The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **PCG St Paul's Court**

Provider: **Praxis Care**

Date of Inspection: **1 July 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(s): -	Mr Greer Wilson
Registered Manager:	Mrs 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 1 July 2025 between 10.30 am and 4.40 pm by a care inspector.

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 last care inspection of the agency was undertaken on 15 July 2024 by a care Inspector. As a result of this inspection, two areas for improvement arising have been assessed as having been addressed by the provider (see section 4.1 & 4.2). One area for improvement relating to care records is being stated for a second time (see section 4.3).

The inspection established that care delivery was safe and that effective and compassionate care was delivered to service users. Full details, including areas for improvement identified, can be found in the main body of this 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

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

We spoke to service users, a relative 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.

Some service users who gave feedback made the following comments about their experience:

- "I just love it and I love my bungalow"
- "I am enjoying taking part in the activities"
- "It's good here and they are all good – the staff are nice"
- "The service is very good and the girls are very attentive and supportive of my needs".

Observations of staff interacting with service users was noted to be person centred and respectful.

One relative who spoke with the inspector spoke very positively in regard to the care delivery in the agency.

Staff who spoke with the inspector felt the quality of care and support in the agency was good and confirmed they enjoyed working in the service; and that their training and support from the manager was good.

A number of staff responded to the electronic survey which gave mixed views on the agency. Whilst, the respondents indicated that they were 'very satisfied' or 'satisfied' that care provided was safe, effective and compassionate and that the service was well led, a concern was raised around staffing levels and manager presence within the service. This was discussed with the manager who provided assurances around managerial support and sufficient staffing levels for the numbers of service users currently being supported by the service.

The manager was optimistic that the newly recruited staff being inducted or commencing imminently would be positive for both staff and service users. This is discussed in more detail in section 4.2.

3.3 What has this service done to meet any areas for improvement identified at or since the last inspection?

The last care inspection of the agency was undertaken on 15 July 2024 by a care inspector. A Quality Improvement Plan (QIP) was issued. Two areas for improvement were assessed as having been addressed during this inspection. One area for improvement is being stated for the second time (See section 5).

4.0 Inspection findings

4.1 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.

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.

Staff had managed incidents appropriately and reported to RQIA within appropriate timeframes in keeping with the regulations. In response to the previous quality improvement plan, training is provided to all staff in respect of accident and incident management and reporting. It was positive to note that this is now incorporated into the induction for all new staff and that new staff benefitted from trialling this within a mock incident/accident reporting system.

The agency had an up to date policy and procedure to manage complaints. The manager confirmed that service users were advised regularly how to make a complaint at service user tenancy meetings and that no complaints had been received since the last inspection. Details relating to the complaints process was included in the statement of purpose and service users guide.

The agency held meetings with service users on a monthly basis which enabled the service users to discuss the provisions of their care and prepare for their annual care review meetings. On review of the minutes of these service user meetings, there was evidence that service users availed of a variety of activities such as music, dancing arts and crafts and visits to local coffee shops and restaurants. These activities were planned and reflected the individual choices of the service users.

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

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

4.2 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 all 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. 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. 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.

Training records for all staff are held on a colour-coded electronic matrix. On review of the records of all staff training it was noted that some staff required refresher training in Adult Safeguarding. The manager has since confirmed that all staff have now completed this training.

On examination of the training records of agency staff supplied to work within the agency it was confirmed that training requirements were up to date. On this basis the previous quality improvement plan is deemed to have been addressed by the provider.

Staff confirmed that they found the training to be beneficial and commensurate with their role.

An examination of the staff duty rota and discussions with the manager confirmed that there was sufficient staff on duty to support service users on the day of inspection which included use of regular agency staff. The manager advised that recruitment efforts remain ongoing and that the agency is in the process of inducting new staff. It is expected that this will reduce reliance on agency staff. There was no evidence of any dissatisfaction in relation to the staffing levels voiced from staff who spoke with the inspector and it was evident that there were enough staff to meet the needs of service users on the day of inspection. Staff said that they felt well supported in their role by the manager.

There were no volunteers deployed within the agency.

Supervision is an important part in professional development and staff should complete supervision in line with their professional bodies' guidance and retain a written record as evidence for inspection purposes. The manager confirmed that all staff received regular supervision which is recorded on a matrix. Records examined evidenced that this is completed on a more frequent basis for newly recruited staff.

4.3 Adult Safeguarding

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.

Discussions with staff 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 however a number of staff required refresher training. The manager advised that that there had been a waiting list for this training and that all of the staff have since been booked on to the next available training session. 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 and there was a tracker for staff to record all safeguarding incidents. It was recommended that further columns be added to this to indicate if a protection plan had been implemented as well the outcome of the safeguarding investigation. This 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).

4.4 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 DoLS, and some restrictive practices were in place. There was a restrictive practices register in place which was reviewed and kept up to date. On review of one service user's records, a review of DoLS safeguards authorised under emergency provisions was required.

The manager was able to provide evidence of continued efforts to follow this up with the Trust key worker and of the reasons for not having the relevant supporting paperwork on file. This will be reviewed at a future inspection.

4.5 Care Records

A quality improvement plan arising from the last inspection related to inaccurate or missing information and incorrect dates on service users care plans. From reviewing service users' care records, it was good to note that service users had an input into devising their own plan of care and that they were regularly reviewed. 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. One care record that had been recently reviewed however, omitted to fully update a risk assessment in light of changes to a service user's routine and information relating to DoLS. Other care records examined were missing dates and some relatives had signed in the place of the service user's signature. This is an area for improvement that is stated for the second time.

The manager reported that none of the service user currently required the use of specialised equipment, such as walking aids. They were aware of how to source training should it be required.

5.0 Quality Improvement Plan/Areas for Improvement

An area for improvement and details of the Quality Improvement Plan were discussed with Ms Lesley Burke Manager, 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

* the area for improvement relates to one that has been stated for a second time and which is carried forward for review at the next 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 (3)(b) **Stated:** Second time	The registered person shall keep the service users plan under review; this relates specifically to omissions, inaccurate/out of date information and incorrect dates found in documentation Ref: 4.5
To be completed by: Immediately and ongoing	**Response by registered person detailing the actions taken**: A full review of all Everday Living Plan, Risk Assessment and Management Plan documentation is currently undergoing review for each of the People that we Support. This has been addressed in Supervisions and Staff Meetings. Where a Person that We Support is unable to sign documentation this will be recorded on Everyday Living Plan, Risk Assessment and Management Plan. Team Leaders will be allocated to carry out monthly File audits for their case load of People that We Support..

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