The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Lawnfield House

Provider: Presbyterian Council for Social Witness

Date of Inspection: 14 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 – acting
Registered Manager:	Mrs Hazell Owens – not registered
Service Profile – This home is a registered residential care home, which provides health and social care for up to 20 residents with a range of needs, including: learning disabilities, physical disabilities, sensory impairments and those over 65 years of age. The home is separated across two floors and has access to a number of communal areas.	

2.0 Inspection summary

An unannounced inspection took place on 14 January 2026, from 10.30 am to 5.30 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 25 February 2025 were also reviewed as part of this inspection.

Some of the areas of concern regarding staffing arrangements, inductions of staff and the manager and systems to support staff were substantiated during this inspection. Six previous 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 spoken with provided positive feedback about their experiences in the home. Some of the comments shared included, "I love it in here" and "my favourite thing is the food, I love chips and sausages."

Residents were observed engaging in their own preferred activities for example, drawing, playing on their iPad or watching television. Residents commented positively about the care they received in the home and said the staff were approachable and supportive.

Discussion with residents confirmed that they were able to choose how they spent their day. For example, residents could have a lie in or stay up late to watch TV.

3.3 Inspection findings

3.3.1 Governance and management arrangements

RQIA were informed by Dermot Parsons, Responsible Individual (RI), on the 7 November, 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 a change to the day to day operational management of the home since the last inspection. Mrs Hazel Owens commenced her position as the manager in this home on 25 March 2025. The manager was on leave on the day of the inspection; the regional manager for the home facilitated the inspection.

Review of records evidenced that the manager had not received an induction at the time of taking up the post; an induction was commenced on 27 November 2025 and was ongoing at the time of inspection. The Regional Manager confirmed that when they became aware of this oversight a full and meaningful induction with the manager had been commenced. The importance of a timely management induction to ensure the manager is prepared for the role, feels supported and does not become overwhelmed with the job was discussed at length.

The arrangements for supervision and appraisal for the manager were discussed; the regional manager advised that systems were in place to ensure the manager received both.

Residents and staff commented positively about the manager and the regional manager and described them as supportive, approachable and able to provide guidance. Staff were confident that if they had any complaints or concerns they knew who to raise these with and felt these would be managed appropriately.

Review of a sample of records evidenced that a system of audit for reviewing the quality of care, other services and staff practices was in place, however it was not effective in driving the necessary improvements. For example the systems to review the environment, care records and management of agency staff were not effective in identifying improvements needed.

There was a lack of oversight by the manager of the audit process to ensure that any deficits identified were addressed. These issues were shared with the regional manager and an area for improvement was identified.

The duty rota did not accurately reflect that the manager was on leave. The duty rota was not in keeping with good record keeping principles, for example, there was evidence of red pen and pencil used. The recording of the duty rota was identified as an area for improvement at the previous inspection, has not been met and has been stated again for a second time.

The home was visited each month 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. The reports of these visits were completed in detail; where an action plan to drive improvement was put in place, these were followed up to ensure that the actions were addressed. Where actions were not met within the originally agreed timeframes there was ongoing review to ensure they were completed. The reports were available for review by residents, their representatives, the Trust and RQIA.

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 management team would address these concerns. There was evidence of a system in place to monitor complaints or concerns in the home. 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 a system in place which evidenced reporting of incidents and accidents to the appropriate organisations and bodies.

3.3.3 The lived experience of Residents

The atmosphere in the home was calm and relaxed. Residents chose to spend their day either in the lounges or their bedrooms if this was their preferred choice. Some residents were supported by staff to walk in the grounds.

Whilst we observed some positive interactions between residents and staff, the majority of interactions were task driven, neutral in nature and were generally not tailored to the resident as an individual. Care records did not support staff to deliver care in a person centred manner as they were not individualised or inclusive of what mattered most to the residents with regard to their care delivery. This was discussed at length with the regional manager for further consideration.

Residents commented positively on their experiences of living in the home, some of the comments included, “I like it in here, all the girls (staff) are good.”

The residents commented positively about staff in the home and said they were offered choices throughout the day, for example, residents said they were able to go out into the community and attend their own preferred activities, such as going to Slieve Donard spa or going out for walks. Other residents who preferred to remain in the home were provided with opportunities to engage in their own preferred activities, for example: sketching pieces of art or playing games on their iPad’s.

Lunch was served in the main dining room over two sittings to ensure everyone enjoyed an unhurried meal service. The menu was on display and reflected the food options that were on offer and tables were set appropriately. There were sufficient staff present to support residents with their meal in a timely manner. The food served smelt and looked appetising and nutritious.

There were systems in place to ensure residents received the correct diet. In keeping with the overall observations of the care delivery, there was limited evidence of staff promoting a social environment for residents during the lunchtime meal. The dining experience was discussed with the regional manager who agreed to review this further.

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 mostly clean and tidy. Good progress was noted with the previous refurbishment plan with further works planned for the end of January. The refurbishment plan remained under review by management in the home.

Further areas for redecoration were identified in the November 2025 environmental audit; there was no timescale for when these improvements would be made. The need for further improvements to the environment were identified during this inspection; as previously discussed these had not been identified through the home’s environmental audits. Areas requiring attention included the paintwork in the bedrooms which was worn and in need of repair, and

worn vanity units. It was agreed that an updated refurbishment plan would be submitted to RQIA detailing the additional refurbishments required to residents' bedrooms with the projected timeframes for these works to be completed.

Shortfalls were identified concerning the effective management of potential risk to residents' health and wellbeing; specifically, open access to the sluice room and a cleaning trolley left unattended. An area for improvement was identified.

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.

Improvements were required with regards to the number of staff who had attended fire warden training and an area for improvement was identified.

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.

The regional manager confirmed that there were a number of staff vacancies, but could not provide details. This information was requested and provided by the Applicant RI following the inspection, who advised that recruitment was ongoing across all roles in the home.

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 agency staff were not fully completed or robust. For example, gaps were noted throughout the induction records and signatures, to evidence completion, were missing. Agency staff on night duty had the responsibility of being in charge of the home in the absence of the manager; the induction process did not include any information with regard to taking charge of the home. Senior managers confirmed that plans were in place to improve the induction process and ensure staff working in the home were suitably inducted into their specific roles. Two areas for improvement were identified.

A review of staff rotas confirmed that the planned staffing needed to meet the needs of the residents were generally provided. Some staff raised concerns about the impact of the use of agency staff on the continuity of care delivery; this may be a symptom of a lack of meaningful induction for agency staff.

There was evidence that agency staff profiles were not up to date to evidence that the appropriate checks were in place for agency staff to work in the home. The systems in place to monitor these profiles were insufficiently robust in identifying this. An area for improvement was identified.

Whilst systems were in place for staff supervision and appraisal a number of staff had not received individual, formal supervision or their annual appraisal. Two areas for improvement were identified.

3.3.5 Adult Safeguarding

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 clearly demonstrated a sound understanding of their role within the safeguarding processes 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 recent changes to the safeguarding champion and signage was in place throughout the home to reflect this.

There were systems in place to monitor safeguarding referrals and concerns to ensure that these were recorded and reported appropriately. In one instance, RQIA were not assured that all relevant agencies had been notified of a safeguarding incident and there was no clear record of the decision making around this. Assurances were provided that actions would be taken to ensure the appropriate agencies were notified. An area for improvement was identified.

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. However, care plans were not always in place to direct care for individual assessed need, for example: catheter care or falls. An area for improvement was identified.

Care plans were not always regularly reviewed or updated when changes occurred in residents' needs. The previous area for improvement identified with regards to this was not met however as improvements were noted this area for improvement has been stated again for a third and final time.

As previously discussed care records were not individualised to reflect residents' preferences or inclusive of what matters most to the residents with regard to their care delivery. Care records which are person centred can improve the quality and consistency of care by helping staff understand the residents' preferences, needs and routines. 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	2*	14*

*The total number of areas for improvement includes two standards that have been stated again and one regulation and three standards that have been carried forward for review at a future inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with the Regional Manager, 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) **Stated:** First time **To be completed by:** Immediate and ongoing (18 October 2024)	The registered person shall ensure that the maximum, minimum and current temperatures of the medicine refrigerator are monitored and recorded daily and appropriate action is taken if the temperature recorded is outside the recommended range of 2-8^{o}C. Ref: 2.0
	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.
Area for improvement 2 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** 14 January 2026	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: 3.3.3
	Response by registered person detailing the actions taken: The Service Manager, completes and records daily walkarounds, ensuring all store doors are kept locked. The importance of ensuring all doors are locked at all times was discussed at the full staff meeting on the 22/01/26, reminding all staff when accessing a store room/sluice room that the door is to be locked when exiting. The Regional Manager completes and records a walk around when visting the service, providing additional oversight in regard to compliance that all store/sluice room doors are locked.

Action required to ensure compliance with the Residential Care Homes Minimum Standards (Dec 2022)	
Area for improvement 1 **Ref:** Standard 27 **Stated:** Second time **To be completed by:** 1 December 2024	The registered person shall ensure that the home is well maintained and decorated to a standard acceptable for residents. This is specifically in relation to the following areas; • Replacing carpets where needed • Painting of identified areas throughout the home • Replacing items of furniture that are worn A refurbishment plan should be shared with RQIA for review with the quality improvement plan. Ref: 2.0 & 3.3.3
	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 10 **Stated:** First time **To be completed by:** Immediate and ongoing (18 October 2024)	The registered person shall ensure that the management of "when required" medicines prescribed for distressed reactions is reviewed to ensure that detailed care records are in place to direct care and that the reason for and outcome of each administration is recorded. 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 3 **Ref:** Standard 12.10 **Stated:** First time **To be completed by:** Immediate and ongoing (18 October 2024)	The registered person shall ensure that the management of thickening agents is reviewed to ensure that care records are in place to direct staff and that records of prescribing and administration which include the consistency level are maintained. 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 4 **Ref:** Standard 6.6 **Stated:** Third time **To be completed by:** 1 April 2025	The registered person shall ensure that care plans are kept under review and amended as changes occur to accurately reflect the needs of residents. Ref: 3.3.6
	Response by registered person detailing the actions taken: The Service Manager and senior staff team, are rewriting all the Service Users care plans, these are now being individualised with a review document for each identified care plan. The Service Manager completes a monthly care plan audit, to ensure care plans are accurate and refect the needs of the service users. The Regional Manager, reviews two care files during the monthly monitoring visits, ensuring care plans are reviewed regularly and highlighting any discrepancies.
Area for improvement 5 **Ref:** Standard 25.6 **Stated:** Second time **To be completed by:** 25 February 2025	The registered person shall ensure that changes are made to the rota in a timely way to ensure an accurate record is maintained of staff working in the home. The rota must be legible and maintained as per good record keeping principles. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Service Manager has instructed the senior staff team that the rota is to be maintained with all changes to accurately reflect the staffing levels within the service. The staffing rota is reviewed daily by the Service Manager to ensure that the rota is accurate and legible. The Service Manager, has developed an agency rota, to work alongside the staff rota, that will ensure that the staffing rota is legible and maintained. The staff rota, is also reviewed by the Regional Manager during the monthly monitoring visit to ensure accuracy.
Area for improvement 6 **Ref:** Standard 20.10 **Stated:** First time **To be completed by:** 14 January 2026	The registered person shall ensure that audits are completed consistently to identify deficits and action plans are developed to drive the necessary improvements. The manager should retain oversight of the audit process to ensure the necessary improvements are made. Ref: 3.3.1 & 3.3.4
	Response by registered person detailing the actions taken: The Service Manager, has an audit schedule in place,identifying responsbilities for the Service Manager, as well as other responsible individuals, to support and maintain audits, as well as identified timeframes of when the audits are required to be completed.

	This has been discussed with the senior staff team, and heads of departments, to ensure audits are being completed. The Service Manager, reviews the audits weekly and completes and audit analyisis monthly, to ensure any identified actions are captured and actioned to ensure necessary improvements are made. The Regional Manager, during the Monthly Monitoring Visit reviews the audits, to ensure completion and identified actions are completed in a timely manner.
Area for improvement 7 **Ref:** Standard 23.4 **Stated:** First time **To be completed by:** 11 February 2026	The registered person shall ensure that staff complete fire warden training. Ref: 3.3.3
	Response by registered person detailing the actions taken: Fire Warden Training took place on the Tuesday 10th February.
Area for improvement 8 **Ref:** Standard 23.1 **Stated:** First time **To be completed by:** 11 February 2026	The registered person shall ensure that agency staff receive a structured induction. Records must be maintained to evidence full completion and managerial oversight of the induction process. Ref: 3.3.4
	Response by registered person detailing the actions taken: The Service Manager has removed all agency staff profiles, and previous inductions, and created a structured induction template to ensure that all agency staff receive a structured induction that is meaningful to the Service. The Service Manager completes an agency audit monthly, inclusive of ensuring the profile is in place, and a structured induction has been completed. This was an agenda item and discussed at the staff meeting on the 22/01/26.
Area for improvement 9 **Ref:** Standard 25.3 **Stated:** First time **To be completed by:** 11 February 2026	The registered person must ensure any agency staff who have the responsibility for taking charge of the home are appropriately inducted to undertake the role. Ref: 3.3.4
	Response by registered person detailing the actions taken: As well, as an agency induction record, a Person in Charge competency template has been developed for Agency Staff, who are to be in charge of the Service. These are now located with the agency profile and induction records and readily available for inspection.

	This is reviewed by the Service Manager, for accurate completion.
Area for improvement 10 **Ref:** Standard 19 **Stated:** First time **To be completed by:** 14 January 2026	The registered person shall ensure that agency profiles are in place and up to date for those staff prior to commencing work in the home. Ref: 3.3.4
	Response by registered person detailing the actions taken: The Service Manager, has removed all Agency Staff profiles and has received and continues to receive up to date profiles to ensure these are in place. The Service Manager, completes an agency staff audit monthly to ensure all relevant documents are in place.
Area for improvement 11 **Ref:** Standard 24.2 **Stated:** First time **To be completed by:** 11 February 2026	The registered person shall ensure that all staff have recorded individual, formal supervision no less than every six months. Ref: 3.3.4
	Response by registered person detailing the actions taken: The Service Manager has developed a supervsion matrix. Supervisions have been preplanned, ensuring that supervisions are occurring every quarter. The Regional Manager during the Monthly Monitoring Visits reviews the Supervsion Matrix, to ensure compliance and provide oversight.
Area for improvement 12 **Ref:** Standard 24.5 **Stated:** First time **To be completed by:** 11 February 2026	The registered person shall ensure that all staff have an annual recorded appraisal with their line manager to review their performance against their job description and to agree personal development plans. Ref: 3.3.4
	Response by registered person detailing the actions taken: The Service Manager has developed an appraisal matrix, with all appraisals for the year being preplanned, this will ensure that all staff receive a recorded appraisal. The Regional Manager, during the Monthly Monitoring Visits reviews the Appraisal Matrix, to ensure compliance and provide oversight.

Area for improvement 13 **Ref:** Standard 16.4 **Stated:** First time **To be completed by:** 14 January 2026	The registered person shall ensure that records are maintained to evidence decision making as to which statutory bodies are to be informed about any suspected, alleged or actual incidents of abuse. Ref: 3.3.5
	Response by registered person detailing the actions taken: The Service Manager, checks all incident records daily, ensuring these are maintained/reported in a timely mannner and to the correct statutory bodies. All updates/discussions with statutory bodies are now being stored with the original documentation, located within the safeguarding folder, within the Service Managers office to ensure oversight is maintained.
Area for improvement 14 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 14 January 2026	The registered person shall ensure that residents have care plans in place to direct assessed need, this is with specific reference to falls and catheter care. Ref: 3.3.6
	Response by registered person detailing the actions taken: The Service Manager and the Senior staff team, have developed and implemented care plans for falls and catheter care for all identified Service Users.

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

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