The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Portadown Bespoke Services**

Provider: **Praxis Care**

Date of Inspection: **16 October 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 Niamh Fleming
Service Profile: Portadown Bespoke Service is a domiciliary care agency, supported living type. It provides 24 hour care and support to service users who have a range of complex needs who reside in accommodation in a number of houses situated in the Portadown area.	

2.0 Inspection summary

An unannounced inspection took place on 16 October 2025 between 10.30 am and 4.20 pm by a care Inspector.

The last care inspection of the agency was undertaken on 28 November 2024 by a care inspector. No areas for improvement were identified. This care inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; and to determine if the service is delivering safe, effective and compassionate care and if the service 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.

This inspection established that care delivery was safe and that effective and compassionate care was delivered to service users. There were no areas for improvement identified as a result of this inspection. Further details of the findings of this inspection are outlined in the main body of the report.

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.

To prepare for this inspection we reviewed information held by RQIA about this agency. This included any previous area for improvement issued, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning Trust.

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

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

We spoke with service users, relatives and staff to seek their views of living, visiting and working within Portadown Bespoke Service.

Service users we spoke with indicated that they were satisfied with the care and support provided by the staff in the agency.

One relative who spoke with the inspector indicated that they were satisfied with the care provided to their loved one and that they were good at responding to any concerns raised.

Staff who spoke with the inspector spoke very positively about the approachability and support of the manager and said that the care provided to service users was safe, effective and compassionate. Staff felt that the service was well-led, that there was good teamwork and that the training was useful.

A number of staff responded to the electronic survey and highlighted high levels of satisfaction regarding the manager and quality of care provided to service users.

4.0 Inspection findings

4.1 Staff Recruitment, Induction and Training Arrangements

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.

Review of a sample of the most recently appointed staff, evidenced that staff had completed a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care. There was a robust, structured, induction programme which included shadowing of a more experienced staff member. This was reviewed periodically and signed off to ensure competence in carrying out the duties of their job in line with the agency's policies and procedures.

The agency maintained an electronic record of all staff training; however a review of this record, indicated that a number of the more recently recruited staff required mandatory training in areas such as Adult Safeguarding, Manual handling, DoLS, Medicines Management, Basic Life Support and Dysphagia. The manager explained that the matrix had not been updated to reflect that some staff had completed this training and confirmed after the inspection that all identified staff have either completed this training or are booked on to the next available date. This will be reviewed at a future inspection. Staff confirmed that they were provided with opportunities to complete training commensurate with their role and that they found the training was good.

All staff had been provided with training in relation to medicines management. Competency assessments were undertaken with staff to ensure that they were proficient in administration of medications. It was positive to note that three competency assessments are undertaken with staff before they are deemed competent in this task. Training is refreshed annually thereafter. From reviewing medication errors which occurred since the last inspection, it was noted that one medication error investigation report was not fully complete with a record of the actions taken and timescales set in respect of a medication under dose. This was discussed with the manager who acknowledged the oversight within the medication error investigation report however they were able to evidence that the staff member received further training and completed a reflective account as per the policy. The manager agreed to ensure that all aspects of the medication error reports are completed with clear timescales set for action and review. This will be reviewed at a future inspection.

4.2 What are 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) who has responsibility for implementing the regional protocol and the agency's adult safeguarding policy.

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 responsibilities 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.

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. The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. A review of safeguarding records evidenced that these were 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). It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm. The annual safeguarding position report had been completed.

The agency's governance arrangements for the management of accidents/incidents was examined and confirmed that an incident/accident reporting policy and system was in place. A review of the accident/incident records confirmed that these were managed appropriately. 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. There was evidence that incidents were audited on a regular basis, to establish any patterns/trends. It was good to note that these were reviewed in detail as part of the monthly quality monitoring process.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

4.3 Mental Capacity Act / Deprivation of Liberty Safeguards (DoLS) and Restrictive Practice

The Mental Capacity Act (Northern Ireland) 2016 (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.

There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had had their capacity considered and, where appropriate, assessed. The manager confirmed that no service users were subject to DoLS.

There was a policy in place for the use of restrictive interventions and any restrictive practices applied such as locked doors or medication boxes were documented in a restrictive practice register which is reviewed regularly alongside the support plan, care review and includes multidisciplinary input for the safety and well-being of the individual.

4.4 Management of Care Records and Care delivery

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.

Care records were person centred, regularly reviewed and updated to ensure they continued to meet the service users' needs. The service users' care plans contained details about their likes and dislikes and the level of support they may require. There was evidence of regular contact with service users and their representatives, in line with the commissioning trust's requirements.

There was a daily handover at the beginning of each shift and staff recorded regular evaluations about the care and support provided. This included information about any changes to the service users' care needs so that staff could assist them as needed accordingly.

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.

4.7 Managerial oversight and Governance

There has been no change in the management of the service since the last inspection. Staff commented positively about the manager and described them as supportive, approachable and able to provide guidance. Staff told us that they would have no issue in raising any concerns regarding service users' safety or care practices. Both staff and a service user representative indicated that they were confident that the manager would respond as needed to address their concerns.

Procedures were in place for appraising staff performance and staff told us they felt supported and involved in discussions about their personal development. Records evidenced staff appraisals had been completed on an annual basis.

The agency was visited each month by a representative of the registered provider to consult with service users, their relatives and staff and to examine all areas of the running of the service. Review of a sample of records evidenced that a robust system for reviewing the quality of care and staff practices was in place.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. Any complaints received since the last inspection had been managed appropriately. 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.

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 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 Ms Niamh Fleming, Manager, as part of the inspection process and can be found in the main body of the report.

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