The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Coleraine and Magherafelt Supported Living Services

Provider: Praxis Care

Date of Inspection: 19 November 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:	Mrs Leanne McIlvenny

Service Profile: This is a domiciliary care agency supported living type located across the Coleraine and Magherafelt areas. The agency's registered office is based in Magherafelt.

The service users care and support is commissioned by the Northern Health and Social Care Trust (NHSCT). At the time of the inspection there were 24 individuals in receipt of a service.

This organisation also provides floating support, an older peoples floating support; and a befriending service to service users who live in the community. RQIA does not regulate these elements of support.

2.0 Inspection summary

An unannounced inspection took place on 10 November 2025, between 9.45 am and 4.45 pm by a care Inspector.

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 9 December 2024; 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. Improvements were required, however, to ensure the effectiveness and oversight of certain aspects of the agency, such as the care plans and the recruitment policy.

Service users said that the care and support provided by Coleraine and Magherafelt Supported Living Services was a good experience.

As a result of this inspection the area for improvement previously identified was assessed as having been addressed by the provider. 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.

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 Quality Improvement Plan issued, 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/examine a sample of records to evidence how the agency is performing in relation to the regulations and standards.

3.2 What people told us about the service

Through active listening, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

Service users told us that everything was great. One respondent described the service provided as being 'excellent' and described how they can access help when needed. They said that there is always someone is nearly always available to see them promptly and that it makes a huge difference to them. Another respondent said that the staff listen to any problems they may have.

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 no evidence that the staffing levels were not sufficient to meet the needs of the service users. A staffing contingency plan was in place to manage any staffing shortages.

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

Whilst there was evidence of two references in place in the records reviewed, improvements were required in relation to the management of references where applicants may have been self-employed before applying to work in the organisation. An area for improvement has been identified.

Checks were made to ensure that staff were appropriately registered with Northern Ireland Social Care Council (NISCC) or any other relevant regulatory body; there was a system in place for professional registrations to be monitored by the manager.

There was a robust, structured, induction programme which also included shadowing of a more experienced staff member.

Records of all staff training were available and there were mechanisms in place to support oversight of the training matrix to ensure compliance. The training matrix did not include training provided in relation to Mental Health awareness. This was discussed with the person in charge who agreed to liaise with the Learning and Development team ensure that this training is mandatory for all staff and added to the training matrix going forward. It is also recommended that the staff undertake training in relation to Positive Behaviour Support. This will be reviewed at a future inspection.

Competency assessments were undertaken on all staff to ensure that they were competent to be in charge in the absence of the registered manager.

Procedures were in place for appraising staff performance and all staff received regular supervision.

3.3.2 Care Delivery and care records

There was a daily handover at the beginning of each shift, which included information about any changes to the service users' care, which the staff needed to assist them in their roles.

Regular staff meetings were held and minutes maintained of the meetings for staff, unable to attend, to read for information sharing.

There was a timetable of services in place which detailed the type and duration of support each service user needed. Additionally, service users were encouraged to attend group activities such as walking groups, games night, gardening group, quizzes and going for a bite to eat.

Service user meeting were held on a regular basis. This forum was used to provide information and encouragement to service users to avail of resources such as the Recovery College, stress control, cognitive behaviour therapy; and strength and balance classes. The meetings also included matters such as the complaints procedure, winter readiness, scam awareness and tips to becoming healthier.

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.

Promoting Quality Care (PQC) is regional guidance on the assessment and management of risk in mental health and learning disability services. A core function of mental health and learning disability services is to assess the treatment and care needs of people presenting to them. An integral part of such an assessment is the consideration of risks posed by some people with a mental disorder to either themselves or others. Understanding the level of risk that a service user may present forms part of the service users' overall assessment, nevertheless it is an integral part of formulating an appropriate care package.

Where service users were under PQC, a Comprehensive Risk and Management Plan was in place. It was noted, however, that multidisciplinary reviews of the PQC had not been undertaken on a six monthly basis, in keeping with good practice guidance. Whilst it is the responsibility of the Trust to ensure that multidisciplinary reviews are undertaken on a six monthly basis, advice was given in relation to more joined up working to ensure that no risks are missed.

Care records were not sufficiently detailed to inform staff as to what they needed to do in certain situations. For example, there was insufficient detail included regarding what staff should do if a service user was not contactable. In one instance, this led to a delay in the Police Service of Northern Ireland (PSNI) being notified in a timely manner, when a service user was not contactable. Where service users were under Promoting Quality Care (PQC), this was not sufficiently clear within the care plan. The care plans also did not sufficiently detail the support required where a service user may have been experiencing thoughts of self-harm. Additionally, the care plans did not detail the type or length of call each service user required. An area for improvement has been identified.

Advice was given in relation to centrally recording any cancelled or non-attended Out Patient Appointments, in each service users care record. This would enable any patterns or trends to be identified in a timely manner.

Service user agreements were in place in the records reviewed.

It was evident that the service users had been included in the development of their care plans. The care plans were retained in the registered office. It was explained that the service users had declined to have the care plans retained in their own homes and that where this occurs, a note is made of same. Advice was given in relation to ensuring that a blanket approach is not adopted in this regard. This will be reviewed at a future inspection.

Staff recorded regular evaluations about the care and support provided. A review of a sample of these records evidenced that they were legible, up to date and signed by the person making the entry. These notes were retained in both the Coleraine and Magherafelt offices.

Following the inspection, the operation of the Coleraine office was discussed with a member of the senior management team. Assurances were provided that the Coleraine office would not be used as a fully functioning office and that all records would be retained within the Magherafelt office; and that care and support would also be coordinated out of the Magherafelt office, going forward.

There was a procedure in place for the use of restrictive interventions. Advice was given in relation to maintaining a restrictive practice register, which should improve manager oversight and regular review of any restrictions. This will be reviewed at a future inspection.

3.3.3 Quality of Management Systems

There has been no change in the management of the agency since the last inspection. Mrs Leanne McIlvenny has been the manager in this agency since 26 November 2009.

Review of a sample of records evidenced that a robust system for reviewing the quality of care and staff practices was in place.

Complaints and incidents were managed appropriately and it was good to note that the electronic records management system used to record both of these, automatically categorised the information, to enable any patterns/trends to be identified immediately. It was good to note that these were reviewed in detail as part of the monthly quality monitoring process. Trust' representatives had been informed in a timely manner.

The annual quality report was reviewed and noted to include stakeholder feedback.

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. A specific individual was identified as the agency's ASC. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm. Review of staff meeting minutes evidenced that safeguarding matters were included as a standing item for discussion at each meeting. This gave the staff the opportunity to discuss different safeguarding scenarios.

The annual safeguarding position report had been completed. Given that this document was developed for the whole Praxis organisation, advice was again given in relation to appending a service-specific table to the report.

There was evidence that the agency responded to any concerns, raised with them or by their processes, and took measures to improve practice and/or the quality of services provided by the agency, as necessary.

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	1	1

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 Regulations (Northern Ireland) 2007	
Area for improvement 1 **Ref:** Regulation 15 (2)(a)(b) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that care plans are person centred and detailed; this relates particularly to but is not limited to, what staff should do if a service user is not contactable; the type/length of call each service user requires; details of the supports required where a service user may be at risk of self-harming; and more detail regarding any service user who may be under Promoting Quality Care (PQC). Ref: 3.3.2
	Response by registered person detailing the actions taken: Undertake a review and update everyday living plans within the service to ensure that all relevant details are included such as, details regarding support times and location of support, the steps staff will take should an individual not be present for support, details regarding those managed under Promoting Quality Care. Ensure that clear communication and direction is provided to the staff team to ensure that everyday living plans are not read in isolation, with reference to Risk assessment and management plans, support agreements and any 3rd party documents as supplementary interventions.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 11 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the policy and procedure relating to recruitment is further developed to ensure that adequately addresses references for applicants who are self-employed. Ref: 3.3.1
	Response by registered person detailing the actions taken: The recruitment policy has been amended with additions to include that in the case the proof of self employment is not obtained from HMRC/Accountant, that a third reference will be required from a professional, such as GP, accountant, teacher, clergy, in relation to those individuals coming from a self employed background. This addition will be reviewed by the director of human resources before being circulated to the organization.

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

The Regulation and Quality Improvement Authority

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