

Inspection Report

Name of Service:	Enable Care Services (UK) Ltd
Provider:	Enable Care Services (UK) Ltd
Date of Inspection:	25 June 2026

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

1.0 Service information

Registered Provider:	Enable Care Services (UK) Ltd
Responsible Person:	Mrs Christine McGirr
Registered Manager:	Mrs Edel Beatty
Service Profile – Enable Care Services (UK) Limited is a domiciliary care agency which provides a range of personal and social care services, meal provision and sitting services to people living in their own homes. Service users have a range of diagnoses including dementia, mental health conditions and learning and physical disabilities. The agency provides care to 828 service users, commissioned by the Southern Health and Social Care Trust (SHSCT) and the Northern Health and Social Care Trust (NHSCT). The agency also has a small number of private service users within the Western Health and Social Care Trust (WHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 25 June 2026 between 10.10 am and 4.35 pm by a care Inspector.

The last care inspection undertaken on 5 June 2025 identified two areas for improvement relating to staff training and the storage of records. This inspection was undertaken to assess the progress with the areas for improvement identified by RQIA at the previous inspection and also to evidence how the agency is performing in relation to the regulations and standards. It also sought to determine if the agency is delivering safe, effective and compassionate care; and if the service is well led.

As a result of this inspection both areas for improvement were assessed as having been addressed by the provider. This is discussed in more detail in sections 3.3.1& 3.3.5. Three new areas for improvement were identified during this inspection relating to the recording of accidents/incidents, recording of restrictive practices and quality monitoring reports. This is discussed in sections 3.3.2, 3.3.3 & 3.3.5.

Overall, the inspection established that care delivery was safe and that effective and compassionate care was delivered to service users. Full details of the new 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 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 the previous areas for improvement issued, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning trusts.

Throughout the inspection process inspectors will seek the views of service users and the relatives of those in receipt of a service, and examine a sample of records to evidence how the 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

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

We spoke to a range of service users, agency staff, relatives and HSC staff to seek their views of the agency.

Service users who provided feedback on the agency spoke in positive terms about the care provided to them. Comments included - "I couldn't be happier – they are very, very good" and; "it's all going great – I have the supervisor's number if I need anything".

Relatives who provided feedback to the inspector spoke positively about the agency and the care provided to their loved one. Some comments included; "the girls are very good" and; "Enable are very responsive – they do the all the tasks my relative needs – they can adapt as needed and are very courteous and kind".

Some relatives provided feedback by completing the electronic survey. Comments received included the following statements - "All staff are very pleasant and brighten up my relative's day" and "my relative looks forward to the carers coming in and it gives us peace of mind knowing they will call and how well they look after him".

Staff working for the agency told us they were satisfied with the care delivery, training and management support. A number of staff who completed the electronic survey also expressed satisfaction that the care provided by the agency was safe, compassionate, effective and well led. Some comments included; "Delighted to work for Enable Care – a very rewarding job"

and; “they encourage us to provide safe, person-centred care while treating every service users with dignity and respect”.

HSC staff members contacted for feedback about the service commented that service users are satisfied with the care provided by the agency.

3.3 Inspection findings

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

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring sufficient staffing levels to meet the needs of service users.

An examination 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.

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to NISCC’s 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 induction programme which also included shadowing of a more experienced staff member.

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.

Competency assessments were undertaken with all staff tasked with assisting with medication to ensure that they were competent in their roles and responsibilities. Staff received face- to- face training and online training with respect to assisting with the administration or prompting of medication. There was evidence that where medication errors occurred by staff, that this was addressed through a targeted work shop that enabled shared learning and an opportunity to refresh training and knowledge with respect to the administration of medication.

An area for improvement identified at the previous inspection and stated for a second time related to staff training. A review of records of all staff training which were held electronically identified that a small number of staff required refresher training in Fire Safety and Adult Safeguarding. This was discussed with the manager who explained reasons for this and it was later confirmed that the identified staff had completed this training. On this basis the area for improvement was assessed as met.

3.3.2 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’s adult safeguarding policy and procedures were reflective of the Department of Health’s (DoH) regional policy. The organisation had an identified Adult Safeguarding Champion (ASC) who completed the annual position report which was 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.

The agency retained records of any referrals made to the HSC Trusts in relation to adult safeguarding. A review of records confirmed that safeguarding concerns had been managed appropriately and it was positive to note that the manager recorded these centrally on a tracking log to enable the swift identification of any trends arising.

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 recorded all reports of accidents and incidents that had occurred on an electronic spreadsheet. However, there was no centralised record keeping system to evidence how these reports were received, recorded and responded to when first reported to the agency. This was discussed with the manager and an area for improvement was identified. A review of a sample of incident records identified two incidents where carers had not been able to safely locate a client within their home. This led to changes within the agency around how such occurrences are managed and the agency's non-access policy was revised in response. This was examined and deemed satisfactory. It was recommended that the agency ensure all staff access and review this policy to ensure ongoing appropriate management of such occurrences. This will be examined at a later inspection.

3.3.3 Mental Capacity Act and Restrictive Practice

The Mental Capacity (Northern Ireland) Act 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 had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The manager reported that one service user was subject to DoLS and an examination of this service user's care records confirmed that these included details of assessments completed and agreed outcomes developed in conjunction with the HSC Trust representative.

There was evidence that service users may require interventions that could be considered restrictive such as bed rails or locked medication boxes to keep them safe. There were no recording arrangements in place however, to ensure necessity and proportionality of such interventions.

Advice was given to the manager during the previous inspection about the need to review care practices that may amount to restrictions on liberty and to develop a way of monitoring such practices. As this had not been implemented an area for improvement was identified.

3.3.4 Care Records and Service User Input

A sample of service users' care records was examined; these contained sufficient information about the level of support required. Care plans reflected the multi-disciplinary input and collaborative working undertaken to ensure service users' health and social care needs were met.

A number of service users were assessed by a Speech and Language Therapist (SALT) with recommendations provided, and some required their food and fluids to be of a specific consistency. Staff were familiar with how food and fluids should be modified and implemented the specific recommendations of the SALT.

A review of a sample of care records identified that moving and handling risk assessments and care plans were up to date. There was evidence that regular contact was made with service users and relatives to review how care and support was being delivered, in keeping with the agency's policies and procedures and in line with the commissioning Trust's requirements. 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.

3.3.5 Governance and Managerial Oversight

There were monitoring arrangements in place in compliance with Regulations and Standards. An examination of a sample of the most recent reports established these were not robust and lacked detail. The reports evidenced engagement with service users, representatives/relatives and staff but lacked engagement with HSC Trust representatives. Reports did not evidence a review of the professional registrations of staff, complaints or any deficits to action where service user records had been audited. Recorded incidents related to bruising lacked detail around the cause and did not evidence any consideration under Adult Safeguarding policies and procedures. Furthermore, the action plan stated that all actions arising from the previous inspection had been completed which was inaccurate in light of the staff training deficits identified. An area for improvement was been identified.

The Annual Quality Report was reviewed and was satisfactory.

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

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

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Where complaints were received since the last inspection, these were appropriately managed and were reviewed as part of the agency's quality monitoring process. All complaints were recorded on an electronic database and advice was given to the manager around ensuring that this includes recording when a complaint is considered to be resolved.

An area for improvement identified at the last inspection related to the secure storage of records. On review of this there was evidence that records retrieved from discontinued packages of care were stored in a secure filing cabinet. On this basis the area for improvement was deemed to have been addressed.

Where staff are unable to gain access to a service user's home, the service had revised their operational policy and procedure to clearly direct staff as to what actions they should take to manage and report such situations in a timely manner. It was recommended that the manager ensure that all staff evidence their knowledge and adherence to this policy. This will be reviewed at a future inspection

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	2	1

Areas for improvement and details of the QIP were discussed with Mrs Edel Beatty, 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 15 (4)& (10) Stated: First time To be completed by: Immediately and ongoing	The registered person shall ensure the prescribed services which the agency provides to any service user meets the needs specified in the service user's care plan and shall not subject the service user to any restraint unless it is employed as the only means necessary to secure their welfare. This relates to the need to ensure that all restrictive practices such as bed rails or locked medication boxes are recorded and reviewed regularly to ensure appropriate assessment of need and review by the multi-disciplinary team. Ref: 3.3.3
	Response by registered person detailing the actions taken: We have established all service users that may need assessment for restrictive practice such as bed rails and medication locked boxes. We have reached out to keyworkers for these. A register is in place and working towards receiving all necessary paperwork from professionals involved. On acceptance of a new package of care we request all paperwork from outset of any restrictive practice such as medication locked boxes and bed rail assessments if profiling bed in place. These will be reviewed regularly. All senior staff within teams are aware to notify any change to need to the careplan when a medication locked box or bed rail assessment may be required. In respect of (DOL) Deprivation of Liberty - Any extension of Careplans have been reviewed and updated accordingly with the keyworker and placed into the service user's care record.
Area for improvement 2 Ref: Regulation 23 Stated: First time To be completed by: Immediately and ongoing	The registered person shall establish and maintain a system for evaluation the quality of the services which the agency arranges to be provided. The person carrying out the visit shall prepare a written report which describes the extent to which the agency has responded to the recommendations imposed by RQIA in relation to the agency over the specified period. Ref: 3.3.5
	Response by registered person detailing the actions taken: Monthly Monitored Report are re-evaluated to ensure all actions are recorded alongside all new improvements since inspection.

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards 2021	
Area for improvement 1 Ref: Standard 8.16 Stated: First time To be completed by: Immediately and ongoing	All accidents and any incidents occurring when an agency worker is delivering a service are reported as required in accordance with legislation and procedures and a record of these is maintained for inspection. This relates to ensuring all initial accidents/incidents reported are recorded and held with in a centralised record keeping system that is available for review on inspection. Ref:3.3.2
	Response by registered person detailing the actions taken: Incidents and accidents matrix is in place. We have introduced a centralised system which records all incidents/accidents, the reporter, the date time and actions taken. We have actioned a separate log for unexplained bruising which is captured in an app1 and sent to relevant keyworker/ASGT. We also send all warranted incidents to corporate governance when the report was made and by who. It also records the actions taken by ourselves.

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



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