

Inspection Report

Name of Service:	Domiciliary Care Services (North Down & Ards)
Provider:	South Eastern Health and Social Care Trust
Date of Inspection:	16 June 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:	South Eastern Health and Social Care Trust (SEHSCT)
Responsible Individual/Responsible Person:	Ms Roisin Coulter
Registered Manager:	Mrs Nicola Donnelly
Service Profile: Domiciliary Care Services (North Down & Ards) is a domiciliary care agency located in the Ards and North Down area. The agency's aim is to provide care to meet the individual assessed needs of people living in their own homes. The services are commissioned by the South Eastern Health and Social Care (HSC) Trust.	

2.0 Inspection summary

An unannounced inspection was undertaken 16 June 2026, between 10.10 am and 5.05 pm by a care Inspector.

The last care inspection of the agency was undertaken on 24 June 2025 by a care Inspector. No areas for improvement were identified. This inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; 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 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, such as recruitment and selection processes, service users' care plans, training and quality monitoring reports.

Feedback from service user representatives with regard to their experience of Domiciliary Care Services (North Down & Ards) was mixed. This was discussed with the registered manager to address where appropriate. Refer to Section 3.2 for more details.

Following the inspection, RQIA invited the Responsible Individual and the Registered Manager to a meeting on 8 July 2026. The purpose of the meeting was to provide feedback on the inspection findings and to discuss how identified deficits were to be addressed.

During this meeting representatives of the Responsible Individual provided details of the actions taken or those they planned to take to address the matters raised.

RQIA was assured that there were measures in place to address any identified issues in a robust and timely manner.

Full details, including areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

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 Domiciliary Care Services (North Down & Ards) 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 a range of information held by RQIA about this agency was reviewed. 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 seek the views of the service users who are in receipt of care and support; service user representatives; the staff who work for the agency; and review a sample of records to evidence how the agency is performing in relation to the regulations and standards.

Information was provided to service users, their representatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included questionnaires, an electronic survey, and contact details of the Inspector.

3.2 What people told us about the service

Through active listening, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

Feedback from service user representatives varied in terms of their experience of Domiciliary Care Services (North Down & Ards). One service user representative named a specific member of the management team for whom they found to be "receptive" and "responsive" to any issues brought to their attention. They also told us that "there are some [staff] that are very, very good at their job, who go over and above" and in describing the practice of one staff member described them as "exceptional", "very thoughtful, considerate and caring". Another service user representative told us that whilst within the home staff were at all times respectful.

Whilst positive feedback was received, some issues were raised regarding aspects of care delivery and communication. Two service user representative reflected that care delivery could at times feel rushed, that there was a variation in staff's level of engagement and relationship building, and a lack of knowledge in supporting people living with dementia.

The feedback received also indicated that there were concerns relating to consistency in staffing and the completion of and/or noncompliance with care plans.

Feedback received as part of the consultation process was considered and discussed with the Registered Manager, who provided assurances that appropriate action would be taken to address matters raised. These issues will be considered at a future inspection, alongside any additional information received.

All staff consulted commented positively about their employment with of Domiciliary Care Services (North Down & Ards), with several advising “I love my work”. The agency’s management were consistently praised, with staff advising they “work with you”, they are “supportive” and “so approachable and easy to talk to. They have been brilliant”. Staff consulted also commented positively about their colleagues describing cohesive team work.

It was positive to find staff felt there was effective communication and that they were kept informed regarding any changes relating to the care and support to be provided to service users. In speaking with staff they demonstrated clear knowledge as to policies and procedures to be followed in the event of an accident, incident or safeguarding concern. It was reassuring to hear staff express confidence that management were readily available to offer any advice and/or guidance as needed.

Staff felt that calls were appropriately timed to allow them to safely deliver care and support. A suggestion was made by one staff member who proposed it would be beneficial for the agency to review time allocated between calls to ensure it allowed for adequate time for travel.

Staff who provided feedback spoke positively of their experience of induction and ongoing training provided. Some suggestions were received regarding provision of additional training, for example, enhanced dementia training to further develop staffs knowledge and skills in working with service users with this condition. It was also positive to hear staff comment as to a recent team meeting for which changes to service user care plans were being made to remove any ambiguity regarding the level of support required in relation to medications.

HSC Trust representatives consulted commented positively about the agency. They described efficiencies in relation to the referral process and time from referral to commencement of care delivery. HSC Trust representatives told us that service users feedback for which they had received in relation to staff had been positive. HSC Trust representatives commented spoke positively about the registered manager and described communication with the agency as effective, timely and professional.

3.3 Inspection findings

3.3.1 Staffing 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. There was evidence of robust systems in place to manage staffing. Forward planning was evident in respect of staff schedules. Through discussion with the registered manager and staff it was reassuring to find that the agency had contingency plans in place to ensure safe staffing.

Review of the agency's staff recruitment records identified that a new criminal record check (AccessNI) had not been completed in respects of one employee who had worked in a different role with the same provider. Provider communication sent by RQIA 14 April 2026 regarding AccessNI Enhanced Disclosure Checks was discussed with the registered manager, who provided assurances regarding knowledge of, and compliance with its contents from 1 June 2026.

Review of three employee's recruitment records identified concerns pertaining to a lack of assurance regarding the authenticity and veracity of references. RQIA had sent communication to providers, 28 October 2025 highlighting the importance of ensuring existing selection and recruitment policies and procedures are robust and fit for purpose which highlighted associated risks were systems fail. Although it was positive to find that references received from personal email addresses had been flagged to the attention of the registered manager, there was no further action taken to assure the legitimacy of the sender. An area for improvement was identified.

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 structured induction programme which also included shadowing of more experienced staff members. It was also reassuring to find that the agency actively sought feedback from staff in relation to their experience of induction; utilising feedback received in order to further improve induction.

Review of the agencies training compliance found that the system utilised to monitor training did not contain information relating to all staff. An alternative system was shown to the Inspector, however it was found that this system lacked accuracy, containing data pertaining to employee's who were no longer in post. A further system was shown to the Inspector which proposed to contain compliance rates for mandatory training. On review however it was identified that this document did not contain all mandatory training such as complaints, human rights, supervision and appraisal. An area for improvement was identified.

Poor compliance rates were evident in relation to basic life support practical training and dementia awareness. Additionally, although no compliance rate was available, it was apparent that a low numbers of staff had completed epilepsy awareness and stoma care training. There was no training available to staff in relation to diabetes awareness. These concerns were discussed during the meeting on 8 July 2026 and will be reviewed at a future inspection.

Issues were identified with regards to medication competency assessments for staff. It transpired there exists a current contradiction between current policy and procedure in that domiciliary care staff only to prompt service users to take medications independently and practice which sees staff involved in the preparation and administration of medication. This was discussed with SEHSCT representatives who provided assurances as to interim measures taken by the agency to ensure safe practice in respects of medication until the new policy and procedure is implemented. This will be kept under review and examined again at a future inspection.

There were no competency assessments available during the inspection for staff expected to act up in the absence of the registered manager.

Discussion occurred with SEHSCT representatives in respects of this and the Inspector was satisfied that key competencies had been assessed during an employee's probationary period to establish they have the suitable knowledge, skills and capabilities for their role. The robustness of the current template was explored for further consideration of the provider.

The system utilised by the agency to monitor supervision and appraisal was unable to generate compliance rates. This limitation made it difficult to determine whether practice was consistently aligned with the agency's policies and procedures. This was brought to the attention of the registered manager, who agreed to discuss the issue with the software provider to identify a suitable resolution. Review of records available confirmed staff had engaged in regular supervision and that annual appraisals had been completed.

3.3.2 Care Delivery and Management of Care Records

The registered manager and office staff completed a management overview on a daily basis, to ensure that important information was communicated effectively amongst the management team. Communication with staff was aided via use of an electronic system, which enabled mass communication to facilitate shared learning as well as timely sharing of information pertaining to change in needs of service users to be supported. There was evidence of regular staff meetings were minutes were maintained and made available to staff unable to attend, to read for information sharing.

Service users care records were held confidentially in line with data protection regulations.

With the transition towards electronic recording, assurances were provided regarding processes in place for the exchange of information where a service user needs are being jointly met by Domiciliary Care Services (North Down & Ards) and an alternative provider.

When reviewing one service user's records it was found that the incorrect assessed international dysphagia diet standardisation initiative (IDDSI) levels were recorded within the tracker. Furthermore, the speech and language therapy (SALT) plan available to staff was not the most up-to-date available, with the most recent SALT plan illustrating a change in assessed IDDSI levels. Risk of harm to the service user was stressed. Similar issues were identified in respects of another service user's records.

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. Where a service user was experiencing a deprivation of liberty, the care records contained details of assessments completed and agreed outcomes developed in conjunction with the HSC Trust representative. Any service user subject to authorised Deprivation of Liberty Safeguards (DoLS) had their care plan reviewed by an HSC professional annually to ensure that they were not used disproportionately or for longer than is necessary.

It was therefore concerning to find information contained within the agency's central register that updated documentation relating to DoLS had expired in 2024. Upon request to review the service users records it transpired that service provision had ended several months previous. Concerns regarding the agency's failure to keep records up-to-date were shared with the registered manager.

Due to the aforementioned issues in respects of service user records an area for improvement was identified.

In relation to risk assessments one service user only had a generic risk assessment in place which had not been updated to reflect personal risks identified. This was despite the service user having a known medication allergy, mobility issues and a SALT assessment. A second service users' risk assessment did not include risks identified in the care plan, for example skin viability or SALT. The process for identification and management of risks were discussed during the meeting on 8 July 2026. Assurances were provided as to actions taken, and those to be taken by the agency to address this. This will be reviewed at a future inspection.

3.3.3 Quality of Management Systems

There has been no change in the management of the agency since the last inspection. Mrs Nicola Donnelly has been the manager in this agency since 11 May 2022 and she is also the Registered Manager of another registered domiciliary care agency.

Staff consulted with commented positively about the management team and described them as supportive, approachable and able to provide guidance.

Complaints were managed appropriately and it was good to note that any identified learning was shared with staff on a regular basis. It was also positive to find that SEHSCT complaints training had recently been updated to reflect Northern Ireland Public Services Ombudsman (NIPSO) Model Complaints Handling Procedures and that all staff were expected to complete this training. It was also reassuring that a service user representative who had made a complaint was satisfied with the agency's management of this.

An area of good practice was identified regarding the system utilised to enable review of incidents and accidents reported by the agency. Means of further improving this, such as the ability to filter by service user, were discussed with the registered manager who agreed to review the capabilities of the system. In discussion with the registered manager we were advised that analysis of incidents and accidents occurs on a weekly and monthly basis through internal governance meetings.

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 agency. The quality monitoring reports reviewed lacked sufficient detail and analysis to effectively drive service improvement. The reports contained inaccurate information regarding the complaints process, directing service users' representatives to an inappropriate route for raising concerns. Where issues had been identified, actions required to address these were not consistently documented. Furthermore, there was no analysis of incidents and accident data to identify trends and/or encourage facilitation of wider learning. It was concerning to find the reports failed to reference the ongoing Serious Adverse Incident investigation or associated recommendations. A number of issues identified during the inspection had not been recognised or addressed through the provider's own quality monitoring processes and based on this an area for improvement was identified.

Domiciliary Care Agencies are required to have a person known as the Adult Safeguarding Champion (ASC), who has responsibility for implementing the regional protocol and the setting's adult safeguarding policy. It was established that there were systems and processes in place to manage the safeguarding and protection of adults at risk of harm.

The annual quality report was in draft at the time of the inspection however upon review it was found to include stakeholder feedback. It was positive to find that the agency had developed service specific goals and objectives for the year ahead based on analysis of the agency's performance in the previous year.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Regulations and the Standards.

	Regulations	Standards
Total number of Areas for Improvement	3	1

Areas for improvement and details of the Quality Improvement Plan were discussed Mrs Nicola Donnelly, Registered 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 16(2)(a) Stated: First time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure that an effective system is in place to monitor training compliance of all staff employed by the agency. Furthermore, the Registered Person shall ensure staff receive training in line with the assessed needs of service users to assure staff have the appropriate knowledge, skills and competencies to safely undertake all tasks associated with the prescribed care and support of service users. Ref: 3.3.1
	Response by registered person detailing the actions taken: A training compliance target of 95% or above has been established for all mandatory training. Training compliance reports will be reviewed monthly by the Registered Manager and discussed at governance meetings. Any member of staff whose training has expired or is due to expire within 8 weeks will be identified through the monitoring system and booked onto the next available training session. Quarterly audits of training records will be undertaken to verify the accuracy of compliance data and ensure all active employees are included within monitoring systems. Competency assessments for staff undertaking specialist tasks will be reviewed annually or sooner if practice concerns are identified. Progress against training compliance targets will be reported through monthly quality monitoring reports.
Area for improvement Ref: Regulation 15(2)(a)(b)(c)(3)(b) Stated: First time To be completed by: Immediate from the date	The Registered Person shall ensure plans relating to the delivery of care and support of service users detail individual needs, manner for which these are to be met and that these are consistent with any plan prepared by any HSC professional involved in the care of the individual. Service user plans must be kept under regular review to ensure prescribed service remains responsive to the presenting needs of the service user. Ref: 3.3.2
	Response by registered person detailing the actions taken: Monthly audits of a minimum of 10 service user records or 10% of active caseloads (whichever is greater) will be undertaken to assess compliance with care planning requirements.

	All newly received professional recommendations, including SALT, nursing and allied health professional assessments, will be incorporated into care documentation within five working days of receipt. Care plans will be formally reviewed at least every six months and immediately following any significant change in assessed need. Audit findings, identified deficits and corrective actions will be recorded and reviewed through monthly governance meetings. The agency will maintain a target of 100% compliance for completed care plan reviews and risk assessments
Area for improvement Ref: Regulation 23 Stated: First time To be completed by: 15 September 2026	The Registered Person shall ensure monthly monitoring reports are completed in a meaningful manner in order to drive service improvement. Ref: 3.3.3 Response by registered person detailing the actions taken: Monthly quality monitoring reports will be completed by the end of each calendar month and reviewed by the Registered Manager and Senior Management Team. Each report will include consultation with a minimum of: • 8 service users • 5 staff members • Any available representatives or family members consulted during the reporting period. A minimum of 8 care records, 5 staff files and all incidents, complaints, safeguarding referrals and missed calls arising during the reporting period will be audited and analysed. All actions identified through quality monitoring will be assigned: • a named lead officer; • a completion date; • a review date; and • evidence of completion. A target of 100% completion of quality monitoring actions within agreed timescales will be monitored through governance meetings. Trend analysis will be undertaken monthly and reported quarterly to senior management to evidence service improvement and organisational learning.

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement Ref: Standard 11.2 Stated: First time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure that all efforts are made to assure the legitimacy of references received in respects of applicants. Ref: 3.3.1
	Response by registered person detailing the actions taken: A recruitment file audit will be undertaken quarterly on 100% of newly recruited staff. All references received from personal email accounts will be independently verified prior to appointment. No member of staff will commence employment until all recruitment checks have been completed and verified in line with agency procedures. Quarterly recruitment audit findings will be reported through governance structures, with a target of 100% compliance with recruitment requirements.

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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