The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Locke House**

Provider: **Praxis Care**

Date of Inspection: **5 February 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/Responsible Person:	Mrs Rosemary Doherty (Application pending)
Registered Manager:	Ms Elisha Mulholland (Acting)
Service Profile – 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. 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.	

2.0 Inspection summary

An unannounced inspection took place on 5 February 2026, between 9.45 am and 3.20pm by a care Inspector.

The last care inspection of the service was undertaken on 13 January 2025 by a care inspector. No areas for improvement were identified. This inspection was undertaken to evidence how the service is performing in relation to the regulations and standards; and to determine if it 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 and service user involvement. The reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS) and restrictive practices were also examined.

This inspection established that care delivery was safe and that effective and compassionate care was delivered to service users.

No areas for improvement were identified during this inspection. The findings of this inspection can be found 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 service 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 received from service users, relatives, staff or the commissioning Health and Social Care Trust.

Throughout the inspection process inspectors will seek the views of those living, working and visiting the service; and review/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 service provision. This included questionnaires and an electronic survey.

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

We spoke to a service user, relatives, staff and HSC professionals to seek their views of the service. The information provided indicated that the staff were very caring and attentive to service user's needs and that the care and support provided was of a good standard.

One service user who spoke with the inspector said that they enjoyed living in Locke House and were satisfied with the support from staff.

Relatives who provided feedback on the service indicated that they were satisfied with the care given to their loved one and that staff were approachable and treated the service users well.

Staff spoke very positively in regard to the care delivery, training and management support in the agency. Two comments included the following statements; "the service users mean a lot to us and we are a good team. We are in a good place and believe that the new management team has been positive for the service" And; "the service users get good support and are treated well. It is very enjoyable work."

We contacted a number of HSC staff to obtain their views on the service. The feedback received was positive and indicated that there was excellent communication with good collaborative working. Staff were said to be prompt to raise any issues arising with service users and care plans completed promptly with time taken to explore what the service user's needs and how the service can best support them.

The information provided from feedback on the service indicated that there were no concerns in relation to the agency.

3.3 Inspection findings

3.3.1 Adult Safeguarding and Accident/ Incident Management

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 person in charge 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 incidents of abuse and the process for reporting concerns during and/or outside normal business 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.

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.

The agency's governance arrangements for the management of accidents/incidents were reviewed and confirmed that an effective incident/accident reporting policy and system was in place. Staff were required to record any incidents and accidents in a centralised electronic record, which is then reviewed by the senior management team. A review of a sample of accident/incident records evidenced that these were managed appropriately.

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

3.3.2 Mental Capacity Act and Restrictive Practice

The Mental Capacity Act (NI) 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.

Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles. The person in charge reported that none of the service users were subject to DoLS.

There was a policy in place for the use of restrictive interventions which was reviewed and updated regularly. The manager confirmed that any restrictive practices in place for any of the

service users such as locked medication cabinets, are recorded on a restrictive practice register and reviewed regularly to ensure necessity and proportionality of need as per the advice and guidance of the multi-disciplinary team.

3.3.3 Staff Selection, Recruitment and Induction

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 evidence of robust systems in place to manage staffing.

A review of the agency's staff selection and recruitment records confirmed that all pre-employment checks, including enhanced criminal record checks (AccessNI) had been completed and verified for new staff members prior to them engaging in direct contact with service users.

On review of the recruitment records of a sample of the most recently recruited staff, it was noted that a full employment history and any explanations for gaps in employment were not recorded in respect of one staff member employed within the agency. This was discussed with the manager who agreed to review this employee's record and obtain this information retrospectively. It was further agreed that the recruitment checklist would be reviewed and amended to include these checks as part of robust recruitment practice in the future. This will be reviewed at a future inspection.

Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC) or the Nursing and Midwifery Council (NMC) or any other relevant regulatory body; there was a system in place for professional registrations to be monitored by the manager. Staff spoken with confirmed that they were aware of their responsibilities to keep their professional 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, induction programme which also included shadowing of a more experienced staff member. Written records were retained by the agency of the person's capability and competency in relation to their job role.

3.3.4 Staff Training and Management

There were good systems in place to manage staffing. There were enough staff on duty to support service users. Staff said there was good teamwork and that they felt well supported in their role and that they were satisfied with the staffing levels.

Staff consulted with spoke positively about the training they receive and confirmed that they received sufficient training to enable them to fulfil the duties and responsibilities of their role and that training was of a good standard. Staff confirmed that they could approach management if they had any concerns.

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. In the event of any error occurring in respect of medication administration, staff are required to undertake refresher training and a renewed competency assessment to ensure they are competent in assisting with this task.

It was evident that staff received regular supervision and that there were procedures in place to appraise staff performance. It was positive to note that a competency assessment had been completed with staff who may be left in charge in the absence of the manager.

A review of training records confirmed that staff had completed training in dysphagia and in relation to how to respond to choking incidents. Staff had also completed training n personal safety and positive behavioural support, Human Rights, Control of Substances Hazardous to Health (COSHH) and Infection, Prevention and Control (IPC).

3.3.5 Care Records and Service Users' Input

From reviewing service users' care records, it was good to note that the service users' care plans contained details about their likes and dislikes and the level of support they may require. Care and support plans had been kept under regular review and services users and/or their relatives had been enabled to participate, where appropriate, in the review of their care on an annual basis, or when changes had occurred. Care reviews had been undertaken in keeping with the agency's policies and procedures. There was also evidence of regular contact with service users and their representatives, in line with the commissioning Health and Social Care Trust's requirements.

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. There was evidence that staff made referrals to the multi-disciplinary team and that these interventions were proactive, timely and appropriate.

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. Service users were also invited to come together twice weekly to the drop- in communal meetings where they could plan and partake in a range of activities such as baking, cooking, bingo, movie nights and a cycling club. One relative who spoke to the inspector was complimentary about the different activities that service users could avail of including day trips and residential trips away.

3.3.6 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 by senior staff with service users, service users' relatives, staff and Health and Social Care Trust representatives. The reports included details of a review of service users' care records; accident/incidents; safeguarding matters; staff selection, recruitment and training, and staffing arrangements.

It was positive to note that staff reported feeling well supported by managers and that they felt part of a team.

The Annual Quality Report was reviewed and was satisfactory.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure.

There has been a change in the management of the agency since the last inspection. Ms Elisha Mulholland has been the acting manager since 13 February 2025 and advised of the intention to apply to register as the manager of this service.

The registration certificate requires to be updated to reflect change in Responsible Individual arrangements. This will be reviewed in due course.

Current certificates of public and employers' liability insurance were reviewed and were satisfactory.

There was a system in place to ensure that complaints had been managed in accordance with the agency's policy and procedure. Complaints that had been received since the last inspection had been managed appropriately and were reviewed as part of the agency's quality monitoring process.

There was a robust system in place for staff to follow when unable to gain access to a service user's living accommodation.

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 Elisha Mulholland, Acting Manager, as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority

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