The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Harold McCauley House

Provider: Presbyterian Council of Social Witness

Date of Inspection: 30 September 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:	Presbyterian Council of Social Witness
Responsible Individual:	Mr Dermot Parsons
Registered Manager:	Miss Megan James, not registered
Service Profile: Harold McCauley House is a nursing home registered to provide nursing care for up to 32 patients. The home operates over two floors with shared communal lounges, a dining room and outdoor spaces.	

2.0 Inspection summary

An unannounced inspection took place on 30 September 2025, from 10.25am to 2.45pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. However, improvements were necessary in relation to management of medicines for distressed reactions.

Whilst areas for improvement were identified, there was evidence that patients were being administered their medicines as prescribed.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, and the new area for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients well.

RQIA would like to thank the staff for their assistance throughout the 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 home 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 service 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 home was reviewed. This included areas for improvement identified at previous inspections registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

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

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each patient liked to take their medicines and medicines were administered in accordance with individual patient preference. Staff also said that they prioritised patients who required pain relief and time-critical medicines during each medicine round.

RQIA did not receive any completed questionnaires or responses to the staff survey following the inspection.

3.3 Inspection findings

3.3.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments.

The personal medication records reviewed were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. A photograph of the patient was not available on two of the personal medication records. This was discussed with staff and assurance was provided these would be put in place immediately.

Copies of patients' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets etc.

The management of insulin and warfarin was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. Directions for use were recorded on the personal medication record, however resident centred care plans, including the parameters for the administration of medicines were not in place. The reason for and outcome of each administration was not consistently recorded. An area for improvement was identified.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans were in place and reviewed regularly. One patient did not have a care plan in place for the management of pain, this was put in place at the time of the inspection. .

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

The management of thickening agents was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained. Two personal medication records needed updating in line with the most recent speech and language assessments and one administration record needed the consistency level updated. This was discussed with staff for immediate corrective action.

3.3.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

Records reviewed showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage, the storage of controlled drugs and the safe disposal of medicines.

3.3.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. Records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. Staff were reminded to ensure that the quantity administered is always completed when signing for the administration of controlled drugs. This was discussed with the manager after the inspection to ensure on-going monitoring.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits had been discussed with staff and addressed. The date of opening was recorded on medicines to facilitate audit and disposal at expiry.

3.3.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

A review of records indicated that satisfactory arrangements were in place to manage medicines at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy as necessary. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

3.3.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

3.3.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that their staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Medicines management policies and procedures were in place.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

4.0 Quality Improvement Plan/Areas for Improvement

An Area for improvement has been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	4*	7*

* the total number of areas for improvement includes ten which were carried forward for review at the next inspection.

The area for improvement and details of the Quality Improvement Plan were discussed with nurse in charge and a member of the senior management team, 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (7) **Stated:** Second time **To be completed by:** 7 August 2024	The registered person shall ensure that the IPC issues identified during inspection are addressed and a system is implemented to monitor compliance going forward. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 2.0
Area for improvement 2 **Ref:** Regulation 27 (2) (b) **Stated:** First time **To be completed by:** 7 November 2024	The registered person shall ensure that the environmental/maintenance related issues identified during the inspection are addressed **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 2.0
Area for improvement 3 **Ref:** Regulation 27 (2) (t) **Stated:** First time **To be completed by:** 7 September 2024	The registered person shall ensure that all exposed hot water pipes are reviewed and covered where necessary. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 2.0
Area for improvement 4 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** 7 August 2024	The registered person shall ensure that monthly monitoring reports are available within the home at all times. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 2.0

Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 30 September 2025	The registered person shall review the management of medicines prescribed ‘when required’ for distressed reactions to ensure that person centred care plans are in place and the reason for and the outcome of each administration is recorded. Ref: 3.3.1
	Response by registered person detailing the actions taken: Person centered careplans are now in place for all residents that are prescribed 'when required' medications for distressed reactions. An audit of these careplans has since been carried out which shows these are being completed in full by the registered nurses when administering the 'when required' medications.
Area for improvement 2 **Ref:** Standard 23 **Stated:** Second time **To be completed by:** 14 August 2024	The registered person shall ensure that the following action is taken where a wound has been assessed as requiring treatment: • the care plan includes the recommended dressing type and frequency of dressing renewal • wound assessment charts are fully completed following each dressing renewal and are reflective of the directions within the care plan • a body map is completed to provide the location of the wound and date identified • the type of pressure relieving equipment required is recorded within the care plan.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0
Area for improvement 3 **Ref:** Standard 4.8 **Stated:** Second time **To be completed by:** 14 August 2024	The registered person shall ensure that where a patient is at risk of dehydration daily fluid target is recorded within the patients’ dietary/fluid intake chart and care plan. With the action to be taken, and at what stage, if the recommended target is not met, clearly documented within the care plan.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0

Area for improvement 4 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 14 August 2024	The registered person shall ensure that care plans provide sufficient details that are reflective of the patients' health and personal care needs and any relevant medical conditions. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 2.0
Area for improvement 5 **Ref:** Standard 41 **Stated:** First time **To be completed by:** 14 August 2024	The registered person shall ensure that patient dependency assessments are carried out on a regular basis to ensure that there are sufficient staffing levels on duty to meet the needs of the patients. Records of these assessments must be available within the home. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 2.0
Area for improvement 6 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 28 August 2024	The registered persons shall ensure that the provision of activities is reviewed to ensure that there are meaningful activities at all times and especially in the absence of the activity person. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 2.0
Area for improvement 7 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 7 September 2024	The registered person shall ensure that quality governance audits are effective at identifying and addressing the areas requiring improvement as outlined in this report. With specific reference to: • environmental audits • care record audits **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 2.0

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