The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **The Croft**

Provider: **Praxis Care**

Date of Inspection: **3 December 2025**

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

1.0 Service information

Organisation:	Praxis Care
Responsible Individual:	Mr. Greer Wilson
Registered Manager:	Mrs. Gail Kirkland
Service Profile – The Croft is a domiciliary care agency, supported living type, which provides support, care and accommodation for up to 28 people, usually over the age of 65 years, who have a diagnosis of dementia and who require support to live in the community as independently as possible. Praxis Care manages the service, which is a partnership with Choice Housing, while the Northern Health and Social Care Trust (NHSCT) is the commissioner.	

2.0 Inspection summary

An unannounced inspection took place on 3 December 2025, between 9.00 am and 1.00 pm. A care Inspector carried out the inspection.

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.

The Inspector identified good practice in relation to care planning; training and feedback from staff, service users and relatives. There were good governance and management arrangements in place.

The Croft uses the term 'tenants' 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.

The Inspector identified no Areas for Improvement during this inspection.

3.0 The inspection

3.1 How we inspect

A care Inspector completed the last care inspection of The Croft on 19 March 2024. No areas for improvement were identified.

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how The Croft 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 any previous areas for improvement issued, registration information, and any other written or verbal information received from relatives, staff or the commissioning trust.

Throughout the inspection, the Inspector will seek the views of those working in the agency, as well as those of relatives and visiting professionals. The Inspector will also review a sample of records to evidence how the agency is performing in relation to the regulations and standards.

The Inspector provided information to 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, staff, as well as visiting professionals, for their opinions on the quality of the care and support provided by the agency, as well as their experiences of visiting or working in the agency.

Respondents spoken to by the Inspector gave positive feedback.

One service user commented that 'I love it here. They look after me so well'. Another stated that 'the staff are fabulous'.

Staff reported that they enjoyed working in the agency and that the manager was very good. One stated that 'the training is intense but far better than not enough'. Another commented that she feels well supported and confident in safeguarding issues'.

Family of the service users also gave positive reviews of the agency. One stated that 'the staff are great to [my relative]. I'm very happy'. Another commented that 'it has been a great relief to have [my relative] safe and well cared for'.

A visiting professional commented that 'The Croft is a fantastic community service that our dementia community teams avail of. The staff have good knowledge & understanding of dementia, and their daily practice with residents is above standard – very person-centred. The

environment feels like 'home' as opposed to a care-facility. Staff promote this environment by being part of, and involved in, the residents' daily living'.

Returned questionnaires indicated that the service users were happy with the care they received in The Croft and were complimentary towards staff.

4.0 Inspection findings

4.1 What are the systems in place for identifying and addressing risks?

The Inspector reviewed the agency's provision for the welfare, care and protection of service users. The organisation's policy and procedures reflected information contained within the Department of Health's (DoH) regional policy 'Adult Safeguarding Prevention and Protection in Partnership' July 2015 and clearly outlined the procedure for staff in reporting concerns. There was an identified Adult Safeguarding Champion (ASC).

Discussions with the manager established that she was knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting and managing adult safeguarding concerns.

The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. The inspector discussed these with the manager and confirmed that the agency had managed these appropriately.

The manager was aware that she must inform RQIA of any safeguarding incident concerning a service user that is reported to the Police Service of Northern Ireland (PSNI).

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. 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.

Service users said 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 they received. The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any concerns.

The agency provided staff with training appropriate to the requirements of their role. The manager advised that no current service users required assistance with moving and handling. A review of care records identified that risk assessments and care plans were up to date. A review of the policy pertaining to moving and handling training and incident reporting identified that there was a clear procedure for staff to follow in the event of deterioration in a service user's ability to weight bear.

Agency staff had undertaken care reviews in keeping with the agency's policies and procedures.

All staff, including bank and agency staff, had received training in relation to medicines management. The organisation has recently introduced a new system for training in medication management. The manager rechecks medication competency after any medication error. The manager advised that no service users require the administration of oral medication via syringe. 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 staff assist only when required to do so. 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. The manager reported that one service user is subject to DoLS. A resource folder is available for staff to reference if needed. Restrictive practices are in place for a number of service users. These are mostly environmental in nature. The Inspector confirmed that these are recorded in service users' care plans and are subject to regular review.

The Inspector viewed the agency's fire risk assessment and found this to be within date. A fire drill is scheduled for 16 December 2025.

4.2 What are the systems in place for the promotion of service user involvement?

From reviewing service users' care records and through discussions with the manager and service users, the Inspector noted that service users had an input into devising their own plan of care where possible. Service users' care plans contained details about their likes and dislikes and the level of support they may require. The agency keeps care and support plans under regular review and services users and /or their relatives participate, where appropriate, in the review of the care by both the agency and the commissioning trust.

It was also good to note that the agency had service users' meetings on a regular basis, which enabled the service users to discuss the provisions of their care. The Inspector viewed evidence of an extensive activities list for service users.

The inspector reviewed the annual quality report and this demonstrated evidence of service user consultation. It was good to note that the agency provided a wide range of activities focused on the needs of the service users and which evidenced extensive partnership with the local community.

4.3 What are the systems in place for meeting the Dysphagia needs of service users?

The manager reported that several service users require a modified diet. The Inspector confirmed that these requirements formed part of individual care plans and matched the professional assessments. The manager confirmed that all staff had received training in Dysphagia and were aware of action required in the event of a service user choking.

4.4 What systems are in place for recruitment and are they robust?

The Inspector reviewed the agency's staff recruitment records and 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. The manager confirmed that the agency had a monthly process in place to check that staff held appropriate registration with the Northern Ireland Social Care Council (NISCC). The Inspector spoke with staff who confirmed that they were aware of their responsibilities to keep their registrations up to date by the completion of Post Registration Training and Learning.

4.5 What arrangements are in place for staff induction and training?

The Inspector confirmed that all newly appointed staff completed a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care. This ensured that staff were competent to carry out the duties of their job in line with the agency's policies and procedures. There was a formal induction programme of at least three days, which included shadowing of a more experienced staff member. The agency retained records of the staff member's capability and competency in relation to their job role.

The agency has maintained a record for each member of staff of all training, including induction and professional development activities undertaken; the agency does use agency staff and these staff can avail of specific training such as medication competency, which they cannot obtain through their agency. The inspector reviewed the training matrix maintained by the agency and found all the majority of training to be up to date. The manager has completed CLEAR dementia training and all staff are encouraged to download the CLEAR app.

4.6 What are the arrangements to ensure robust managerial oversight and guidance?

The Inspector confirmed that there were monthly monitoring arrangements in place in compliance with regulations. A review of the reports of the agency's monthly 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 the care records of service users; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

The Annual Quality report reviewed by the inspector and was satisfactory.

The person in charge confirmed that no incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure.

The agency's registration certificate was up to date and displayed appropriately, along with the insurance, which was within date and provided the correct level of cover.

There was a system in place to ensure that the agency managed complaints in accordance with the policy and procedure of the agency. Where the agency had received complaints, the inspector found that the agency had managed these appropriately. The Inspector confirmed that the agency reviewed complaints as part of the monthly quality monitoring process.

The Inspector reviewed records of regular staff supervision as well as annual appraisals. This confirmed that the agency carried out these regularly as per the policies and procedures of the agency.

5.0 Quality Improvement Plan/Areas for Improvement

The Inspector did not identify any areas for improvement during this inspection. The inspector discussed the findings of the inspection with Mrs. Gail Kirkland (Manager) as part of the inspection process. These can be found in the main body of the report.

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