Inspection Report

Name of Service: Castle Lane Supported Living Service

Provider: Praxis Care

Date of Inspection: 4 April 2025

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:	Praxis Care
Responsible Individual/Responsible Person:	Mr. Greer Wilson
Registered Manager:	Ms. Leona Lavery
Service Profile – Castle Lane is a domiciliary care agency, supported living type which provides personal care and housing support to 18 service users with learning disabilities. Some service users also have enduring mental health problems and/or complex needs. Service users live at two locations within the Lurgan town area.	

2.0 Inspection summary

An unannounced inspection took place on 4 April 2025, between 10.40 am and 3.55 pm. It was carried out by a care inspector.

The last care inspection of the agency was undertaken on 12 December 2023 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, some improvements were required to ensure the oversight of certain aspects of the agency, such as staff training and signing of records. 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.

Service users said that the care and support provided by Castle Lane Supported Living Service was a good experience

It was established that staff promoted the dignity and well-being of service users and that staff were knowledgeable in relation to the needs of the service users.

We would like to thank the person in charge, service users and staff for their help and support in completion of 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 we reviewed information held by RQIA about this agency. This included registration information, and any other written or verbal information received service users, relatives, staff or the commissioning Trust.

Information was provided to service users, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included User Friendly 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 and staff to seek their views of living within and working within the agency.

Service users told us they like living in the agency and had no issues with the care and support provided. One service user told us they never wanted to leave.

Staff told us that they were satisfied that the care and support was safe, compassionate, effective and well led. One issue was raised that was discussed with the manager after the inspection.

The information provided indicated that they had no concerns in relation to the service.

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.

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) or the Nursing and Midwifery Council (NMC) or any other relevant regulatory body; there was a system in place for professional registrations to be monitored by the manager. Discussion took place with the person in charge regarding ensuring there was clear recording in place of the frequency of this monitoring. This will be reviewed at the next inspection.

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, three-day induction programme which also included shadowing of a more experienced staff member. Discussion took place with the person in charge regarding the requirement for the dates of these shadow shifts were clearly recorded in staff induction records. This will be reviewed at the next inspection. Written records were retained by the agency of the person's capability and competency in relation to their job role.

Records of all staff training were retained and the manager maintained oversight of the training matrix to ensure compliance. However, review of the training records and discussion with the person in charge identified that some staff had not received certain elements of training that would be required for a supported living setting. For example, all staff had not completed training in respect of Deprivation of Liberties Safeguards (DoLS), Adult Safeguarding and Dysphagia. An area for improvement has been identified in this regard.

A review of the records relating to staff that were provided from recruitment agencies identified that they had been recruited, inducted and trained in line with the regulations.

3.3.2 Care Delivery

Staff interactions with service users were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual service users' needs, their daily routine, wishes and preferences.

It was good to note that service users were involved in planning various activities. These included:

- Men's Shed
- Food Hygiene Class
- Snooker tournament
- NOW Group
- Lunch Group
- Trips to local towns – one service user told us they had recently been on a trip to Newcastle

It was also good to note that the agency had service users' meetings on a regular basis which enabled the service users to discuss the provisions of their care. Some matters discussed included personal care, staying safe and activities.

Service users said they had no concerns regarding their safety; they described how they could speak to staff if they had any concerns about safety or the care being provided. The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any concerns.

3.3.3 Management of 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.

Service users care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the service users' needs. Staff recorded regular evaluations about the care and support provided. It was noted that some of these records had not been signed by the appropriate staff member. It was also noted that some records in relation to staff inductions had not been signed. This has been identified as an area for improvement.

Service users, where possible, were involved in planning their own care and the details of care plans were shared with service users' relatives, if this was appropriate.

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.

The organisation had an identified Adult Safeguarding Champion (ASC). The agency's annual Adult Safeguarding Position report was reviewed and found to be satisfactory. The agency retained records of any referrals made to the Health and Social Care Trust in relation to adult safeguarding. A review of records confirmed that these had been managed appropriately.

Some service users had been assessed by a Speech and Language Therapist as requiring their food and fluids to be modified. These recommendations were recorded is service users' care plans.

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, being helped to do so when needed, and any decisions made on their behalf are in their best interests and as least restrictive as possible.

Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their roles. Where service users were subject to DoLs, the required documentation was in place and was kept under regular review.

The agency maintained a detailed Restrictive Practice register. There was evidence that this was regularly reviewed in conjunction with service users' HSCT key workers.

3.3.4 Quality of Management Systems

Ms. Leona Lavery has been appointed as registered manager within the agency since the last inspection. Staff commented positively about the manager.

Discussions with the person in charge 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.

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 or that required to be notified to RQIA.

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

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.

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	0	2

Areas for improvement and details of the Quality Improvement Plan were discussed with the person in charge 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 Minimum Standards, revised 2021

Area for improvement 1 **Ref:** Standard 12.3 **Stated:** First time **To be completed by:** Immediate and ongoing from the date of inspection	The Registered Person shall ensure that staffs' mandatory training requirements are met. Ref: 3.3.1
	Response by registered person detailing the actions taken: There has been an ongoing effort made at the service to address compliancy rates with training. This is a targeted focus. All staff have completed their level 1 safeguarding and safeguarding of adults and young children. All level 2 and level 3 refresher safeguarding training has been actively booked for period June/July . The majority of staff have completed DOL'S and there has been an improvement from the inspection, with staff who need to renew or complete being allocated time to do so. This is being prioritised. Dysphagia training rates have greatly improved and as above this is being prioritised with only trained staff undertaking the role of supporting the people we support in their dsyphagia management plans, to enable any new starter staff or staff who are due to complete time to do so.
Area for improvement 2 **Ref:** Standard 5.6 **Stated:** First time **To be completed by:** Immediate and ongoing from date of inspection	The Registered Person shall ensure all records are signed and dated by the person making the entry. Ref: 3.3.3
	Response by registered person detailing the actions taken: The induction syllbus is being overseen by the team leaders to include the person's individual supervisor who after each shadow day will ensure that the induction sheets have been signed. All supervisory files and induction files will be subject to a planned audit and review by management to ensure that signing of essential documents are being completed in line with training deadlines and induction requirements. Care plans and risk assessments will be reviewed on a regular basis to ensure any entries to documents is signed and dated.

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

The Regulation and Quality Improvement Authority

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