the inspector advised that they were satisfied with the care and support provided by staff within the agency.

Service users' social needs were met through attendance at a local day centre, a community farm and also through one-to-one activities with staff which included shopping, going for coffee and attending hair dressing appointments. Staff and a service user who spoke with the inspector indicated that recent changes in rota scheduling had made planning for activities in advance more difficult and could impact on time spent with service users. This was discussed with the manager who explained the reasons for changing how rotas were drawn up. Assurances were provided that this has since been reviewed for future rota plans to allow sufficient time to arrange service user's activities.

A comment reported in the service feedback survey by a visiting professional suggested that there was not enough choice of activities for service users and that some staff had expressed they had not enough time. Improvements were recommended in relation to this in respect of staff's communication with service users and ways to motivate to reduce feelings of boredom and frustration. The manager agreed to review the feedback and link with the relevant professional staff to ensure that the activities available for each of the service users are in keeping with the service user's care plans and their expressed choices. It was further advised that staff be provided with the opportunity to complete training around effective communication. RQIA will keep this under review.

3.3.3 Management of 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 held both in hard copy in the service user's homes and within the service user's electronic healthcare record. The manager was not able to access the electronic care records on the day of the inspection due a technical issue. A review of a sample of hard copy records only was completed. It was evident that these included updated care and support plans for each of the service user's identified care needs and risk assessments. The service users' care plans contained details about the level of support they may require. Staff confirmed that they held their own logins to the electronic records system which provided access to care needs assessments and that they completed daily records/regular evaluations about the care and support provided. The manager has since confirmed that access to records has been fully restored. This will be reviewed at a future inspection.

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.

3.3.4 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.

There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had their capacity considered and, where appropriate, assessed. The manager advised that there was one service user who was experiencing a deprivation of liberty and the manager advised that this was due for review.

Where there was where there were restrictive practices applied, these were recorded in a restrictive practice register and subject to regular review alongside the associated care and support plan.

3.3.5 Quality of Management Systems

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. A review of a sample of these reports found that these did not include sufficient evidence of consultation with service user representatives and there was no actions to carry forward with respect to driving improvement in the quality and delivery of the service. It was

suggested that a review of service user records and staff NISCC registrations as part of quality assurance checks would further enhance the assessment of quality of services. An area for improvement was identified.

There was a process in place to manage any complaints. The manager advised that none had been received since the last care inspection.

The annual quality report was reviewed and noted to include stakeholder feedback.

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

Acting management arrangements have been in place since 8 August 2025 and plans for a newly recruited manager to apply for registration were discussed with the Inspector. RQIA will keep this under review.

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	1	0

The area for improvement and details of the Quality Improvement Plan were discussed with the manager Mike Barton, 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 23 (1)(2)(3)(4)(5) Stated: First time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure that quality monitoring reports are robustly and comprehensively completed in keeping with Regulation; the reports must contain a time bound action plan; and must evidence meaningful consultation with service users and representatives. Ref: 3.3.5 Response by registered person detailing the actions taken: Through the quality audit process, a variety of audits are completed on a weekly and monthly basis to ensure quality, compliance and governance of the service. These audits include feedback from supported individuals and staff and an action plan for any improvements required. We also complete QCC returns for WHSCT on a quarterly basis which includes feedback from families and professionals as well as complaints and compliments. Action plans have been undertaken but it is recognised they were not held with the Reg 23 Report. All future monthly Regulation 23 Report will provide a comprehensive review of the quality of care and service delivery, including clear time-bound actions and evidence of consultation with service users, relatives and relevant professionals. Feedback will be sought, recorded and used to inform continuous improvement and evidenced in the Reg 23 Report.

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