The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Jark (Downpatrick) Limited**

Provider: **Jark (Downpatrick) Limited**

Date of Inspection: **25 August 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:	Jark (Downpatrick) Limited
Responsible Individual/Responsible Person:	Mrs Danielle Theresa Mahon
Registered Manager:	Mrs Emma Brown (acting)
Service Profile Jark (Downpatrick) Limited is a domiciliary care agency which provides a range of services such as personal care, meals, sitting services and community outreach to people living in their own homes. Services are commissioned by the South Eastern Health and Social Care Trust (SEHSCT) and the Southern Health and Social Care Trust (SHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 25 August 2026, between 9.10 am and 3.55 pm by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 15 April 2025; and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

The inspection examined the agency's governance and management arrangements, reviewing areas such as staff recruitment, professional registrations, staff induction and training and adult safeguarding. The reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS), Service user involvement, Restrictive practices and Dysphagia management.

As a result of this inspection the area for improvement previously identified was assessed as having not been addressed by the provider. This area for improvement has been stated for a second time. 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 4.

The three new areas for improvement identified related to staff recruitment, induction records and staff supervision and appraisal.

Good practice was identified in relation to training compliance; the agency's engagement with a Dementia Nurse Specialist and planned participation in Dementia Awareness training.

Jark (Downpatrick) Limited uses the term 'people who we support' 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 the previous QIP issued, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning trust.

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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 for staff.

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.

Service users and/or their relatives provided very positive feedback. One relative commented, "I have nothing but positive things to say about Jark"

Staff who spoke with the Inspector stated that they enjoyed working with the agency; they described the training as "exceptional". All staff stated that the manager is supportive and that they believed service users get very good care.

Trust representatives stated they had no concerns in relation to the agency and communication was good.

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.

We discussed the acting management arrangements, which have been ongoing since 30 March 2026, RQIA will keep this matter under review.

There were monitoring arrangements in place in compliance with Regulations and Standards. A review of the reports of the agency's quality monitoring established that there was engagement with service users, service users' relatives, staff and HSC Trust representatives. 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.

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

Review of the complaints policy identified it outlined the process of how to complain. This policy required updating to ensure it contained contact details for the Regulation and quality Improvement Authority (RQIA), Patient Client Council (PCC) and the Trust's Complaint Department. Complaints were managed appropriately and it was good to note that any identified learning was shared with staff on a regular basis.

Where staff are unable to gain access to a service user's home, the service has an operational policy, procedure or protocol that clearly directs staff from the agency as to what actions they should take to manage and report such situations in a timely manner.

3.3.2 Staffing (recruitment and selection, induction and training).

Safe staffing begins at the point of recruitment and continues through to staff induction and regular staff training.

A 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. 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. However, it was noted references had not been sought in accordance with the legislation. An area for improvement was identified.

From speaking to staff and the manager they confirmed newly appointed staff had completed a structured, three-day induction programme which also included shadowing of a more experienced staff member. Written records of staffs' inductions were not available during the inspection. An area for improvement was identified.

All registrants must maintain their registration for as long as they are in practice. This includes renewing their registration and completing Post Registration Training and Learning. Post registration training requirement was discussed at supervision with staff to ensure that all staff are compliant with the requirements.

The agency's training provider maintained a record for each member of staff of all training, including induction and professional development activities undertaken. 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. The manager was advised the oversight arrangements in relation to training compliance requires strengthening to ensure the manager maintains oversight of ongoing training compliance. This will be reviewed at the next inspection.

Staff supervisions and appraisals had not been undertaken in keeping with the agency's policy and procedures. An area for improvement was identified.

3.3.3 Care Records and Care Delivery

A formal review of a service user's care plan should take place at least once per year. The manager confirmed that annual review meetings organised by the Trust were not consistently arranged for all service users. They were unable to provide records to evidence that the agency contributes to the annual review of all service users care plans by either attending meetings or submitting a report in advance. Review reports should refer to any matters regarding the current care plan; general changes in the service users' situation; and details of important events including incidents or accidents occurring during the review period. The agency was advised at the previous inspection on 15 April 2025, the dates for all care reviews should be recorded and there should be a system in place to provide an overview of who has received a review and when they have been completed. This area for improvement has been assessed as not met and therefore stated for a second time.

A review of care records identified that a significant number of risk assessments such as Occupational Therapist assessments; restrictive practices; and those relating to manual handling were not available for a number of service users. The manager was advised to complete a scoping exercise to identify those missing from each service users' records and action appropriately. It is good to note the manager has confirmed following the inspection, the scoping exercise has been completed and they have engaged with the Trust to ensure that the agency are in receipt of all the appropriate information. This will be reviewed at the next inspection.

A number of service users were assessed by SALT with recommendations provided and some required their food and fluids to be of a specific consistency. A review of training records confirmed that the majority of staff had completed training in Dysphagia and in relation to how to respond to choking incidents.

Consultation with service users and their representatives established there were no concerns regarding service users receiving their calls in keeping with the care plan.

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); it was noted that their training required updating. The manager has provided assurances that a new date for this training had been secured. 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.

The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. A review of records confirmed that these had been managed appropriately.

The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any concerns.

The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

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 none of the service users were subject to DoLS, however some restrictive practices were in place. The agency maintained oversight in relation to services users were restrictive practices were in use.

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*

* the total number of areas for improvement includes one that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Danielle Theresa Mahon, Responsible Individual and Mrs Emma Brown, 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 full and satisfactory information is available in relation to the candidate in respect of the matters specified in Schedule 3;this relates specifically to obtaining references from employers where the applicant has worked previously as a care worker. Ref: 3.3.2
	Response by registered person detailing the actions taken: All references are being checked thoroughly and our new compliance manager has corrected any which were not adequate
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 **Ref:** Standard 6.4 **Stated:** Second time **To be completed by:** Immediate from the date of inspection.	The registered person shall ensure accurate records are maintained in relation to all services users' care reviews, including those whose care needs remain unchanged; these records should include completion dates and staff signatures; there should be a system in place that provides an overview of who has received a review and when it has been completed to allow for robust governance and oversight of the care review process. Ref: 3.3.2
	Response by registered person detailing the actions taken: All records in relation to care reviews have been recorded on the system which flags up when due
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 they maintain written records of all staff inductions. Ref: 3.3.2
	Response by registered person detailing the actions taken: We have implemented a new training system which holds all induction information online & shadowing review forms have been restructured

Area for improvement 3 **Ref:** Standard 13 **Stated:** First time **To be completed by:** Immediate from the date of inspection	The registered person shall ensure that staff receive supervisions and appraisals in accordance with the Agency's policy. Ref: 3.3.2
	Response by registered person detailing the actions taken: Our new compliance manager has been ensuring that supervision and appraisals have been completed for all staff in accordance with our policy

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The Regulation and Quality Improvement Authority

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