The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **The Croft**

Provider: **Praxis Care**

Date of Inspection: **7 September 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:	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. The agency is also funded by Supporting People; and a number of service users pay privately for their care and support.

2.0 Inspection summary

An unannounced inspection took place on 7 September 2026, between 8.50 am and 1.30 pm by a care Inspector.

The last care inspection of the agency was undertaken on 3 December 2025 by a care Inspector. No areas for improvement were identified. This inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

The inspection found that safe, effective and compassionate care was delivered to service users and that the agency was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of service users and that staff were knowledgeable and well trained to deliver safe and effective care.

Service users said that the care and support provided by The Croft was a positive experience. Refer to Section 3.2 for more details.

No areas for improvement were identified during this inspection.

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 registration information, and any other written or verbal information received from service users, relatives, staff 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.

3.2 What people told us about the service

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

Staff said that they were 'very happy' in their roles and described The Croft as 'a great place to work'. They expressed a high level of satisfaction with all aspects of the service and highlighted the strong emphasis placed on teamwork and the delivery of person-centred care. Staff spoke positively about the supportive working environment and demonstrated a shared commitment to achieving positive outcomes for service users.

Service users told us that they were 'very happy' with the service and described The Croft as 'excellent'. They spoke positively about the staff, describing them as 'very attentive', 'brilliant', 'wonderful', 'friendly and helpful' and 'very good'. Service users said that 'all the staff are respectful' and that they felt 'very safe' living at the service.

One service user commented that The Croft was 'like a five-star hotel and the (staff) are angels', reflecting the high regard in which they held both the environment and the care provided. Service users told us that staff routinely asked about their likes, dislikes and preferences and supported them to make choices about how they spent their day. They also confirmed that they felt comfortable raising any concerns and said that they could speak to staff or the manager if they experienced any problems.

Service users' representatives described The Croft as 'absolutely brilliant'. They said that service users were 'clearly well cared for' and that staff were very effective in keeping family members informed about their relatives' care and wellbeing. Representatives explained that this communication provided them with confidence and reassurance when they were unable to be present.

Service users' representatives further described their experience of The Croft as being 'extremely positive'. They characterised the service as 'very well managed', 'pristinely clean' and 'well-staffed'. Representatives stated that they believed their relatives felt safe living at The Croft and commented that they felt reassured knowing that they were being well cared for and supported.

One service users' representative suggested that the staff photograph identification board should be kept up to date and that staff should consistently wear their identification badges displaying both their name and photograph. They advised that this would assist service users to recognise the staff supporting them and provide an additional sense of familiarity and reassurance. It may also reduce any embarrassment or discomfort experienced by service users who may otherwise need to repeatedly ask staff members for their names. This feedback was shared with the manager for review and action as appropriate.

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.

There were systems in place to manage staffing. There was sufficient staff in the agency to meet the needs of the service users.

All appropriate recruitment safety checks had been verified prior to staff commencing in post.

Newly employed staff completed a structured induction at the commencement of their employment which included mandatory training. Induction was also provided to staff from recruitment agencies.

A robust system was in place to ensure that all staff were compliant with pre-determined mandatory training requirements. Advice was given in relation to monitoring agency staff profiles, to ensure that their training remained in date.

Competency assessments were undertaken on all staff to ensure that they were competent in their roles and responsibilities. This included medicines competency assessments and in relation to staff who had the responsibility of being in charge of the service in the absence of the manager.

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

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.

Staff meetings were held on a regular basis, with minutes available for staff unable to attend. Review of the meeting notes identified that there was a strong emphasis on shared learning.

Service users' meetings were held on a regular basis. Discussion items included fire safety, complaints, safeguarding, home maintenance and the importance of staying well hydrated in the warm weather.

Service users enjoyed regular music sessions and were encouraged to attend activities such as going for walks to Loughshore and going on shopping trips to the Abbey Centre. Visits to The Dementia Library were also encouraged. It was good to note that service users also celebrated Dementia Action week by having a therapy pony visit the service users. They also had primary school children visit them and the service users had the opportunity to visit a children's' nursery. They also attended a party at another Praxis service. Service users' relatives told us that there are plenty of activities and outings available, and that the service users go out regularly with members of staff.

Service users' needs had an Assessment Review (ART) tool and a Risk Assessment and Management Plan (RAMP) completed when they were first referred to the agency and before care delivery commenced. Following these initial assessments, support plans (Everyday Living 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 service user agreement was in place for each service user. Advice was given in relation to ensuring that these are signed by the service user and or their representative within five days of commencement of service, in keeping with the minimum standards. The manager agreed to address this matter with the staff. Additionally, advice was given in relation to the need for the Service User Agreements to include reference to service users' access to the internal corridor. The manager agreed to address this.

The agency sought service users' consent in relation to a number of matters such as, contacting/requesting information from other healthcare professionals on their behalf; whether or not they wanted their photograph taken and used in any organisational promotional material or social media.

Service users care records were held confidentially.

The service promoted the use of the Herbert Protocol for service users who may be at risk of going missing. Relevant information was maintained and reviewed to ensure that, should a service user be reported missing, key details could be provided promptly to the police and other emergency services, supporting a timely and effective response. This is good practice and is commended.

Staff recorded regular evaluations about the care and support provided. A review of a sample of these records evidenced that they were legible, up to date and signed by the person making the entry.

There was a policy in place for the use of restrictive interventions and a register was in place. Advice was given in relation to the frequency of review.

3.3.4 Quality of Management Systems

There has been no change in the management of the agency since the last inspection. Mrs Ms Gail Kirkland has been the manager in this agency since 15 August 2024.

Service users' relatives described the manager in positive terms; one comment included that 'the manager 'has always been available to speak with me when I ask. She is extremely approachable, makes time to talk and gives me confidence that any concerns or questions I have are listened to, heard and addressed'.

Review of a sample of records evidenced that a robust system for reviewing the quality of care was in place; this included annual and monthly processes.

There was a process in place to manage complaints and incidents; RQIA had been notified appropriately of any incidents in line with requirements.

There was a system in place for professional registrations to be monitored by the manager. Advice was given in relation to the frequency of checks by the manager. The manager welcomed this advice and agreed to implement monthly checks from the date of the inspection.

The annual quality report was reviewed and noted to include stakeholder feedback.

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.

It was established that effective 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. Given that this document was developed for the whole Praxis organisation, advice was again given in relation to appending a service specific data to the report. This will be reviewed at a future inspection.

There was a protocol in place for staff to follow should require to gain access to the service users' homes in an emergency.

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.

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 Mrs Gail Kirkland, Manager, as part of the inspection process and can be found in the main body of the report.

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