The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: NDA Mental Health Services

Provider: Praxis Care

Date of Inspection: 29 July 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 Hazel Campbell

Service Profile –

NDA Mental Health Services is a domiciliary care agency, supported living type; the agency office is located in Newtownards. The agency's aim is to provide care and support to meet the individually assessed needs of service users who are living in their own homes or shared accommodation. Staff are available to provide care and support to service users with tasks of everyday living, emotional support and assistance to access community services, with the overall goal of promoting health and maximising quality of life.

2.0 Inspection summary

An unannounced inspection was undertaken on 29 July 2025 between 9.20 am and 3.15 pm. by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards. The inspection also sought to determine if the agency is delivering safe, effective and compassionate care and if the agency 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 and restrictive practices was also examined.

A care inspector undertook the last inspection on 2 November 2023. No areas for improvement identified.

One area for improvement was identified; this related to the supply of staff from other Praxis services and the mechanisms in place to ensure these staff have a valid Northern Ireland Social Care Council (NISCC) registration, if they are involved in any safeguarding investigations and/or subject to restrictions, and have completed all necessary training.

Good practice was identified in relation to service user involvement and to care records, which were detailed and contained evidence of service user involvement and person centred care plans.

NDA Mental Health Services 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 registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning trust.

Throughout the inspection, the RQIA inspector will seek to speak with service users, their relatives or visitors and staff for their opinions on the quality of the care and support, their experiences of living, visiting or working in this agency.

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 and their quality of life

As part of the inspection process, we spoke with a number of staff and contacted service users and representatives from the commissioning Trust. Service users indicated that staff treated them with respect and they were very satisfied with the support they received. The feedback staff provided indicated that staff felt supported by the manager, enjoyed working at the agency and they worked well together as part of a team. Trust representatives stated communication was good, relationships are good between the Trust and the manager who actively engages with them in matters such as safeguarding and the completion of care reviews. They also confirmed the agency responds promptly and appropriately to resolve concerns/issues.

A number of staff responded to the electronic survey. The respondents indicated that they were 'very satisfied' or 'satisfied' that care provided was safe, effective and compassionate and that the service was well led.

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.

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 a sample of service user' care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

There were processes in place to review the quality of the service on an annual basis. The Annual Quality Report was reviewed and was satisfactory.

There was a system in place to ensure that complaints are managed in accordance with the agency's policy and procedure. Staff demonstrated a good awareness of both the complaints procedure and whistleblowing policy. The agency had an up to date register of complaints. There was evidence of a system to ensure oversight of complaints; this included a review of complaints during the monthly quality monitoring visits. Details relating to the complaints process was included in the Statement of Purpose and Service Users Guide (SUG). The SUG required updating with the Trust's Complaints Department contact details and those of the Patient Client Council (PCC). The manager agreed to revise the SUG, this document will be reviewed at the next care inspection.

There was a selection of policies available to direct staff in care delivery and support planning based on individual risk assessments. The complaints policy requires updating to include the contact details for the Trust's complaints department and the Patient Client Council (PCC) this policy will be reviewed at the next inspection. Staff confirmed they had access to policies.

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

There was evidence of monthly team leader meetings following which information was cascaded to support workers. The manager confirmed staff had opportunity to attend staff meetings at which they are provided with updates on policies and additional training requirements. Staff stated they could add to the meeting agenda if there were items they wished to discuss.

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

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 meets the needs of service users.

The manager confirmed that they were advised by the organisation's human resource department when all pre-employment checks, including criminal record checks (AccessNI), were completed and verified by the manager before staff members commenced employment and had direct engagement with service users. Confirmation of these checks was contained in each staff member's personnel file. Checks were made to ensure that staff were appropriately registered with NISCC or any other relevant regulatory body; there was a system in place for professional registrations to be monitored by the manager.

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to the 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 robust, structured, three-day induction programme, which also included shadowing of a more experienced staff member. Written records were retained by the agency of the person's capability and competency in relation to their job role.

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. Staff said they get an opportunity to discuss the post-registration training requirements during supervision and appraisal meetings.

Records of all staff training were available and there were mechanisms in place to support oversight of the training matrix to ensure compliance. It was evident a number of staff had not completed Mental Health training. This was discussed with the manager who agreed to arrange for staff to be booked onto mental health training at a level to meet the needs of service users. The manager confirmed they are liaising with the Learning and Development team to scope what additional training would be suitable for staff to complete.

There were systems in place to manage staffing. The manager provided information relating to the use of the organisation's online staff internal booking platform. This system allows staff from any Praxis service to book to work a vacant shift in any Praxis service. It was noted a relief member of staff had been booked at short notice prior to the agency completing checks in relation to their training and professional registration. The manager stated checks had been completed retrospectively. There was evidence of communication with the individual's line manager in relation to their practice. During the inspection, some gaps were evident in this individual's training record and there was no confirmation relating to their NISCC status. Confirmation of all training and NISCC registration was provided following the inspection. There were no policies or procedures available to guide staff in relation to the application of this booking system to ensure robust governance and oversight mechanisms were in place. An area for improvement has been identified in relation to the booking of staff from other Praxis services and the associated assurances being in place for managers in agencies receiving such staff.

There were no volunteers deployed within the agency.

3.3.3 Care Records

From reviewing service users' care records, it was good to note that service users had an input into devising their own plan of care. The service users' care plans contained details about their likes and dislikes and the level of support they may require. Care and support plans were kept under regular review. It was evident services users and /or their relatives participate in this

process, where appropriate, and a review of the care provided is completed on an annual basis, or when changes occur.

The manager reported that none of the service users currently required the use of specialised equipment. They were aware of how to source training in the use of such equipment should it be required in the future.

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. There was evidence that staff made referrals to the multi-disciplinary team and these interventions were proactive, timely and appropriate.

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). 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. 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 Trust in relation to adult safeguarding. A review of records confirmed that these had been managed appropriately.

RQIA must be notified by the agency of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI). The agency had not submitted a notification for one incident involving the PSNI. This was discussed with the manager and it was clarified with them that incidents were the agency have not directly contacted the PSNI must also be reported to RQIA. A notification was submitted retrospectively.

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 was subject to DoLS, but some restrictive practices were employed. There was a restrictive practices register in place, which was reviewed and kept up to date.

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	0

The areas for improvement and details of the Quality Improvement Plan were discussed with Hazel Campbell, 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 13 (b) and (d) **Stated:** First time **To be completed by:** Immediately from the date of the inspection	The Registered Person shall ensure that no domiciliary care worker is supplied by the agency unless- • they have the experience and skills necessary for the work that he is to perform; and • full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 3. This relates specifically to those staff booked through the organisation's internal booking platform, SONA. Currently this system does not provide the manager with access to all relevant staff information in advance of confirmation of the booking. Ref: 3.3.2
	Response by registered person detailing the actions taken: Following on from meeting with the RQIA inspector, a number of actions have been taken to address this QIP and provide organisational-wide assurance of processes in relation to e-rostering (SONA). The Head of Operations, Head of HR and Head of Quality & Governance met on 24-09-2025; -To review actions arising from the QIP in NDAMHSLS -To review exisiting organisational policies, procedures and processes -To propose changes to policies, procedures and processes that would better assure both the regulator and organisation where staff working in services, orriginally from other services, have the required skills, training, experience, police checks (access ni) and registration (NMC/NISCC) Amendmends to the exisiting duty rota management guidelines and HR recruitment were proposed and referred to the Operations Senior Management team for review and consideration in October 2025. Operations Senior Management team met on 07-10-2025; discussed the arising QIP, impact on other services using e-rosters and to agree process for assurance providing for registered managers. There is to be restrictions put onto the SONA app that precludes any staff picking up shifts in any service without first being 'added onto' a service by the Manager – subsequently they will have had

	to be checked for training, registration and induction commenced before being added to the app. This is to be added into our policy and procedure concerning duty rota management and our overall HR Recruitment policy and procedure. It will provide organisational direction of: -Any staff working or wishing to undertake shifts in other services must first have this agreed with the other Service Manager ---To clarify and hold record of the staff's training ---" " staff's NISCC registration ---" " staff's access NI -Where this occurs out of hours, the duty senior (team leader) from each service will confirm training, NISCC and access NI before a shift is taken up. -The next working day the Manager will review this and be assured that any staff working in their service they are responsible for meets the requirements needed. This was agreed at Operations Senior Management level and is being drafted into Policy amendmend for final sign off. Expected in November 2025.

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

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