

Inspection Report

Name of Service: Castle Lane Supported Living Service

Provider: Praxis Care

Date of Inspection: 27 July 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:	Ms. Grainne Close
Registered Manager:	Mr. Jack Bibb. Acting
Service Profile – Castle Lane is a domiciliary care agency, supported living type which provides personal care and housing support to service users with learning disabilities. Some service users also have enduring mental health problems and/or complex needs. Service users live at two locations within the Lurgan town area.	

2.0 Inspection summary

An unannounced inspection took place on 27 July 2026, between 10.35 am and 4.50 pm. It was carried out by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 4 April 2025; and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

As a result of this inspection one of the two areas for improvement previously identified was assessed as having been addressed by the provider. The second is stated for a second time. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

Service users said that the care and support provided by Castle Lane was a positive experience.

It was established that the staff promoted the dignity and well-being of service users.

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.

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

Throughout the inspection process Inspectors seek the views of those working for or being supported by the agency; and review/examine a sample of records to evidence how the agency 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

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

Service users told us that they felt safe living in the agency and how they felt happy living there.

Several completed questionnaires received from service users raised issues that were discussed with the agency's Head of Operations. Discussions are ongoing with RQIA in this regard.

Staff told us that 'things were improving within the agency' and that they were very motivated in regard to this.

3.3 Inspection findings

3.3.1 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 skill of staff on duty each day meets the needs of service users.

Review of the 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.

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to the Northern Ireland Social Care Council's (NISCC) 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.

Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC); there was a system in place for professional registrations to be monitored by the manager.

Records of all staff training were retained. It was noted that not all staff were up to date in respect of training in Deprivation of Liberties Safeguards (DoLS) and Dysphagia. An area for improvement in this regard is stated for the second time.

Competency assessments were undertaken on all staff to ensure that they were competent in their roles and responsibilities.

Procedures were in place for appraising the staffs' performance and supervisions were undertaken in keeping with the agency's policy and procedures.

Service users told us how staff were 'able to adapt' to what they liked and were very supportive.

3.3.2 Care Delivery and Care Records

There was a daily handover at the beginning of each shift, which included information about any changes to the service users' care that the staff needed to assist them in their roles. A new procedure for handovers had been implemented within the agency since the last inspection. One member of staff told us that 'the handover procedure is much better now'.

Regular staff meetings were held, with minutes recorded and circulated to ensure staff unable to attend remained informed.

Staff were knowledgeable of individual service users' needs, their daily routine wishes and preferences. Staff interactions with service users were observed to be friendly and supportive. Staff were skilled in communicating with service users; they were respectful, understanding and sensitive to service users' needs.

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 being provided. They further described how they could make choices about how they spend their day

Activities for service users were provided incorporating both group and one to one activities. Planned activities included gardening, arts and crafts, gym and overnight trips. A recent service users' meeting included discussions on activities, the environment and the agency's vehicle. One service user told us that they had a wipe board for their day to day activities.

There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had their capacity considered and, where appropriate, assessed. Where a service user was experiencing a DoLs, the care records contained the relevant authorisation documents. A central register was in place to enable tracking of any DoLs due for review.

There was a policy in place for the use of restrictive interventions and a register was in place which was reviewed and updated regularly. Any restrictive practices were reviewed alongside the support plan, care review and subject to multidisciplinary review.

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.

A review of a sample of service users' care plans identified that care reviews had not been undertaken in keeping with the agency's policies and procedures. Care reviews are fundamental in promoting service user input into their care and ensuring care plans match any changing needs. This has been identified as an area for improvement.

3.3.3 Quality of Management Systems

There are currently acting manager arrangements in place within the agency. We discussed these arrangements with the agency's Head of Operations after this inspection; RQIA will keep this matter under review.

In the absence of the manager there was a nominated person-in-charge (PIC) to provide guidance and leadership. Discussion took place with the manager in relation to the requirement for the PIC to be clearly identified on the duty rota.

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.

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.

The Annual Quality Report was reviewed and was satisfactory.

Agencies are required to have a person known as the Adult Safeguarding Champion (ASC), who has responsibility for implementing the regional protocol and the agency's adult safeguarding policy. A specific individual was identified as the agency's ASC.

There was a Safeguarding Log in place within the agency. However this was not fully up to date. Consequently, the manager had no or limited awareness or oversight of any potentially open or ongoing safeguarding referrals within the agency. This also meant they had no

mechanism to review any potential trends around adult safeguarding matters. This has been identified as an area for improvement.

The annual safeguarding position report had been completed.

Review of incident records identified that they were managed appropriately. 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. 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.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	2	1*

* the total number of areas for improvement includes one that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr. Jack Bibb, Acting Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007	
Area for improvement 1 Ref: Regulation 15(2)(b) Stated: First time To be completed by: Immediate and ongoing from date of inspection	The Registered Person shall keep service user care plans under review Ref: 3.3.2
	Response by registered person detailing the actions taken: Team Leaders have been actively updating the pws core documentation to ensure all information is correct and up to date, reviews have been planned with statutory keyworkers and will be completed by 31 st October
Area for improvement 2 Ref: Regulation 15(6)(a) Stated: First time To be completed by: Immediate and ongoing from date of inspection	The Registered Person shall ensure that there is an up to date Safeguarding Log in place within the agency Ref: 3.3.3
	Response by registered person detailing the actions taken: Quality and Governance plan to add a safeguarding log to the service Q&G platform, though this may take some time, in the interim the service will keep its own tracker in the safeguarding file and review monthly and retain copies of email sent to statutory keyworkers requesting updates. A safeguarding record is kept centrally and discussed monthly at senior manager level This is shared with with Head of Operations to share with the service. Since 2026, the organisational Safeguarding Champion has met with Regional Directors every eight weeks to review safeguarding data, monitor trends, and track the progress of open safeguarding cases. This provides additional organisational oversight and assurance regarding safeguarding governance and case management.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards (revised) 2021	
Area for improvement 1 Ref: Standard 12.3 Stated: Second time	The Registered Person shall ensure that staffs' mandatory training requirements are met. Ref: 3.3.1

To be completed by: Immediate and ongoing from date of inspection	Response by registered person detailing the actions taken: Mandatory training remains an agenda item on team meetings and individual staff supervision, all contracted staff have completed Dysphagia, DOL's and Safeguarding Relief staff who are currently completing shifts in the service have completed Dysphagia, DOL's and Safeguarding training The Head of Operations reviews the services training matrix monthly via EMMR and addresses any deficits in training compliance with the manager to action plan
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