The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Ards Community Supported Living Services (SLS)**

Provider: **Praxis Care**

Date of Inspection: **3 June 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:	Miss Justine Osbourne
Service Profile – This is a domiciliary care agency which provides personal care and housing support for up to 8 individuals living with learning disabilities and/or mental health problems residing in their own homes and rented accommodation. Services have been commissioned by The South Eastern Health and Social Care Trust (SEHSCT), The Belfast Health and Social Care Trust (BHSCT), and The Northern Health and Social Care Trust (NHSCT).	

2.0 Inspection summary

An unannounced inspection took place on 3 June 2025, between/from 9.00 am. to 2.00 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, restrictive practices and dysphagia management were also examined.

One area for improvement was identified in relation to training.

Good practice was identified in relation to service user involvement. There were good governance and management arrangements in place.

It was established that staff treated service users with dignity and respect, effective and compassionate care was delivered to service users receiving support from the agency and care records were person centred and provided evidence of service user involvement.

Ards Community Supported Living Services (SLS) 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 service 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 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 those living, working and visiting the home; and review/examine 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.

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

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

We contacted a range of service users, relatives and staff to seek their views of living within, visiting and working within agency. The overall response was positive with one comment in relation to the use of agency staff. This information was shared with the manager following the inspection.

Staff told us they enjoyed their job, that the manager was approachable. There were concerns expressed by staff in relation to the current staffing arrangements. This information was shared with the manager for consideration.

3.3 What has this service done to meet any areas for improvement identified at or since the last inspection?

The last care inspection of the agency was undertaken on 5 October 2023 by a care inspector. No areas for improvement were identified.

3.4 Inspection findings

3.4.1 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.

The manager had submitted an application to RQIA for registration as manager; this will be reviewed in due course.

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.

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.

Staff had managed incidents appropriately and reported to RQIA within appropriate timeframes in keeping with the regulations.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Staff demonstrated a good awareness of both the complaints procedure and whistleblowing policy. A register of complaints was retained by the service. Details relating to the complaints process were included in the statement of purpose and service users guide. There was evidence of a system to ensure oversight of complaints, this included a review of complaints during the monthly quality monitoring visits

The agency does not have service users' meetings on a regular basis, the manager was advised to consider commencing such meetings as they were a forum which enabled the service users to discuss the provisions of their care. A contemporaneous record of these meetings should be available for review. The service users availed of a variety of activities which included visiting family, going to the gym and cinema, bowling, mini golf, visiting peers and travel opportunities.

There was a selection of policies available to direct staff in care delivery and support planning based on individual risk assessments. Staff confirmed they had access to policies and that those relevant to individual service users would be reflected in their care plans.

Staff confirmed they had opportunity to attend staff meetings where they are provided with updates on policies and additional training requirements. They stated they could add to the meeting agenda if there were items they wished to discuss. Staff told us that they would have no issue in raising any concerns regarding service users' safety or care practices and that they were confident that the manager would address their concerns.

3.4.2 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 each day meets the needs of service users.

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to the Northern Ireland Social Care Council's (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.

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 NISCC or any other relevant regulatory body; there was a system in place for professional registrations to be monitored by the manager. Staff spoken with confirmed that they were aware of their responsibilities to keep their registrations up to date.

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 retained and the manager maintained oversight of the training matrix to ensure compliance. It was noted that three newly recruited staff had not completed some elements of their mandatory training. This included one staff member who had not completed medication training. The manager was advised they must not administer medications until the appropriate training and competency assessments had been completed. Two other staff had not completed adult safeguarding training, however dates had been secured for this training. The manager advised of difficulty accessing training for new staff in a timely manner. An area for improvement has been identified in relation to training. Following the inspection, the manager confirmed this staff member has now completed the appropriate training required to fulfil their role.

There were good systems in place to manage staffing. There were a number of staff vacancies, it was noted there were currently no team leaders. The lack of team leaders has the potential to impact on the manager's ability to fulfil their role and therefore should be kept under review. The manager stated that given the current staffing all shifts are covered by staff working additional hours and/or they themselves covering gaps in the rota on occasions. They confirmed there had been no negative impact on service users given the current staffing levels. Staff said there was good teamwork and that they felt well supported in their role. Staff were seen assisting service users in a caring and compassionate manner.

There were no volunteers deployed within the agency.

3.4.3 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 are kept under regular review and services users and /or their relatives participate, where appropriate, in the review of the care provided on an annual basis, or when changes occur.

The manager reported that none of the service user currently required the use of specialised equipment. They were aware of how to source such training 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.

3.4.4 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.

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

3.4.5 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, but some restrictive practices were in place. 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

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Justine Osbourne, 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 16 (2) (a) **Stated:** First time **To be completed by:** Immediate from the date of inspection	The Registered Person shall ensure all staff receive training which is appropriate to the work they are to perform. This relates to ensuring staff have completed administration of medicine training prior to performing this duty. Ref: 3.4.2
	Response by registered person detailing the actions taken: Staff member completed care of medicaiton 12/06/2025. Certificate provided on 12/06/2025 for record. Staff member completed x3 medication competencies on 16/06/2025, 17/06/2025 and 18/06/2025.

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