The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Carlisle House**

Provider: **Presbyterian Council of Social Witness**

Date of Inspection: **20 January 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:	Presbyterian Council of Social Witness
Responsible Person:	Mrs Caroline Yeomans - acting
Registered Manager:	Mr David Cuthbert

Service Profile – This home is a registered residential care home which provides health and social care for up to 16 residents. The home offers placements for people who are undertaking treatment for alcohol, drug or substance misuse. The placements are commissioned by the Belfast Health and Social Care Trust and the Northern Health and Social Care Trust.

The service uses two buildings, a main entrance building, also used for group therapy sessions, meetings and one to one sessions and a housing building with bedrooms, bathrooms, a , a dining room and communal lounges. There is a garden area to the front of the building.

2.0 Inspection summary

An unannounced inspection took place on 20 January 2025, from 10.15 am to 4.00 pm by two care inspectors.

Prior to the inspection RQIA received information raising concerns in relation to the overall organisational governance and culture within the Presbyterian Council of Social Witness.

In response to this information, RQIA decided to undertake an unannounced inspection, which focused on the following areas:

- Governance and management arrangements
- the management of concerns
- the lived experience of residents
- staffing arrangements, induction, training and support of staff and managers
- staff knowledge regarding management of adult safeguarding

Areas for improvement identified at the last care inspection on 28 August 2025 were also reviewed as part of this inspection.

Some of the areas of concern regarding inductions of staff and governance arrangements were substantiated during this inspection. One previous area for improvement was 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 commented positively about the home. Comments included, "The staff are very supportive," "I am very happy with the level of support," and "This is a good place."

Staff told us that they enjoyed working in Carlisle House and that they felt well supported by the management team.

No additional feedback was received from residents, relatives or staff following the inspection.

3.3 Inspection findings

3.3.1 Governance and management arrangements

RQIA were informed by Dermot Parsons, Responsible Individual (RI), on the 7 November 2025, that he would be stepping down on a temporary basis and that Caroline Yeomans would be the acting RI from 10 November 2025. RQIA have since been notified that Mr Parsons has resigned from his role with PCSW.

There has been no change to the day-to-day operational management of the home since the last inspection. Mr David Cuthbert has been the registered manager in this home since 4 April 2005; he is supported by a senior practitioner in the home and by a regional manager. On the day of the inspection the manager was on leave; the inspection was facilitated by the senior practitioner.

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

The senior practitioner confirmed that as well as her regular supervision with the manager, both she and the manager received external supervision six weekly to help support them in their role and as part of their professional development. She was able to describe how this was beneficial to her professional development. Given the nature of the service and the intensive role of counselling undertaken by the management team this additional supervision was commended.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. However, these audits were not always robust in identifying deficits. Where deficits were identified, there was no evidence of action plans in place to drive improvement following the audits. For example, an Infection Prevention and Control audit was carried out on 24 November 2025, deficits had been identified but no action plan had been developed to evidence how or when these deficits would be addressed. Other audits, for example health and safety, hand hygiene and food safety were not being completed on a regular basis. An area for improvement was identified

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

Each home should be visited monthly by a representative of the registered provider to consult with residents, their relatives and staff and to examine all areas of the running of the home. There was no recorded visits during November or December 2025. In addition to this, action plans were being carried forward on a regular basis with no evidence of identified actions being completed. For example, an action to bring the homes audits up to date was first identified in August 2025; this action was carried forward at each subsequent visit with no evidence of it being addressed. An area for improvement was identified.

3.3.2 Management of Concerns

Residents and staff said that they knew how to report any concerns or complaints and said they were confident that the manager would address these concerns. A review of complaints to the home evidenced that these had been addressed in a timely manner.

There was evidence of access to the current complaints and whistle blowing policies and signage in place to direct residents, their relatives and staff on how to raise a concern.

A review of the organisations policies and procedures evidenced that although these were in place, they were due to be reviewed. The senior manager confirmed that this review was taking place.

There was systems in place which evidenced reporting of incidents and accidents to the appropriate organisations and bodies.

3.3.3 The lived experience of Residents

The home was warm and welcoming, residents were observed to be relaxing in the communal areas around the home. There was a homely atmosphere.

The standard of décor and cleanliness of the home is important to the well-being and dignity of the residents and their enjoyment of their home. The home was clean and tidy. However, some parts of the home were showing signs of wear and tear. For example, mould was identified in one shower room and ceiling tiles were found to be either broken or cracked. An area for improvement was stated for a second time.

The sluice room containing hazardous substances was found to be unlocked and cleaning chemicals were found in some of the communal spaces around the home, this is not in line with the homes policies and procedures. This was discussed with the senior practitioner for immediate action and an area for improvement was identified.

Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs. Staff were observed to be interacting with residents throughout the day in a kind and compassionate manner.

Residents said that they attended a weekly meeting to discuss the upcoming week and commented positively about the group work in the home, one resident said, "The groups are good, they are well run." Another resident said, "They encourage participation, the staff are very supportive."

Residents said they knew who the manager was and were confident that any concerns raised would be dealt with.

Discussion with staff evidenced good knowledge of residents' needs in the home. Care records were person centred and well maintained.

Discussion with staff and a review of records confirmed that systems were in place to ensure that staff were suitably trained to meet the assessed needs of residents. Staff evidenced good knowledge of the residents living in the home. Staff confirmed that they had received specialised training to meet the needs of residents in the home. One staff member said, "They are good at encouraging training."

3.3.4 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.
Discussion with staff on duty confirmed that before commencing work in the home, they had an induction. However, a review of records evidenced that inductions for permanent staff were not robust, with limited information on what was discussed being recorded. In addition to this, there was no evidence that inductions for agency staff had taken place. Senior managers advised that they were aware of these gaps and were in the process of addressing this. An area for improvement was identified.

Staff and residents said that they were satisfied with the amount of staff on duty. One resident said, “There is enough staff, it is easy to get the staff.”

Discussion with the staff on duty and review of two weeks duty rotas identified that on most days planned staffing levels were met. When staffing fell below the planned levels, agency staff were engaged to cover the shifts, on one occasion this could not be facilitated and staffing fell below the planned levels. Discussion with staff and a review of records evidenced that a lone worker risk assessment and policy was in place.

Systems were in place to ensure that all staff received regular supervision and appraisal. Staff meetings can provide staff with opportunities to discuss the day to day operation of the home and consider ways to improve it. There was evidence to confirm that staff meetings were being held on a regular basis.

3.3.5 Adult safeguarding

It was established that systems and processes were in place to safeguard residents and ensure that they feel safe within the home. A safeguarding policy was in place and staff demonstrated a sound understanding of their role within the safeguarding processes. Discussion with staff confirmed knowledge of safeguarding systems and protocols; and how to escalate concerns. There was evidence that staff had attended safeguarding training relevant to their role.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the homes safeguarding policy. The safeguarding officer was identified as the safeguarding champion for regulated services within the organisation. Discussion with staff evidenced that they were aware of the recent changes to the safeguarding champion in the organisation and signage was in place throughout the home to reflect this.

3.3.6 Quality 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, individual plans were developed to direct staff on how to meet residents’ needs.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the residents' needs. Staff recorded regular evaluations about the delivery of care. Residents, were involved in planning their own care and the details of their action plans.

Residents care records were held confidentially.

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	2*	4*

* the total number of areas for improvement includes one that has been stated for a second time and one which is carried forward for review at the next inspection.

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 29 **Stated:** First time **To be completed by:** 31 January 2026	The registered person shall ensure that Regulation 29 visits are carried out on a monthly basis. Ref: 3.3.1
	Response by registered person detailing the actions taken: A full review of the monthly monitoring process has been completed, including new documentation and schedule. This was implemented in January 2026. The new MMV protocols and the importance of timely completion has been addressed at Senior Leadership team level and all Regional Managers are aware of their role in carrying out monthly unannounced inspections of regulated services.
Area for Improvement 2 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** 20 January 2026	The registered person shall ensure that a risk assessment of the storage of cleaning chemicals is completed and any control measures identified are put in place. Ref: 3.3.3
	Response by registered person detailing the actions taken: Risk assessment completed 25.02.26. Additional control measures agreed with cleaning contractor including review of training that the cleaner must adhere to as well as following all CSW organisational policy and procedures. This will be monitored by the Registered Manager and any concerns raised formally with the contractor. Data Safety Sheets for cleaning materials used are laminated and located in the Sluice Room in the House.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (Dec 2022)	
Area for improvement 1 **Ref:** Standard E8 **Stated:** Second time **To be completed by:** 31 January 2026	The registered person shall ensure that an effective system is implemented to alert staff when assistance is required. Whilst awaiting the installation of an appropriate system a protocol must be implemented to ensure that staff can be alerted when assistance is required. Ref: 2.0

	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.
Area for improvement 2 **Ref:** Standard 27 **Stated:** Second time **To be completed by:** 31 December 2025	The registered person shall ensure that the areas identified at this inspection in regards to the home's environment are addressed and a time bound action plan is submitted to RQIA on return of the QIP. Ref: 3.3.3
	Response by registered person detailing the actions taken: A meeting has been set up with the PSO Choice Housing on 3rd March 2026 to formally address the issues raised. This was completed and Registered Manager maintaining regular contact with PSO in moving items forward.
Area for improvement 3 **Ref:** Standard 20.10 **Stated:** First time **To be completed by:** 31 January 2025	The registered person shall ensure that working practices are systematically audited to ensure that they are consistent with the homes policies and procedures. Ref: 3.3.1
	Response by registered person detailing the actions taken: The skirting in shower room 1 and corner bathroom when further investaigated resulting in the flooring of both being replaced. This took place first week in January 2026. Working practice audits are completed during the MMV process to ensure that actions identifed within audits are actioned and followed through to completion.
Area for improvement 4 **Ref:** Standard 20.10 **Stated:** First time **To be completed by:** 31 January 2025	The Registered Person shall ensure that all staff receive a structured induction. Records must be maintained to evidence full completion and managerial oversight of the induction process. This area for improvement refers to both permanent and agency staff. Ref: 3.3.4
	Response by registered person detailing the actions taken: As per organisational decision, the Registered Manager and Senior Practitioner will be reinducted into their roles. The meaningful completion of induction documentation will be reviewed by the Regional Manager as part of the MMV process. Once these inductions are completed by deadline for 31st May 2026 CSW staff will also be meaningfully reinducted.

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

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