

# Inspection Report

**Name of Service:** Locke House

**Provider:** Praxis Care

**Date of Inspection:** 13 January 2025

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

## 1.0 Service information

<b>Organisation/Registered Provider:</b>	Praxis Care
<b>Responsible Individual/Responsible Person:</b>	Mr Greer Wilson
<b>Registered Manager:</b>	Mrs Nicola Cloughan (Acting)
<p><b>Service Profile:</b>            Praxis Care Group is a supported living type domiciliary care agency located in Locke House, Portadown. The agency's aim is to provide care and support to meet the needs of service users who live in individual flats, and a group setting. Under the direction of the manager, staff are available to support service users 24 hours per day 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.</p> <p>This organisation also provides community outreach, floating support and day opportunities to service users who live in the community. RQIA does not regulate these elements of support.</p>	

## 2.0 Inspection summary

An unannounced inspection took place on 13 January 2025, between 9.00 a.m. and 1.00 p.m. The inspection was carried out by a 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 inspection also examined the reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS), service user involvement, restrictive practices and Dysphagia management.

The inspection also examined an existing Quality Improvement Plan (QIP) and this was signed off as completed during the inspection.

There were no areas for improvement noted during this inspection.

Good practice was identified in relation to service user and relatives' feedback, staff training and staff induction. There were good governance and management arrangements in place.

### 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 Locke House 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 Locke House. This included any previous areas for improvement issued, registration information, and any other written or verbal information available at the time of inspection.

Throughout the inspection process inspectors will seek the views of those living and working in and visiting the service and review 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

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

The information provided indicated that there were no concerns in relation to the service.

Comments from service users included:

- "I like it a lot here."
- "I find the staff to be very supportive."
- "They help me a lot."

Comments from the relatives of service users included:

- "I'm very happy with the care."
- "[my relative] finds the one to one sessions very beneficial."
- "Locke House staff always keep me informed."
- "Staff are lovely. [My relative] loves the one to ones."

Comments from staff included:

- "I'm very happy here."
- "The manager is great."

- “Training and induction is good.”
- “Team spirit is good.”
- “The manager is very approachable.”
- “I am confident in action if a safeguarding issue is reported.”

A number of staff and visiting professionals 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. Written comments included:

- “This supported living placement has been an important part to allow my service user to live in a community setting. The service user has his own flat within the agency and receives daily support from the staff to assist him take his medication. The support has been able to be increased during times of need and is reviewed regularly. The communication between myself and the staff has been good. I have always been able to contact a member of staff over the phone and staff have been able to reach out to me with any concerns.”
- “I can say by way of feedback that I’ve always found staff to be very helpful, professional and ethical in their dealings with any of their residents that I’ve key worked.”
- “I must say that, in general, praxis staff are very good at emailing me any concerns relating to my service users and are responsive at implementing changes to support plans, where necessary.”

### 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 7 November 2023 by a care inspector. A Quality Improvement Plan (QIP) was issued. This was approved by the care inspector and was validated during this inspection.

Areas for improvement from the last inspection on 7 November 2024		
Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007		Validation of compliance
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 15 (3) (a)(b)(c)(d)  <b>Stated:</b> First  <b>To be completed by:</b> Immediately from the date of inspection	The registered person shall ensure that service user’s care records are completed accurately and consistently at all times. These care records should also contain service user and / or staff signatures as needed.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> The inspector reviewed a selection of service user files and confirmed that service user/staff signatures were present.	

<b>Area for improvement 2</b>  <b>Ref:</b> Regulation 13 (d) Schedule 3  <b>Stated:</b> First time  <b>To be completed by:</b> Immediately from the date of inspection	<p>The registered person shall ensure that no domiciliary care worker is supplied by the agency unless full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 3.</p> <p><b>Action taken as confirmed during the inspection:</b> New interview assessment form reviewed by inspector which includes prompts about gaps in employment and reasons for leaving.</p>	<b>Met</b>
<b>Area for improvement 3</b>  <b>Ref:</b> Regulation 16 (5)(a)  <b>Stated:</b> First time  <b>To be completed by:</b> Immediately from the date of inspection	<p>The registered person shall ensure that each domiciliary care worker is provided with appropriately structured induction training lasting a minimum of three full working days.</p> <p><b>Action taken as confirmed during the inspection:</b> There is a new induction record which adheres to NISCC guidance of three days duration.</p>	

## 4.0 Inspection Findings

### 4.1 What are the operational management systems and arrangements in place that support and promote the delivery of quality care services?

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).

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.

Locke House 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. Service users reported that 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.

RQIA had been notified appropriately 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.

## **4.2 Governance and Managerial Oversight**

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 since the last inspection that required investigation under the Serious Adverse Incidents (SAI) procedure.

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.

## **4.3 What systems are in place for staff recruitment and are they robust?**

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 any other relevant regulatory body; there was a system in place for professional registrations to be monitored monthly 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 robust, structured six-month induction programme, which also included shadowing of a more experienced staff member. Written records in the form of an



induction booklet were retained by the agency of the person's capability and competency in relation to their job role.

Staff training was examined; the inspector was assured that the agency had a training and development plan in place which highlighted a number of areas that are mandatory. The agency has maintained a training matrix to record all training, including induction and professional development activities undertaken; this included staff that were supplied by recruitment agencies. Competency assessments regarding medication administration and being left in charge were completed and signed off appropriately.

#### **4.4 What systems are in place for ensuring service users' care needs are met?**

From reviewing service users' care records and through discussions with service users, it was good to note that service users had an input into devising their own plan of care. Service users were provided with reports which support them to fully participate in all aspects of their care. The service users' care plans contained details about their likes and dislikes and the level of support they may require. A weekly programme of activities was available and service users were able to choose the activities in which they wished to participate. Care and support plans are kept under regular review and service 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 users currently required the use of specialised moving and handling equipment. Staff were aware of how to source training in the use of specialised equipment, should it be required in the future.

The Manager advised that there were no service users with Dysphagia care needs. All staff had, however, completed training in this area.

It was also good to note that the agency had service users' meetings on a monthly basis which enabled the service users to discuss the various activities available. There was also extensive support available from local companies which was coordinated by a corporate support volunteer. The Manager confirmed that this individual did not undertake any personal care duties and that AccessNI checks had been completed. The Manager also confirmed the existence of a policy and procedure for volunteers which clearly specified their role and responsibilities.

There was a system in place for notifying RQIA if the agency was managing individual service users' monies in accordance with the guidance. The Manager confirmed that the agency was currently not managing the finances of any service user.

Care reviews had been undertaken in keeping with the agency's policies and procedures, though the Manager reported that there were few service users who have designated community named workers. There was evidence of regular contact with service users and their representatives, in line with the commissioning trust's requirements.

All staff had been provided with training in relation to medicines management. A review of the policy relating to medicines management identified that it included direction for staff in relation to administering liquid medicines. The Manager advised that no service users required their medicine to be administered with a syringe. The Manager was aware that, should this be required, a competency assessment would be undertaken before staff would complete this task.

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 Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The Manager reported that none of the service users were subject to DoLS. A resource folder was available for staff to reference if required.

Staff supervision and appraisal arrangements were examined and the agency's policy set out the frequency of supervision in conjunction with NISCC guidelines. Arrangements were in place to help ensure that staff appraisals would occur annually.

Where staff are unable to gain access to service users flats, the Manager confirmed the existence of an operational policy and procedure which clearly directs staff from the agency as to what actions they should take to manage and report such situations in a timely manner. Authorisation of access forms had been signed by service users to be used in the event of an emergency.

## **5.0 Quality Improvement Plan/Areas for Improvement**

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





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Authority

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