The Regulation and Quality Improvement Authority

# Inspection Report

**Name of Service: Magherafelt Community Services**

**Provider: Northern Health and Social Care Trust**

**Date of Inspection: 28 August 2026**

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

## 1.0 Service information

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| **Organisation/Registered Provider:** | Northern Health and Social Care Trust (NHSCT) |
| **Responsible Individual/Responsible Person:** | Ms Claire Appolonia O'Hare |
| **Registered Manager:** | Ms Suzanne Pullins |
| **Service Profile –**<br>Magherafelt Community Services is a NHSCT domiciliary care agency. The staff team provides care and social support to service users in the Magherafelt locality. The agency's aim is to provide care to meet the individual assessed needs of people in their own homes. | |

## 2.0 Inspection summary

An unannounced inspection took place on 28 August 2026, between 9.45 am and 4.30 pm. A care Inspector conducted the inspection.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 28 August 2025; and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to service users and that the agency was well led.

Service users and relatives said that the care and support provided by the agency was a good experience.

The Inspector identified good practice in relation to the feedback from service users, relatives and staff. There were good governance and management arrangements in place.

As a result of this inspection two of the six areas for improvement previously identified were assessed as having been addressed by the provider. Two areas for improvement previously identified have been carried forward to the next inspection. One area for improvement has been stated for a second time and one area for improvement has been stated for a third and final 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 Inspector would like to thank the manager, service users, relatives, HSC staff member and staff team for their support and co-operation during and following the inspection.

## 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 information held by RQIA about this agency was reviewed. This included the previous QIP, 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 those working for or being supported by 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, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included questionnaires and an electronic staff survey.

## 3.2 What people told us about the service and their quality of life

During and following the inspection, the Inspector spoke with a number of service users, relatives, a HSC staff member and staff members to seek their views of the agency.

Service users who spoke with the Inspector said that they were very happy with the care and support provided. Some comments received included; "It is a great service and I am looked after very well" and "The carers treat me with respect and always ask me how I am".

Relatives who spoke with the Inspector said they were very satisfied with the support provided to their loved one and had no concerns about the level of care provided. Some comments received included; "I find the service invaluable and the care and support provided to my husband is very good" and "The carers are lovely, patient and kind and they do a good job".

Staff told us that they were satisfied that the care and support was safe, effective, compassionate and well led. Staff spoke positively about the care delivery, training and .management support in the agency. Staff comments included; "There is good communication within the agency and we have regular team meetings" and "I got a good induction and shadowed another staff member for several shifts".

The HSC staff member who provided feedback about the service commented that the agency was reliable, dependable and that service user's needs were met safely.

## 3.3 Inspection findings

### 3.3.1 Staffing Arrangements

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

Review of the agency's staff recruitment records confirmed that generally pre-employment checks, including criminal record checks (AccessNI), were completed and verified before staff members commenced employment and had direct engagement with service users.

A review of two staff members' recruitment records identified that gaps in employment had not been explored. An area for improvement has been identified.

There was an effective system in place to manage the registrations of care staff with the Northern Ireland Social Care Council (NISCC). 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 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, programme which also included shadowing of a more experienced staff member.

Staff provided positive feedback regarding the training they received and confirmed that it enabled them to fulfil the duties and responsibilities of their roles. Staff were provided with training appropriate to the requirements of their roles, which was recorded and monitored on an electronic training matrix. The review concluded that staff had received mandatory and other role specific training since the previous care inspection, including moving and handling and fire safety.

Review identified that a number of staff had not attended training and/or update training in relation to Deprivation of Liberty Safeguards (DoLS). An area for improvement has been identified.

Review also identified that a number of staff had not attended training and/or update training in relation to adult safeguarding. The Inspector acknowledges since the previous inspection a number of adult safeguarding training sessions have been completed. An area for improvement made in the previous inspection is stated for a second time.

Staff had been provided with training in relation to medicines management and were required to complete a competency assessment prior to undertaking this task.

An area for improvement identified in the previous inspection related to a gap in cover arrangements in the out of hours' rota. Discussion with the manager confirmed that systems were in place where senior management provide out of hours cover for this period. On this basis, the area for improvement was assessed as met.

There was evidence of staff meetings. Staff stated they could add to the meeting agenda if there were items they wished to discuss. Minutes were maintained of the meetings for staff unable to attend, to read for information sharing.

Procedures were established for appraising staff performance and conducting staff supervisions in accordance with policy and procedure. Staff confirmed that appraisals and supervisions had occurred.

### 3.3.2 Care Delivery and Care Records

Service users' needs were assessed when they were first referred to the agency and before care delivery commenced.

Care plans were in place to direct staff on how to meet the service users' needs. The majority of risk assessments and care plans were in date and there was a service user spreadsheet which the manager used to track renewal dates for the relevant documents. A review of the spreadsheet and discussion with the manager identified there were a number of risk assessment, care plans and care reviews that were significantly out of date. This was previously identified as an area for improvement and has been stated for a third and final time.

This system enables the identification of risk assessments, care plans and care reviews that were out of date and the agency staff then follow up with the Trust community services team, who are responsible for formulating these risk assessments and care plans. However, it was evident that these were frequently not returned to the agency staff, when requested. Whilst RQIA acknowledges this, it is the responsibility of the agency to ensure compliance with the Regulations and Standards.

Following a significant medication incident, there was no evidence that the service user's risk assessment or care plan had been reviewed and updated to reflect the identified risks. Staff therefore did not have clear guidance about the actions required to reduce the risk of recurrence. Discussion with the manager and review of records confirmed that the agency had identified the need to progress the matter with the service user's Social Worker. However, there was a delay between the issue being identified and evidence of further contact or action being taken. An area for improvement has been identified.

The manager reported that a number of service users required a modified diet. The Inspector viewed a sample of these care plans and confirmed that these followed the Speech and Language Therapy (SLT) assessments. Staff training records confirmed that staff had received training in Dysphagia and were aware of action to take in the event of a service user choking.

There was a procedure in place for the collection of completed daily notes from service users' homes; the Home Care Officer's collect the notes every three months and return them to the registered office. Review of records identified that the daily notes were not being returned on a regular basis and it was identified that one service users' daily notes had not been returned to the registered office for a 11-month period. An area for improvement has been identified.

## 3.3.3 Quality of Management Systems

Mrs Claire Appolonia O'Hare has been the manager since 18 August 2009; she is also the manager of another registered domiciliary care agency. Staff commented positively about the management team.

The agency maintained a monthly monitoring system for evaluating the quality of the services. The reports included details of a review of service user care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

Agencies are required to have a person known as the Adult Safeguarding Champion (ASC), who has responsibility for implementing the regional protocol and the agency's adult safeguarding policy. There was an individual within the organisation's senior management team who was identified as the appointed ASC for the agency.

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

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.

There was a process in place for the management of complaints. An area for improvement identified in the previous inspection related to the management of complaints. Discussion with the manager and review of records evidenced complaints had been managed appropriately. On this basis, the area for improvement was assessed as met.

A range of policies were held electronically and available to direct staff in care delivery and support.

There was a protocol in place for staff to follow where service users were not at home as planned.

## 4.0 Quality Improvement Plan/Areas for Improvement

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

| | Regulations | Standards |
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| **Total number of Areas for Improvement** | 5* | 3* |

* the total number of areas for improvement includes one that has been stated for a third and final time, one that has been stated for a second time and two which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Claire O'Hare, 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 | |
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| **Area for improvement 1**<br><br>**Ref:** Regulation 15 (2) (a)(b)(c)<br><br>**Stated:** Third and final time<br><br>**To be completed by:**<br>Immediate from the date of the inspection | The registered person shall ensure that risk assessments, care plans and care reviews are up to date; and where there have been a number of requests made to follow up on these matters, Senior Management should be informed.<br><br>Ref: 3.3.2 |
| | **Response by registered person detailing the actions taken:**<br>The registered manager will continue to highlight to senior management of the domiciliary care service, where requests for updated documentation e.g. care plans, risk assessments are not being forwarded to the service and will keep a record of this as evidence for inspection by RQIA Inspectors. This situation has been escalated by senior management of homecare to the Director of Community Care, Assistant Directors/Professional Team Managers. A list of outstanding documentation has been forwarded to professional leads since the Inspection took place, this will be completed on a monthly basis until this are has been improved upon. |
| **Area for improvement 2**<br><br>**Ref:** Regulation 13 (d)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate from the date of the inspection | The registered person shall ensure that AccessNI checks are undertaken on all staff regardless of whether or not they commenced employment via internal Trust transfer arrangements.<br><br>Ref: 3.3.1 |
| | **Action required to ensure compliance with this Regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** |

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| **Area for improvement 3**<br><br>**Ref:** Regulation 13 (d)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate from the date of the inspection | The registered person shall not employ a person to work in the agency unless full and satisfactory information is available in relation to him/her in respect of each of the matters specified in Schedule 3.<br><br>This specially relates to obtaining a satisfactory written explanation of any gaps in employment for all staff.<br><br>Ref: 3.3.1 |
| | **Response by registered person detailing the actions taken:**<br>The registered manager has drafted a proforma to be used for recording the gaps in employment of responses from candidates during interviews. |
| **Area for improvement 4**<br><br>**Ref:** Regulation 21 (1)(c)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate from the date of the inspection | The registered person shall develop and implement a system to ensure that records are retrieved from the service users' homes in keeping with the agency's policy and procedure, to ensure that they are subject to timely audit.<br><br>Ref: 3.3.2 |
| | **Response by registered person detailing the actions taken:**<br>The registered manager is reviewing the current system in place for retrieval of records from service users homes, for the purpose of timely audit requirements which is in keeping with the agency's policy and procedure, in order to implement a more robust system. The agency is also, in the longer term, planning the implementation of a paperless Digital solution 'Care Line Live'. This will remove the need for collection of records for auditing and facilitates audits to be carried out more efficiently from the digital records. |
| **Area for improvement 5**<br><br>**Ref:** Regulation 15 (2) (a)(b)(c)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate from the date of the inspection | The registered person shall ensure that significant incidents are consistently reviewed and that any learning or changes in identified risks are reflected promptly in service user's risk assessments and care plans.<br><br>Ref: 3.3.2 |
| | **Response by registered person detailing the actions taken:**<br>The registered manager is reviewing the significant incidents in relation to identified risks to service users, to ensure that they are promptly referred to the appropriate professional for review and requesting a copy of updated care plan/risk asessments |

| **Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, May, (revised) 2026** | |
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| **Area for improvement 1**<br><br>**Ref:** Standard 14.10<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>Immediate from the date of the inspection | The registered person shall ensure that all staff undertake safeguarding refresher training.<br><br>Ref: 3.3.1 |
| | **Response by registered person detailing the actions taken:**<br>The registered manager has reviewed the numbers requiring updated safeguarding Training and has commenced the roll out of refresher training for all staff from Sept 2026 to February 2027. |
| **Area for improvement 2**<br><br>**Ref:** Standard 14.7<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate from the date of the inspection | The registered person shall ensure that written records are kept of suspected, alleged or actual incidents of abuse and include details of the investigation, the outcome and action taken by the agency.<br><br>Ref: 3.3.1 |
| | **Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this is carried forward to the next inspection.** |
| **Area for improvement 3**<br><br>**Ref:** Standard 12.4<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate from the date of the inspection | The registered person shall ensure that all staff receive appropriate and up to date DoLS training.<br><br>Ref: 3.3.1 |
| | **Response by registered person detailing the actions taken:**<br>The registered manager has reviewed the numbers requiring updated MCA/DoLs Training and has commenced the roll out of refresher training for all staff from week beginning October 2026, Delays in the training were due to waiting confirmation that they recommence the Dols training via the Learn HSCNI platform |

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