

Inspection Report

Name of Service: Praxis – Newry Bespoke Supported Living

Provider: Praxis Care

Date of Inspection: 15 April 2026

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:	Ms. Grainne Close
Registered Manager:	Mrs. Katherine Cunningham
Service Profile – Praxis – Newry Bespoke Supported Living is a domiciliary care agency, supported living type service, based in Newry. Services are commissioned by the Southern Health and Social Care (HSC) Trust and the South Eastern HSC Trust. Under the direction of the Manager, staff are available to support service users with tasks of everyday living with the overall goal of promoting health and maximising quality of life.	

2.0 Inspection summary

An unannounced inspection was undertaken on 15 April 2026 between 11.05 a.m. and 3.25 p.m. This was conducted by care Inspector.

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 reviewed.

The inspection established that care was delivered in a safe, effective and compassionate manner, and that staff promoted the dignity and well-being of service users. There was evidence that staff were knowledgeable about the needs of service users and well trained to meet these needs. Good practice was identified in relation to service user involvement. There were good governance and management arrangements in place.

Praxis – Newry Bespoke Supported Living 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.

RQIA also aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

To prepare for this inspection we reviewed information held by RQIA about this agency. This included the previous area for improvement 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 will seek the views of those using, working in and visiting the agency and will examine a sample of records to evidence how the service 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 survey.

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

During the inspection we spoke with a service user and a member of staff.

The information provided indicated that there were no concerns in relation to the service. The service user described a positive relationship with staff and reported a high level of satisfaction with the level and quality of support offered, especially in regard to attending events and participating in activities. The staff member spoke confidently about all aspects of the care and support delivered to service users and demonstrated familiarity with the care needs of service users and how these needs were met by staff. There was no staff feedback received from the electronic survey.

A number of service users responded to the questionnaire. The respondents indicated that the staff were kind, thoughtful and caring, that staff helped them feel safe, gave them all the help they needed, and that the support was as good as they wanted it to be.

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 21 January 2025 by a care inspector. A Quality Improvement Plan (QIP) was issued which contained one area for improvement. The area for improvement was reviewed and approved by the care inspector during this inspection.

3.4 Inspection findings

3.4.1 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 skills of staff on duty 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) and obtaining suitable references, 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), the Nursing and Midwifery Council (NMC) or any other relevant regulatory body. For those new to working in social care, support was provided to assist such staff to become registered within acceptable timescales. There was a system in place for the status of 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.

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 corporate induction for all staff, followed by a local, structured, three-day induction programme which also included shadowing of a more experienced staff member. Staff were supported during the probationary period by monthly supervision meetings with their line manager.

The agency ensured all staff completed a number of training modules which were considered mandatory, and had maintained a detailed record for each member of staff of all training, including induction and professional development activities undertaken. This included the names and signatures of those attending the training event, the date of the training, and the content of the training programme.

All staff were provided with regular supervision and an annual appraisal, designed to promote the delivery of quality care and services and to support staff in their professional development.

There was a staff rota, which was planned in advance, to ensure sufficient staff were available to meet the needs of service users. Where staff members were required to assume responsibilities in the absence of the Manager, the agency retained written records of the person's competency and capability in relation to their job role.

There was an on-call system whereby staff could contact senior colleagues outside normal business hours in order to obtain guidance or to escalate concerns, if necessary.

The organisation had, as a further support for staff, suitable Whistleblowing arrangements in place to enable them to raise any concerns regarding poor practice. Staff had access at all times to the organisation's electronic policies and procedures available via work mobile phone or at the agency's office.

3.4.2 The systems in place for identifying and addressing risks

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 and a member of staff 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. 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 had been notified of any incidents that had been reported to the Police Service of Northern Ireland (PSNI) in keeping with the regulations. Incidents had been managed appropriately.

Staff reported that none of the service users currently required the use of specialised equipment. There was evidence that where a service user's mobility had decreased, the agency had liaised with appropriate community professionals for the provision of mobility aids, and written records of all contacts were maintained.

Staff had been provided with training in relation to medicines management. Service users' medications were subject to regular review and the system for managing medications was audited monthly.

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 Mental Capacity Act (MCA).

Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. Staff reported that, as all of the service users retained mental capacity, none were subject to DoLS. Where service users needed a degree of support to take medications, any arrangements deemed to be restrictive were well documented, with agreements in place signed by the service user and subject to regular review.

Where staff might be unable to gain access to a service user's home, the agency had an operational protocol that clearly directed staff as to what actions were required to manage and report such situations in a timely manner.

3.4.3 The arrangements for care delivery and promoting service user involvement

The availability of accurate and up to date information, giving holistic detail of the abilities, needs and risks associated with each individual service user, is crucial to the delivery of good care.

The agency had received referral information about each service user from the relevant commissioning HSC Trust, and careful consideration was given by the agency as to whether each service user could be provided with the necessary level of care and support.

Service users were provided with information about the services offered by the agency and each individual had the option to consent to aspects of their information being shared with relevant parties.

There were comprehensive care assessments in place, along with identification of any risks and consideration of how these could be best minimised or managed. Care records were found to be person-centred and written in language which was respectful of the individual. Service users were consulted about how they wished their support to be provided, and details of the care plan were shared with the service user who signed their agreement that the information held about them was accurate.

The care and support needs of service users were monitored regularly, with any changes reflected within care plans, and any updates were shared with service users. Care reviews were undertaken in keeping with the agency's policies and procedures, and service users were encouraged to sign that the review minutes had been shared with them.

There was also evidence of regular contact with service users and their representatives (where appropriate), in line with the commissioning Trust's requirements; this took the form of visits by the Manager and team leaders to service users' homes.

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.

Where a service user experienced difficulty with any aspect of daily living, there was evidence that staff made timely and appropriate referral to the relevant professional service, for example, to the Speech and Language Therapist (SALT) for swallowing assessment and prevention of choking. In the event that the SALT made specific recommendations regarding the consistency of food and fluids, staff ensured these were implemented, thus supporting safe and effective care.

In discussion with staff, it was evident that there were good systems of communication to support care delivery. Staff were provided with the most up to date information by means of daily handovers, with information being confirmed by email, as necessary. Staff were also kept updated via monthly staff meetings.

3.4.4 The arrangements for ensuring robust managerial oversight and governance

The agency's Statement of Purpose and the Service User Guide had been updated when necessary.

There were monitoring arrangements in place in compliance with regulations and standards to ensure a quality service was provided. The Manager conducted regular visits to the homes of service users to ensure care needs were met, that any maintenance issues were addressed, and that service users were satisfied with the support offered. The Manager also completed a regular audit of all operational areas to further support the delivery of a quality service.

There was a system in place to ensure that any complaints were managed in accordance with the agency's policy and procedure.

There were monitoring visits completed by the organisation's Head of Operations on a monthly basis, with a report prepared. The reports included engagement with service users, service users' relatives (where necessary), staff and HSC Trust representatives, along with a review of service user care records; accident/incidents; safeguarding matters; staff recruitment and training, complaints and compliments and staffing arrangements. The report, which identified any necessary improvements, was shared with the Manager to ensure outstanding actions could be addressed.

The organisation also produced an Annual Quality Report in which the overall quality of the services provided by the agency was evaluated.

No new incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure, and there was evidence that the recommendations made as a result of a previous SAI had been embedded into practice.

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

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Katherine Cunningham, Manager, as part of the inspection process and can be found in the main body of the report.



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