The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Adelaide House

Provider: Presbyterian Council of Social Witness

Date of Inspection: 22 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:	Presbyterian Council of Social Witness
Responsible Individual/Responsible Person:	Mr Dermot Parsons
Registered Manager:	Mr Jordan Anderson, not registered

Service Profile – This home is a registered residential care home, which provides health and social care for up to 45 residents. The home is registered to provide care for up to eight residents living with dementia and one resident with a mental health diagnosis. Residents' bedrooms are located over three floors.

Residents have access to communal bathrooms, lounges, a dining room and a garden/courtyard area.

2.0 Inspection summary

An unannounced inspection took place on 22 July 2025, from 9.15 am to 6.30 pm by a care inspector.

The inspection was undertaken to evidence how the home 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 3 March 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

RQIA also received intelligence on 15 July 2025, which raised concerns in relation to staffing levels, care records and supplementary documentation. These concerns were reviewed as part of the inspection process. The concerns raised were substantiated; this is discussed in sections 3.3.1 and 3.3.3.

While we found care to be delivered in a compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery, the completion of care records, the environment and the review of staffing levels within the home.

Although residents said that, they were happy living in the home a number of residents expressed concerns regarding the staffing levels. Refer to Sections 3.2 and 3.3.1 for details.

As a result of this inspection, two areas for improvement were assessed as having been addressed by the provider. Other areas for improvement have either been stated again or will be reviewed at the next inspection. 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.

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 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 home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from residents, 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. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

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.

3.2 What people told us about the service

Residents described staff as "generally very helpful." Residents spoken with said that they were mostly happy living in Adelaide House. Comments included, "The staff are very good, they come quickly when you call them," and "Yes it is lovely here."

However, a number of residents raised concerns regarding the staffing levels in the home, comments included, "There is not enough staff," "They are very short staffed" and "The shortage of staff is dreadful."

Residents told us that staff offered them choices throughout the day, which included preferences for getting up, and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Staff said there was good teamwork and that they felt well supported in their role. However, a number of staff also expressed concerns about staffing levels in the home. Specific feedback was discussed in detail with the management team throughout the inspection. The management team confirmed they were aware of these concerns. This is discussed further in section 3.3.1 of the report.

One response was received from the online survey, which indicated dissatisfaction with some aspects of the home; this was discussed with a senior manager for action. There was no other additional feedback received.

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 residents. A review of records evidenced that that some inductions had not been fully completed or signed off by the manager within the relevant timeframe. An area for improvement was identified

On the day of the inspection, due to unexpected staff absence the home had fallen below the planned staffing levels. Discussion with both staff and residents indicated that this was a regular occurrence. As discussed in section 3.2 residents and staff raised concerns about the staffing levels in the home. One resident said, “The staff are generally very helpful, but there is not enough of them” another resident said, “There is not enough staff, they are very short staffed.” Staff said, “Staffing levels are very low”, and “The staff are not happy with the staffing levels.” Observations and review of the staff duty rotas evidenced that the staffing levels did at times fall below planned levels. An area for improvement in relation to a review of staffing levels was identified.

A review of the duty rota indicated that the person in charge of the home in the manager’s absence had not been consistently identified on the rota. An area for improvement was stated for a second time.

Review of staff training records evidenced that mandatory training compliance levels were low in relation to Control of Substances Hazardous to Health (COSHH), health and safety, dysphagia awareness, moving and handling and medication awareness training. An area for improvement was identified.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the residents. Staff were knowledgeable of individual residents’ needs, their daily routine wishes and preferences.

It was observed that staff respected residents’ privacy by their actions such as knocking on doors before entering, discussing residents’ care in a confidential manner, and by offering personal care to residents discreetly.

A review of records confirmed that residents and their relatives participated in regular meetings that provided an opportunity for them to comment on aspects of the running of the home. For example, planning activities and menu choices. Inconsistencies between the records of the minutes of these meetings was evident. This was discussed with the management team and will be reviewed at a future inspection.

At times, some residents may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that systems were in place to safeguard residents and to manage this aspect of care, however, a review of one care plan evidenced lack of detail in regards to 1:1 support, and this is discussed further in section 3.3.3.

Where a resident was at risk of falling, measures to reduce this risk were put in place. Examination of care records and discussion with the management team confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. For example, residents were referred to the Trust's Specialist Falls Service, their GP, or for physiotherapy.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

There was limited oversight of the mealtime experience, for example, some residents had finished their meal before other residents had been served. There was no coordinator identified to oversee the mealtime experience resulting in residents complaining in a long wait for their lunch. The mealtime experience was rushed and both staff and residents commented on the lack of staffing to help cover the dining room. In addition to this some residents commented on the lack of choice with one resident commenting, "the food is good but there is not enough choice," while another resident complained of the same meat being served on a regular basis. This was discussed with the management team who agreed to carry out a review of the dining experience. An area for improvement was identified.

A review of records relating to dietary requirements evidenced that these were not always correct, for example, one care record omitted that a resident required a specialised diet and a second care record showed inconsistencies in the International Dysphagia Diet Standardisation Initiative (IDDSI) levels. An area for improvement was identified.

On the morning of the inspection staff were observed leading residents in singing hymns and residents reported that they had enjoys this. However, there was a lack of choice of meaningful activities provided in the home. This was discussed with the management team who confirmed that they were reviewing the activities provided in the home and courses have been arranged for activity staff to ensure that a variety of activities would be offered.

The activity folder lacked detail regarding the activities held in the home, and residents' full names were missing from the activity folder making it difficult to identify who had attended the activity. An area for improvement was identified.

3.3.3 Management of Care Records

Residents' needs were assessed by a suitably qualified member of staff at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents' needs and included any advice or recommendations made by other healthcare professionals.

Residents care records were held confidentially.

Staff were able to describe what resident's preference and wishes were but the care plans reviewed did not reflect this level of detail. For example, as mentioned in section 3.3.2 there was a lack of detail in care planning regarding 1:1 care. Inconsistencies were identified between care plans, risk assessments and evaluations. In addition to this, risk assessments for some residents had not been fully completed or signed off in a timely manner two areas for improvement were identified.

Supplementary records, including falls risk assessments, residents' personal inventories, body maps and behaviour charts were noted to be unsigned and undated. An area for improvement was identified.

3.3.4 Quality and Management of Residents' Environment Control

The home was clean and tidy, residents' bedrooms were personalised with items important to the resident. Bedrooms and communal areas were suitably furnished, warm and comfortable. However, some parts of the home were showing signs of wear and tear. For example, two showers were broken on the day of the inspection, handrails throughout the home were in need of repainting and some walls were marked and also in need of repainting. An area for improvement was identified.

It was noted that cleaning schedules for bathrooms had the dates prepopulated; this was discussed with the management team who agreed to address this. This will be reviewed at a future inspection.

Two medication trolleys were found to be unlocked and unattended during both the breakfast and the lunchtime meals, when this was brought to the staff's attention staff told RQIA that the trolley locks were broken and they were unable to secure them. This was brought to the attention of the management team and post inspection assurances were given that new trolleys had been ordered and in the interim new locks had been fitted to the existing trolleys. An area for improvement was identified.

The hairdressing room containing hazardous substances and a cupboard, with cleaning supplies was found to be unlocked. This was discussed with the management team for immediate action and an area for improvement was identified.

There was evidence that systems and process were in place to ensure the management of risk associated with infectious diseases. For example, there was ample supply of personal protective equipment (PPE) within the home. However, it was noted that PPE was being stored inappropriately and was hanging haphazardly from the Dani stations raising the risk of cross infection and aprons coming loose and becoming a trip hazard. An area for improvement was identified.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Mr Jordan Anderson has been the acting manager in this home since 25 March 2025. An application to become the registered manager of the home has been submitted to RQIA for review.

Residents and staff commented positively about the manager and the management team and described them as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. Some areas for improvement identified during this inspection had been identified during the monthly monitoring visits carried out by senior managers and action plans are in place to address these areas and this is being monitored by the regional manager.

There was evidence that the management team responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

Compliments to the home referred to the 'kindness' of staff.

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	3	11*

* 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 the 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) (a) **Stated:** First time **To be completed by:** 22 July 2025	The Registered Person shall ensure that the medicine trolleys are not left unattended at any time. Ref: 3.3.4
	Response by registered person detailing the actions taken: New locks have been secured to the medication trollies. Medications are administered in the Dining room and then staff take the medication trollies with them when going around the home to admininster to residents in their bedrooms. Medication competences will been reviewed, all staff competencies have been completed and an annual schedule of renewal is in place. For all medication trained staff.
Area for improvement 2 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** 22 July 2025	The registered person shall ensure as far as reasonably practicable that all parts of the residential home to which residents have access are free from hazards to their safety. Ref: 3.3.4
	Response by registered person detailing the actions taken: New locks have been fixed to the medication trollies. Staff are reminded through handovers and daily huddles that their trollies are to be kept under supervision and locked to maintain safety. Home Manager and Deputy Home Manager complete walk arounds of the service twice daily to ensure the residents in the home are safe. New Dani stations have been sourced for correct storage of PPE to ensure there is no risk of cross infection
Area for improvement 3 **Ref:** Regulation 27 (2) **Stated:** First time **To be completed by:** 30 September 2025	The registered person shall ensure as far as reasonably practicable that all parts of the home are kept in a good state of repair and reasonably decorated. Ref: 3.3.4
	Response by registered person detailing the actions taken: Staff are now using the maintinence log as standard procedure within the home, which is audited monthly by the home manager and deputy manager. Staff have been reminded to write in this for the maintenince officer who checks this daily to ensure issues are resolved. Maintinence officer has sourced paint for hand rails, this will be completed by 30/09/25.

Action required to ensure compliance with the Residential Care Homes Minimum Standards (Dec 2022)	
Area for improvement 1 **Ref:** Standard 25 **Stated:** Second time **To be completed by:** 23 July 2025	The registered person shall ensure that the duty rota: • Clearly identifies the full name and designation of all staff • The person in charge in absence of the manager is clearly identified. Ref: 2.0 & 3.3.1
	Response by registered person detailing the actions taken: Rota layout has been updated to ensure all staff and their job titles are visable on the rota. Person in charge will be highlighted in Green and when the Manager and Deputy Manager are needed to cover medications they will be highlighted in yellow. Along the bottom of the Rota there is a colour code to indentify the colours used.
Area for improvement 2 **Ref:** Standard 23.1 **Stated:** First time **To be completed by:** 23 July 2025	The registered person shall ensure that all staff receive a completed and structured induction and that there is managerial oversight of the induction process. Ref: 3.3.1
	Response by registered person detailing the actions taken: All staff are currently in the process of being inducted and re-inductied into the home to identify any gaps in knowledge. A list has been created for Home Manager/Deputy Manager/Senior care assistants as to who they are responsible for inducting. This is in the process and will be completed by 28/11/25.
Area for improvement 3 **Ref:** Standard 25.1 **Stated:** First time **To be completed by:** 31 August 2025	The registered person shall ensure that a review of staffing is undertaken to promote a safe and healthy working environment and culture in the home. Ref: 3.2 & 3.3.1
	Response by registered person detailing the actions taken: Adelaide house has a robust staffing model which is used to make sure we have a safe number staff within the home. This is reviewed weekly for the week ahead by the Home Manager/ Deputy Home Manager and Senior Care Assistants. Compliance check box has been placed on the rota for the Home Manager/ Deputy Manager/ Senior Care Assistant to check 1 week in advance to make sure the home is staffed correctly. in the event of being short staffed, Home Manager/Deputy Home Manager/Senior Care Assistant procedure in place for covering shifts which all staff are aware of

Area for improvement 4 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 31 July 2025	The registered person shall ensure that staff who work in the home receive mandatory training as appropriate to their role. Ref 3.3.1
	Response by registered person detailing the actions taken: Staff mandatory training is monitored weekly by the home manager. Staff are reminded of any training they still have to complete or any the requires completing before it expires. There is an organisational process in place re. completion and non completion of training.
Area for improvement 5 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 31 July 2025	The registered person shall review the dining experience for residents to ensure all residents are offered a choice of meals and that the mealtime experience is relaxed and not rushed. Ref: 3.3.2
	Response by registered person detailing the actions taken: Staff read out the daily menu choices to the residents ensuring there is a choice of meals and drinks. Picture Menus are available for those who require. Home Manager has met with Mount Charles Catering Team and have asked Mount Charles to produce menus for the tables for residents. Mount Charles will complete this task by 30/10/25 Meal time co-ordinator to be present at all meal times. Over seeing the dining room experience
Area for improvement 6 **Ref:** Standard 8.5 **Stated:** First time **To be completed by:** 31 July 2025	The registered person shall ensure that records in relation to residents' dietary needs are accurate and up to date. Ref: 3.3.2
	Response by registered person detailing the actions taken: Home Manager and deputy Mnager will ensure the residents dietary needs are accurate andup to date, this will be audited monthly. Home Manager will meet with the Kitchen Manager monthly to ensure all records in the kitchen are accurate and up to date. any changes in dietary requiremnets will be discussed in daily safety huddles, written on handover records and discussed in handovers.
Area for improvement 7 **Ref:** Standard 13.9 **Stated:** First time	The registered person shall ensure that a record is kept of all activities that take place in the home with the full names of the residents who participate. Ref: 3.3.2

To be completed by: 31 July 2025	**Response by registered person detailing the actions taken:** An Activity co-ordinator has been inducted into the home. Activity co-ordinator has been shown all relevent paperwork that need to be completed for planning and implementing activities. A new section of the Daily Allocation sheet has been added to identify a member of staff to do activities in the absence of the Activity Co-ordinator. File is in place for each individual resident for activities. This is in place to capture the activites that are being completed with the residents. The activites co-ordinator reviews and up dates the activities assessment this ensure the activities reflects the residents wishes and interests.
Area for improvement 8 **Ref:** Standard 6.6 **Stated:** First time **To be completed by:** 31 July 2025	The registered person shall ensure that care plans are kept up-to-date and reflect the resident's current needs. Ref: 3.3.3
	Response by registered person detailing the actions taken: Care files are being reviewed to make sure the care plans are up to date and reflect the residents needs. A care file audit is carried out of 10% of the files (5 files a month) to ensure compliance . This is process for a full review will be completed by 30/09/25, going forward there is a planner structure in place to ensure compliance within this area.
Area for improvement 9 **Ref:** Standard 5 **Stated:** First time **To be completed by:** 31 July 2025	The registered person shall ensure that all risk assessments are up to date and reflect the resident's current needs.
	Response by registered person detailing the actions taken: Care file audits are being completed weekly to identify any gaps in care files. Care planning and risk assessment workshop was completed on the 22/08/2025 for all Senior Staff. Risk assessments currently being updated to capture current residents needs. This is process for a full review will be completed by 30/09/25, going forward there is a planner structure in place to ensure compliance within this area.
Area for improvement 10 **Ref:** Standard 8.5 **Stated:** First time	The registered person shall ensure that all supplementary documentation is accurate, up to date, signed and dated by the person making the entry.

To be completed by: 31 July 2025	**Response by registered person detailing the actions taken:** The Registered Manager has discussed in senior meeting the importance of Supplementary documentation being accurate. A regular review process is now in place to ensure the documentation is accurate, up to date, signed and dated by the person making the entry.
Area for improvement 11 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 31 July 2025	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the correct storage of personal protective equipment (PPE) Ref: 3.3.4
	Response by registered person detailing the actions taken: Correct aprons have been sourced that are on the roll to minimise cross infection. New Dani stations have ben sourced to aid the correct storage of PPE throughout the home and so it is accessible for all staff.

Please ensure this document is completed in full and returned via the Web Portal

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