The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Harold McCauley House

Provider: Presbyterian Council of Social Witness

Date of Inspection: 15 and 16 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 Individual:	Mrs Caroline Yeomans - not registered
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 in frail elderly over 65 years of age; up to 7 patients living with dementia and 2 patients with physical disability over and under 65 years of age. 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 15 January 2025, from 9.55 am to 5.05 pm and 16 January 2026, from 10.30 am to 5.30 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 7 August 2024 and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

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 (PCSW); therefore the following areas were also reviewed:

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

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and trained to deliver effective care. There was a calm, relaxed atmosphere throughout the inspection.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

As a result of this inspection 7 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 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. 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

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "The staff are all very good", "I love it in here", "If I press my buzzer the staff attend to me", "Very friendly staff" and "I have everything I need here".

Staff said that the manager was very approachable, teamwork was great and that they felt well supported in their role. Comments from staff included: "Megan (manager) is excellent", "Staffing levels are good", "I love working here", "Staff morale is very good" and "Good induction".

Relatives spoken with during the inspection said they were very satisfied with the overall provision of care delivery. Comments included: "The care is very good here", Megan (manager) takes things seriously", "Good communication from staff", "The home is perfect" and "Very caring and compassionate care delivery".

Three questionnaires were received following the inspection; two from relatives and one from a patient. Two of the respondents were very satisfied with the overall provision of care and comments included: “Care is good”. Everything is ok”, “Happy with the care and the staff”, “I cannot fault the care given to my parent”, “Everything is done with my parent in mind” and “They are always looking out for the residents”. There was a mixed response from a relative regarding the overall provision of care. Comments were shared with the manager to review and action as necessary.

3.3 Inspection findings

3.3.1 Governance and management arrangements

RQIA were informed by Dermot Parson, 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. Miss Megan James has been the manager since 12 April 2024 and is supported by a regional manager. A discussion was held with the manager regarding submitting an application to register with RQIA; the manager confirmed that they were in the process of completing this.

Discussion with the manager evidenced that she had received an induction into her present post and that there were supervision and appraisal arrangements in place to support her in her role.

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

Review of the most recent fire risk assessment completed on 3 March 2025 evidenced that one action needed to be updated to reflect the date that the action had been addressed. Following the inspection, the manager provided written confirmation that this had been completed.

There was evidence that fire evacuation drills had been completed and a system was implemented by the manager to ensure that all staff attend at least one fire evacuation drill yearly.

The manager had a system in place to monitor accidents and incidents that happened in the home, which were notified, if required, to the patient’s next of kin, the Trust and RQIA. However, review of the accident/incident and near misses policy stated that it was underpinned by the Residential Care Home Standards which are not applicable to a registered nursing home. Details were discussed with the management team and an area for improvement was identified.

The risk of falling was well managed and referrals were made to other healthcare professionals as needed. The home's falls management policy had not been reviewed following relevant updates regarding the falls pathway; the policy referred to both the Residential and Nursing Home Standards and stated that a falls risk assessment should be completed every 3 months instead of monthly. An area for improvement was identified.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. Review of a sample of the reports of these visits evidenced that a number of actions from previous visits had not been carried over to the next visit. It was further identified that a number of areas for improvement from the previous care inspection had not been reviewed to drive the necessary improvements. An area for improvement was identified.

3.3.2 Management of Concerns

Patients and staff said that they knew how to report any concerns or complaints and said they were confident that the manager would address any concern raised.

A review of the record of complaints to the home evidenced inconsistencies in the recording of whether the complainant was satisfied with the outcome of the investigation. An area for improvement was identified.

Review of a sample of the organisations policies and procedures evidenced that these were in place and had recently been reviewed, with the exception of the Whistleblowing policy which the manager confirmed was in the process of being reviewed.

3.3.3 The lived experience of Patients

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patients' needs, their daily routine, wishes and preferences.

Staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly. Staff were also observed offering patients choice in how and where they spent their day or how they wanted to engage socially with others.

At times some patients may require the use of equipment that could be considered restrictive to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

Observation of patients being transported in wheelchairs evidenced that the lap belt was not being used to maintain safety. An area for improvement was identified.

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

The dining experience was an opportunity for patients to socialise, and the atmosphere was calm, relaxed and unhurried. It was observed that patients were enjoying their meal and their dining experience. There was a meal time co-ordinator to oversee the correct delivery of meals.

Patients commented positively about the food provided within the home with comments such as: “The food is very good here”, “Good choice of food” and “If you want something different, they (staff) will get it for you”.

The importance of engaging with patients was well understood by management and staff. A schedule of activities was on display within the home offering a range of individual and group activities such as board games, quizzes, prayer services and music.

Care staff were responsible for completing activities in the absence of the activity person, however, there was no documented evidence of this. This was discussed with the management team who took immediate action during the inspection to address this.

Patients commented positively regarding the activities provided within the home and were seen to be content and settled in their surroundings and in their interactions with staff. Comments included: “The activities are very good here”, “Plenty of activities” and “Very happy here”.

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 patients. There was evidence of robust systems in place to manage staffing.

Observation of the delivery of care evidenced that patients’ needs were met by the number and skills of the staff on duty.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels. Comments included: “Staffing levels have improved”, “Great to have an additional care assistant in the morning” and “Staffing levels are good”.

Staff evidenced good knowledge of the patients living in the home and confirmed that they received regular training in a range of topics including Adult Safeguarding (ASG), infection prevention and control (IPC), moving and handling and fire safety. The manager confirmed that measures were in place to drive compliance with training amongst all grades of staff.

Systems were in place for staff supervision and appraisal; the manager confirmed that staff meetings were mostly completed on a quarterly basis and minutes of meetings were available within the home.

The manager advised that a deputy manager had recently been recruited and would be commencing in early February 2026 once relevant recruitment checks have been obtained. The manager welcomed the recruitment of a deputy manager as additional support.

Staff all commented on the positive teamwork in the home and on the support offered to them by the manager. Comments included: “Megan is a great manager, very approachable and always available”, “I love working here” and “(I) can go to the manager anytime”.

3.3.5 Adult safeguarding

Systems and processes were in place to safeguard patients and ensure that they feel safe within the home. A safeguarding policy was in place and staff demonstrated a good 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 ASG training relevant to their role and it was positive to note 100% compliance.

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 changes to the safeguarding champion in the organisation and signage was in place throughout the home to reflect this.

There were records in place to evidence that any safeguarding concerns recorded had been appropriately reported.

3.3.6 Quality of Care records

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

Review of two patients care records regarding the recommended dietary levels as per the Speech and Language Therapist (SALT) assessment, evidenced inconsistencies in care plans. An area for improvement was identified.

Review of a sample of care records regarding patients at risk of dehydration were mostly well maintained, however one patient's daily fluid intake over several days was below the recommended target with no evidence of a referral to their General Practitioner (GP) as per the instructions within their care plan. The manager confirmed that the patient's needs had changed and that the recommended fluid target would be amended to reflect this.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly. Patient care records evidenced that a number of entries within repositioning charts exceeded the recommended frequency of repositioning as detailed within the care plan. An area for improvement was identified.

Review of a sample of care records regarding wound care evidenced that the type of dressings being applied as per wound evaluation records, were not reflective of the care plans and a number of dressings had not been applied within the recommended timeframe. An area for improvement has been subsumed from a standard to a regulation.

Care records were person centred, regularly reviewed and updated and nursing staff recorded regular evaluations about the delivery of care. A small number of care records required updating; this was discussed with the manager and following the inspection, written confirmation was received that relevant action had been taken to address this.

Confidential patient information was accessible within a communal area of the home. This had been identified at the previous care inspection and assurances were received at that time that relevant action had been taken to address this. An area for improvement was identified.

3.3.7 Quality and Management of Patients' Environment

The home was mostly neat and tidy and patient's bedrooms were found to be personalised with items of memorabilia and special interests. Two areas of the home were cluttered with patient equipment; this was discussed with management who had this addressed during the inspection and agreed to monitor going forward. The manager also agreed to review some of the furniture within the lounge on the first floor to enhance the overall ambience of the room.

Discussion with the manager confirmed that action had been taken following the last care inspection to address some of the environmental deficits, including; the cleaning of carpets within corridors and at reception; the painting of all bedroom walls; and the replacement of an identified bedroom floor covering. Whilst it was positive to note that improvements had been made, a number of walls within bedrooms and communal areas required painting again; some carpets were worn or stained and surface damage was evident to door frames/skirting boards. An area for improvement has been stated for a second time.

Other environmental findings were identified during this inspection. Review of the environmental audits evidenced that the issues identified during this inspection, were not included within the audit. It was further identified that where deficits had been identified, there was no timeframe, person responsible or follow up to ensure the necessary improvements were made. The standard of décor of the home is important to the well-being and dignity of the patients and their enjoyment of their home. An area for improvement has been stated for a second time.

The door to a kitchenette on the first floor was left open with access to items such as; food, fluids, hot water and a prescribed thickening agent. The potential risks were discussed with the manager and an area for improvement was identified.

Cleaning products were unsupervised on two domestic trolleys and a cleaning chemical was easily accessible within an unlocked sluice room, not in keeping with Control of Substances Hazardous to Health (COSHH) regulations. An area for improvement was identified.

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	4*	10*

* The total number of areas for improvement includes one regulation and one standard that have been stated for a second time and one standard regarding medicines management that has been carried forward for review at a future 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 27 (2) (b) **Stated:** Second time **To be completed by:** 15 April 2026	The registered person shall ensure that the environmental/maintenance related issues identified during the inspection are addressed. Ref: 2.0 and 3.3.7
	Response by registered person detailing the actions taken: Following the inspection, a comprehensive review of all environmental and maintenance matters highlighted was undertaken with Management Team. An action plan was developed, prioritising works based on risk, and remedial actions were initiated without delay.
Area for improvement 2 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** 16 February 2026	The registered person shall ensure that the monthly monitoring visit reports are robust to drive the necessary improvements. Ref: 3.3.1
	Response by registered person detailing the actions taken: The layout of the MMV was reviewed to ensure that actions are carried forward in to ensure they are met and that they are robust
Area for improvement 3 **Ref:** Regulation 16 (2) (b) **Stated:** First time **To be completed by:** 16 January 2026	The registered person shall ensure that the type of wound care dressings being applied and the frequency of renewal are reflective of the recommendations within the care plan. Where changes are made to the planned care, the care plan is updated to clearly reflect these changes. Ref: 3.3.6
	Response by registered person detailing the actions taken: Immediate action was taken to review all current residents with wound care needs. A full audit of wound management documentation was undertaken to ensure that prescribed dressings and frequency of change correspond precisely with the wound care plan. Any discrepancies identified were addressed promptly. Training has also been organised

Area for improvement 4 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** 15 January 2026	The registered person shall ensure as far as reasonably practical that all parts of the home to which patients have access are free from hazards to their safety. With specific reference to the secure storage of cleaning chemicals. Ref: 3.3.7
	Response by registered person detailing the actions taken: A full environmental walk-through of the home was completed by the Registered Manager to identify and address any potential risks. All cleaning chemicals were attended and stored in designated locked cupboards or rooms, with access restricted to authorised staff only.
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.
	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 2 **Ref:** Standard 35 **Stated:** Second time **To be completed by:** 16 February 2026	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 Ref: 2.0 and 3.3.7
	Response by registered person detailing the actions taken: Following the inspection, a comprehensive review of the home's governance framework was undertaken. The audit tools for both environmental checks and care plan reviews have been revised to ensure they are more robust, clearly structured, and outcome-focused.

Area for improvement 3 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 31 January 2026	The registered person shall ensure that the home's accident/incident and near misses policy is reviewed to reflect the Care Standards for Nursing Homes (December 2022). Ref: 3.3.1
	Response by registered person detailing the actions taken: Policy was reviewed and updated and is now in place, policy reflects care standards for nursing homes 2022.
Area for improvement 4 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 31 January 2026	The registered person shall ensure that the home's falls management policy is reviewed to reflect best practice guidance. Ref: 3.3.1
	Response by registered person detailing the actions taken: Policy was reviewed and updated and is now in place, policy reflects care standards for nursing homes 202.2
Area for improvement 5 **Ref:** Standard 16.11 **Stated:** First time **To be completed by:** 16 January 2026	The registered person shall ensure that complaint records include the date the complainant was informed of the outcome of the home's investigation and the complainant's level of satisfaction. Ref: 3.3.2
	Response by registered person detailing the actions taken: A review of all current and recently closed complaints was undertaken to identify any gaps in recording. Where required, records were updated to reflect the date the complainant was informed of the outcome and, where possible, their level of satisfaction with the handling and resolution of the complaint. The complaints recording template has been updated to include mandatory fields for: the date the outcome was communicated to the complainant, the method of communication and the complainant's stated level of satisfaction.
Area for improvement 6 **Ref:** Standard 47.3 **Stated:** First time	The registered person shall ensure that lap belts are utilised when transporting patients in wheelchairs, in accordance with the patients assessed needs. Ref: 3.3.3

To be completed by: 15 January 2026	**Response by registered person detailing the actions taken:** Lap belts to be utilised when transferring residents, checklist is now in place to ensure Lap belts are checked before transferring residents.
Area for improvement 7 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 16 January 2026	The registered person shall ensure that for any patient requiring a modified diet, the recommended SALT dietary levels are accurately reflected within care plans. Ref: 3.3.6
	Response by registered person detailing the actions taken: A full review was undertaken of all residents currently prescribed modified diets. Care plans were cross-checked against the most recent SALT assessments to ensure the correct dietary texture and fluid consistency levels were clearly documented.
Area for improvement 8 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 16 January 2026	The registered person shall ensure that patients are repositioned within the recommended frequency as stated within their care plan and that this is accurately recorded within the corresponding repositioning charts. Ref: 3.3.6
	Response by registered person detailing the actions taken: Care plans were cross-checked against repositioning charts to ensure the prescribed frequency was clearly stated and consistently recorded. Any gaps in documentation were addressed, and staff were reminded of the importance of repositioning frequency and accurate recording.
Area for improvement 9 **Ref:** Standard 37 **Stated:** First time **To be completed by:** 15 January 2026	The registered person shall ensure that any record retained in the home which details patient information is stored safely in accordance with the General Data Protection Regulation (GDPR) and best practice standards. Ref: 3.3.6
	Response by registered person detailing the actions taken: Care records are now stored in locked cabinets when not in use. Staff were reminded to follow this practice.
Area for improvement 10 **Ref:** Standard 35 **Stated:** First time	The registered person shall review the storage of items within the identified kitchenette, to reduce any potential risks, in accordance with the assessed needs of patients. Ref: 3.3.7

To be completed by: 15 January 2026	**Response by registered person detailing the actions taken:** Staff have been reminded of their responsibility to maintain safe storage practices and ensure kitchenette's are locked when not in use.

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