

Inspection Report

Name of Service: PCG St.Paul's Court

Provider: Praxis Care

Date of Inspection: 16 June 2026

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1.0 Service information

Organisation/Registered Provider:	PCG St.Paul's Court
Responsible Individual/Responsible Person:	Ms Grainne Close
Registered Manager:	Ms Lesley Burke
Service Profile – St Paul's Court is a supported living type domiciliary care agency located in Lisburn. The agency's aim is to provide care and support to meet the individual assessed needs of people living with suspected or mild to moderate dementia. Service users reside in individual bungalows and apartments within a shared complex.	

2.0 Inspection summary

An unannounced inspection took place on 16 June 2026 between 9.30 am and 3.45 pm 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 area for improvement restated during the last care inspection on 1 July 2025. It also sought to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

An area for improvement which had been stated for the second time relating care records was assessed as having been addressed by the provider. This is discussed in more detail in section 3.3.4.

This inspection established that care delivery was safe and that effective and compassionate care was delivered to service users. However, improvements were required to ensure the effectiveness and oversight of certain aspects of the agency. As a result of this inspection, one new area for improvement was identified relating to accident/incident management and recording. This is discussed in more detail in sections 3.3.2. Further details of the findings of this inspection are outlined in the main body of the report and in the quality improvement plan (QIP) in Section 5.

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 this agency. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors will seek the views of those living, working and visiting the agency; and 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

We spoke to service users, relatives and staff to seek their views of living, visiting and working within PCG St Paul's Court. The information provided indicated that there were no concerns in relation to the care and support provided within the agency.

Service users who were approached for feedback on the agency said that the staff were "lovely" and that they enjoyed living at St Paul's Court.

Relatives who spoke with the inspector said they were satisfied with the care and support provided to their loved one. One relative commented that "the staff are amazing and go over and above what is expected".

Staff who spoke with the inspector said they enjoyed working in St Paul's Court and that training and support provided by the manager was good. Staff also said that the standard of care provided to service users was good.

3.3 Inspection findings

3.3.1 Staffing (recruitment and selection, induction and training).

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.

A review of the agency's care staff recruitment records confirmed that pre-employment checks, including criminal record checks (AccessNI), were completed and verified before care staff members commenced employment and had direct engagement with service users. A checklist was completed for each employee however on closer examination of this it was identified that there was limited information recorded to evidence that all pre-employment recruitment checks had been satisfactorily carried out. Further information regarding these checks was provided by the manager after the inspection and it was recommended that checklists include sufficient detail to evidence robust oversight of recruitment practice by the manager. This will be reviewed at a future inspection.

Checks were made to ensure that staff were appropriately registered with NISCC or any other relevant regulatory body; there was a system in place for professional registrations to be monitored by the manager. Staff who spoke with the inspector were aware of their responsibilities to keep their registrations up to date.

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. The induction programme 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.

Training records for all staff are held on an electronic matrix which confirmed that all training requirements of staff were up to date. Staff confirmed that they found the training to be useful.

An examination of the staff duty rota and discussions with the person in charge confirmed that there was sufficient staff on duty to support service users on the day of inspection.

A review of the management of staff supervision and appraisals confirmed that all staff received regular supervision and a yearly appraisal.

3.3.2 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). The agency's annual Adult Safeguarding Position report was reviewed and found to be satisfactory.

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 and the process for reporting concerns in normal business hours and out of 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. Advice was given to the person in charge regarding implementation of a tracker document for staff to record and ensure appropriate management of all safeguarding incidents. This advice was welcomed and will be reviewed at a future inspection.

The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

The agency retained records of all accidents/incidents which were recorded on an electronic recording system. A review of a sample of incidents relating to service users who had experienced a fall and a sustained injury identified that there was no recorded evidence that staff had followed the appropriate falls protocol and that medical advice had been obtained. An area for improvement was identified.

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

3.3.3 Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

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 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 DoLS training appropriate to their job roles. The manager reported that a number of the service users were subject to a deprivation of liberty (DoLS). Where a service user was experiencing DoLS, the care records contained details of assessments completed and agreed outcomes developed in conjunction with the HSC Trust representative.

There were a number of restrictive practices in place such as door sensors, alarms and key pads. There was a restrictive practices register in place which was reviewed regularly and kept up to date with input from the multidisciplinary team to ensure necessity and proportionality.

3.3.4 Care Records

An area for improvement arising from the previous inspection related to inaccurate information contained in service users care plans. A review of a number of service users' care records, confirmed that care and support plans were person centred and are kept under regular review. The service users' care plans contained details about their likes and dislikes and the level of

support they may require. Care and support plans evidenced both service user and relative's participation, where appropriate, in the review of the care provided on an annual basis, or when changes occur.

There was evidence that staff recorded the details of care and support provided, any changes to the service users' needs and regularly reviewed and updated service user records to ensure they continued to meet current service user needs. On this basis the area for improvement was assessed as met.

Service user meetings were held on a regular basis which enabled the staff to keep service users updated on any issues arising that may affect them and for service users to be involved in planning of activities of their choice. Some arranged activities included gardening, a street party, visits from Cat Protection and an animal farm.

3.3.5 Governance and Managerial Oversight

The agency's registration certificate was up to date and displayed appropriately along with current certificates of public and employers' liability insurance.

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 and staff recruitment and training. It was identified that one report inaccurately reported that there had been no areas for improvement identified at the previous inspection. This was discussed with the person in charge who agreed to address this with the writer of the report.

There were processes in place to review the quality of the agency on an annual basis. The Annual Quality Report was reviewed and was satisfactory.

The agency had an up to date policy and procedure to manage complaints. The person in charge advised that one complaint had been received since the last inspection. A review of this confirmed that this had been managed appropriately.

A range of policies were held electronically and available to direct staff in care delivery and support planning based on individual risk assessments.

Where staff are unable to gain access to a service user's home – There is a system in place that ensures that the service has an operational policy, procedure or protocol that clearly directs staff from the Agency as to what actions they should take to manage and report such situations in a timely manner.

5.0 Quality Improvement Plan/Areas for Improvement

One area for improvement was identified where action is required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007.

The area for improvement and details of the Quality Improvement Plan were discussed with Ms Carly Chambers, Head of Operations, as part of the inspection process and can be found in the main body of the report. The timescales for completion commence from the date of inspection.

	Regulations	Standards
Total number of Areas for Improvement	1	0

Quality Improvement Plan	
Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007	
Area for improvement 1 Ref: Regulation 14 (a) Stated: First time To be completed by: Immediately and ongoing	The Registered Person shall make suitable arrangements to ensure that the agency is conducted, and prescribed services arranged by the agency, are provided so as to ensure the safety and well-being of service users. This relates to the need to ensure appropriate management of accidents/incidents and adherence to relevant policies and procedures including the reporting and recording of same. Response by registered person detailing the actions taken: All staff have been made aware of The Prevention and Management of falls guidelines & Form A - Post Fall Assessment and Management Checklist. The policy and reporting requirements have been discussed at a staff meeting 29.7.26 to ensure staff understand their responsibilities in preventing falls and reporting of all-falls related incidents in-line with organisation policy. Staff have access to the current policy and procedure, with additional copies available if required. Compliance with the Policy is reinforced through team meetings, supervision and on-going monitoring of incident reporting by the Manager. A revised version of the policy is expected to become available shortly. In the meantime, we will continue to follow the current version until the policy is formally issued.



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