Inspection Report

The Presbyterian Council of Social Witness

Composite report of RQIA inspections undertaken in January 2026

1.0 Executive Summary

In Autumn 2025, concerns were raised in the public domain about matters of safeguarding within the Presbyterian Church in Ireland (PCI), leading to an ongoing Police Service of Northern Ireland (PSNI) investigation into those issues. RQIA, as the health and social care regulator for Northern Ireland, considered that such matters may also raise concerns about quality and safeguarding issues in the Registered services operated by the PCI's Presbyterian Council of Social Witness (PCSW). On this basis, RQIA proactively undertook a programme of inspections to ten services registered to the Presbyterian Council of Social Witness between 12 and 26 January 2026. For some services, these inspections were in addition to the usual annual inspection programme. During this process, RQIA kept the Health and Social Care (HSC) Trusts involved and updated on the progress of the regulatory work, and kept the Department of Health (DOH) advised.

The inspections focused on the following areas:

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

Following the inspections, each service received an inspection report to reflect how the service was performing against the regulations and standards, in line with our usual procedures. 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 in each individual service.

Areas for improvement (AFIs) were identified in all of the inspections. These were managed through individual Quality Improvement Plans included in the inspection report for each individual service. These reports are available on the RQIA website www.rqia.org.uk

Enforcement action resulted from the findings of the inspection to Aaron House (RQIA ID: 11950) Day Care Setting (DCS), and Willow Brook (RQIA ID: 11003) Domiciliary Care Agency (DCA). The Responsible Individual (acting) and their representatives were invited to Serious Concerns meetings in relation to these services. At both meetings, they provided a full account of the actions they had taken or planned to take, in order to drive improvement and ensure that the concerns raised at the inspection were addressed.

In summary, the inspections carried out did not find cause for concern about the systems to support adult safeguarding. Areas for improvement have been identified for each individual service and these will be followed up in subsequent inspections. Having considered the findings of all the inspections undertaken, a number of themes have been identified for the Organisation as a whole to consider for further action and this composite report refers to these (see Section 3.0 for details).

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2.1 Background

The Presbyterian Council of Social Witness (PCSW) is the registered provider for twelve services registered with RQIA in Northern Ireland. PCSW are currently registered to operate eight residential care homes, one nursing home, one day care setting and two domiciliary care agencies (DCA) (supported living type) services.

In November 2025, RQIA were advised by the then Responsible Individual (RI) for PCSW, that concerns had been identified with the safeguarding processes within the Presbyterian Church in Ireland (PCI); these concerns focused on issues identified within the church and are subject to an investigation by the PSNI. At this time, the PSNI investigation does not extend to any of the 12 registered services operated by the Presbyterian Council of Social Witness (PCSW). However, in order to provide pro-active assurance to the public, RQIA established a Health and Social Care Investigation Oversight Group. This included representatives from each of the five HSC Trusts, Department of Health (DOH), Strategic Planning and Partnership Group (SPPG) and the PSNI, to provide oversight and co-ordination, while RQIA undertook a proactive inspection programme of the registered services.

2.2. Inspection Methodology

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (The Order) and its supporting regulations, requires the Regulation and Quality Improvement Authority (RQIA) to inspect, monitor and drive improvement in the quality of health and social care services in Northern Ireland.

Registered providers/managers of regulated establishments are required to comply with The Order and the regulations specific to the service. They are also required to ensure that their service operates in accordance with the care standards issued by the Department of Health (DOH). The legislative framework for this programme of inspections included:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Residential Care Homes Regulations (Northern Ireland) 2005
- The Domiciliary Care Agencies Regulations (Northern Ireland) 2007
- The Day Care Setting Regulations (Northern Ireland) 2007
- The Care Standards for Nursing Homes (DHSSPS; updated December 2022)
- The Residential Care Homes Minimum Standards (DHSSPS; updated December 2022)
- The Day Care Settings Minimum Standards (DOH; August 2021)
- The Domiciliary Care Agencies Minimum Standards (DOH; August 2021)

Following a review of the inspections completed in the three months prior to receipt of the information ten services were identified for inspection as follows:

Aaron House (RQIA:11950) Day Care setting

Carlisle House (RQIA:1587) Residential Care Home

Corkey House (RQIA:1591) Residential Care Home

Harold McAuley House (RQIA:1196) Nursing Home

Lawnfield Domiciliary Services (RQIA:020309) DCA (Supported living type)

Lawnfield House (RQIA:1597) Residential Care Home

River House (RQIA:1646) Residential Care Home

Sunnyside House (RQIA:1658) Residential Care Home

Trinity House (RQIA:020243) Residential Care Hoe

Willow Brook (RQIA:11003) DCA (Supported living type)

The programme of inspection did not include Adelaide House (RQIA: 10055) or Aaron House (RQIA: 10054) Residential Homes as these services had been inspected in November and December 2025 respectively. A retrospective assessment of those inspection reports provided assurance that the issues being explored in this programme of inspections had been covered.

The inspections were unannounced and were completed by care inspectors between 12 and 26 January 2026. The inspections focused on the following areas:

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

Throughout the inspection process inspectors sought the views of those living, working and visiting the service; reviewed a sample of records to evidence how the service is performing in relation to the regulations and standards.

Following the inspections, each service received a report to reflect how it was performing against the regulations and standards; these reports are available on the RQIA website www.rqia.org.uk

2.3. Inspection findings

2.3.1 Governance and management arrangements

A review of the governance and management arrangements in place for each service was undertaken. This included:

- the structures in place to support the manager, for example induction, supervision and appraisal arrangements
- the availability / access of the manager to residents, service users, relatives and staff
- the system of audits to assure the quality of the service
- the effectiveness of the monthly monitoring visits undertaken on behalf of the RI.

The inspections evidenced that whilst systems were in place to provide managers with a full and meaningful induction, the completion of inductions was inconsistent across the services. Of the 10 services inspected, only five managers had received an induction on commencement of the post. The manager of Lawnfield House and Lawnfield Domiciliary Services commenced their post in March 2025, however their induction programme did not formally commence until November 2025, a delay of eight months. The managers of Aaron House Day Setting and Willow Brook DCA had not received any formal induction despite both being in post from 2023.

A timely management induction will help ensure the manager is prepared for the role, feels supported and does not become overwhelmed with the job. For managers to gain the best value from induction the process should be initiated at the commencement of their role.

In the registered residential and nursing homes, managers were provided with regular supervision and appraisal to support them in their role. These arrangements were largely supported by the regional manager. Due to the intensive role of counselling undertaken by the management team in Carlisle House additional supervision arrangements were in place to support the manager and deputy manager; an external provider facilitated these.

In one domiciliary care agency and a day care setting, the managers were not in receipt of supervision or appraisal to support them in their role.

Throughout the services, staff expressed confidence in the managers, commenting positively on their approachability and effectiveness. The recent support provided by the regional managers was also acknowledged positively by managers and staff. One manager confirmed that they were completing the ‘My Home Life’ leadership program with the University of Ulster providing them with an opportunity to engage in shared learning and peer support.

In Sunnyside House, staff discussed the impact of frequent changes to the management arrangements. RQIA were notified of three changes to the

management arrangements since March 2025. Whilst no other comments were received during the inspections, a review of the notifications of manager changes submitted by the PSCW to RQIA evidenced frequent changes to management arrangements across the majority of services.

The manager in Willow Brook DCA was providing regular managerial support to another registered service operated by PCSW, which impacted on their availability and presence within Willow Brook.

Number of notification of manager absence received 1 April 2023 to 27 November 2025

Service	No of notification of manager absence
Aaron House (RQIA:11950)	**1**
Aaron House (RQIA: 10054)	**4**
Adelaide House (RQIA: 10055)	**5**
Carlisle House (RQIA:1587)	**0**
Corkey House (RQIA:1591)	**4**
Harold McAuley House (RQIA:1196)	**4**
Lawnfield Domiciliary Services (RQIA:020309)	**5**
Lawnfield House (RQIA:1597)	**8**
River House (RQIA:1646)	**9**
Sunnyside House (RQIA:1658)	**3**
Trinity House (RQIA:020243)	**3**
Willow Brook (RQIA:11003)	**6**

Frequent changes to the management arrangements within a service has the potential to impact negatively on the staff and the service's day to day operation. The need to ensure that managers receive the correct support at the correct time can reduce the risk of them becoming overwhelmed and leaving.

Robust and comprehensive systems of audits were largely in place to monitor and provide the manager with oversight of the quality of the service provided. Managers' oversight of the audit system was clearly evidenced.

Under regulation the registered provider is required to visit services monthly to monitor the quality of services and prepare a report on their conduct. A written report should be available for each visit. Within PCSW, the regional managers complete these visits on behalf of the applicant RI who, along with the manager, receives a copy of the report.

The reports of these visits were completed in detail and were available for review. However, there was an inconsistency with the robustness of the reports to drive improvement. For example, in five of the services in which issues were identified in the report, these were not always followed up to ensure that actions were taken to drive the required improvements.

2.3.2 The management of concerns

Each service had a process in place for the management of complaints. Residents / service users and staff across the services were knowledgeable in how to report any concerns or complaints and were confident that the management teams would address any concerns raised. Relatives in Aaron House Day Care Setting provided comment in the returned questionnaires regarding the robustness of the complaints process and a lack of accessible information about how to make a complaint. This was addressed with the individual service.

Detailed records of the nature of any complaints received were well recorded and demonstrated that any concerns were responded to in a timely manner.

A whistleblowing policy was in place; staff were knowledgeable of their responsibility in raising any concerns. PCSW had recently revisited the whistleblowing policy with staff after they were advised of the concerns shared with RQIA. In a number of the services, the whistle blowing policy is now displayed for ease of reference for staff.

Discussion with staff across each of the services provided RQIA with assurance that they had a good understanding of their role in relation to reporting poor practice.

Some staff in Aaron House Day Care Setting reported limited confidence in the whistleblowing process. This was attributed to a perception that concerns raised may not result in timely and / or appropriate action, alongside anxiety regarding potential negative treatment following disclosure. These opinions were shared with the regional manager and acting Responsible Individual for their consideration and action, as needed.

It was noted that PCSW's policies and procedures were due to be reviewed. It was confirmed by the regional managers that this review was taking place. It is essential that this review is completed to ensure that policies are up to date and reflective of current guidance and best practice.

2.3.4 The Lived Experience of service users

Throughout the inspections, RQIA sought the views of residents and service users and their experience of the service. Generally, residents and service users spoke positively about life in the various services.

In Lawnfield Domiciliary Services DCA, service users told us that they felt listened to by staff who they described as respectful and responsive. Staff in the DCA supported living services were seen to promote autonomy and choice with the service users, who advised RQIA that they were actively engaged in devising their support plans and would discuss goals and objectives regularly with staff. Overall, feedback indicated that service users felt valued, involved in decisions about their support, and they were aided to live safely and with dignity in their own home.

Service users' representatives in Willow Brook DCA were dissatisfied with the provision of communal space which impacted on their ability to meet up and socialise and a recent reduction in the range of activities provided. These opinions were shared with management for further review.

Within Aaron House Day Care setting, we observed person-centred interactions between service users and staff. Staff demonstrated a good understanding of service users' individual communication and delivered inclusive activities that supported the engagement of all service users.

Service users' representative feedback reported considerable improvement in the provision of activities. One service user's representative told us, "I am very happy but more importantly my *(loved one)* is very happy and that is what matters … it is an excellent place".

A number of concerns were identified in Aaron House Day Care Setting and Willow Brook DCA and assurances were provided of the actions taken to address these issues at the serious concerns meetings held on 5 February 2026.

Staff interactions with service users in the residential homes were generally polite, warm and supportive. RQIA were satisfied that staff were knowledgeable of individual service user needs, their daily routine and what mattered most to them with regard to their care. We saw that service users were enabled to exercise choice in relation to their lives in the home including daily routines and social activities.

In Lawnfield House and Trinity House, whilst we observed some positive interactions between service users and staff, many of the interactions were task driven, neutral in nature and were generally not tailored to the service user 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 service user with regard to their care. These observations were discussed with each of the service managers for further reflection.

Across all of the services the lived experience was described positively by service users. Staff were described as approachable, helpful and friendly.

The standard of décor and cleanliness of the service environment is important to the well-being and dignity of the residents / service users and has the potential to impact on how they live, feel and enjoy their surroundings. In four of the residential homes, improvements were required with décor and up keep of the building. It is important that the refurbishment plans are invested in and the necessary improvements made to ensure the homes remain pleasant places for the service users to live.

In six of the services inspected, shortfalls were identified in the Control of Substances Hazardous to Health (COSHH) specifically the storage and unrestricted access to cleaning chemicals, posing a potential risk to service users. Given that this was an issue in a significant number of services, the storage of cleaning chemicals and arrangements for COSHH should be reviewed across all services to ensure they are stored securely in line with COSHH regulations.

2.3.5 Staffing arrangements

In seven services, there was evidence of adequate staffing provision. Observations of care delivery and comments received from service users confirmed that the number of staff rostered daily was adequate to ensure care was delivered in a timely manner.

In Corkey House and Sunnyside House, the planned staffing was not always provided. Recruitment was ongoing in both services. Agency staff were employed in one service to augment the staffing, however in the other service the use of agency staff was not embraced by the manager or staff. In Aaron House Day Care Setting, the staffing arrangements were assessed as insufficiently robust with regard to the complexity of service users' needs. Whilst no impact on care was noted during the inspections, prolonged periods of staff shortages has the potential to impact on the quality of care. An area for improvement in relation to staffing levels was included in the QIP for each service.

Staff in Willow Brook DCA were of the opinion that recent changes to staffing had impacted on their ability to support service users' engagement in the local community. This was discussed locally with the manager.

All newly appointed staff or staff provided via an agency are required to complete a structured orientation and induction to the service. Whilst systems were in place to provide staff with a full and meaningful induction the implementation of this system was inconsistent across the services; this included both permanent and agency staff. In eight of the services inspected, the induction process was insufficiently robust; where a level of induction had been completed records did not evidence the detail of what induction had taken place.

In one service, it was the accepted practice that agency staff did not receive induction. As agency staff are not part of the regular workforce they will be less familiar with the needs of the service users and the environment. Therefore, a robust induction is essential to allow them to work effectively as part of the team.

Agency staff were employed across the majority of services inspected. In one service, staff raised concerns about the impact of the use of agency staff on the continuity of care delivery; in another service staff found it preferable to work below the planned staffing levels rather that work with agency staff. Staff negative opinion of the use of agency staff may be symptomatic of a lack of meaningful induction for agency staff.

In the absence of a robust induction RQIA were not assured that staff were appropriately supported to understand the service, its operational requirements and their role and responsibilities. This had the potential to impact on the quality of care offered to residents/service users.

Staff supervision and appraisal are essential components to support staff to develop, achieve and maintain competency. RQIA observed that there were systems in place but these were not being consistently implemented and staff were not receiving

regular supervision. Staff were generally receiving an annual appraisal but in seven of the ten services, staff were not receiving regular, formal supervision sessions. It was further noted that the revised supervision policy for Aaron House Day Care Setting was not in keeping with the frequency set out in The Day Care Settings Minimum Standards 2021 (Version 1.1: August 2021).

2.3.6 Adult safeguarding

There were systems and processes in place to safeguard service users and ensure that they feel safe within the services. A safeguarding policy was in place and staff demonstrated a sound understanding of their role within the safeguarding processes. Generally, discussions with staff confirmed knowledge of safeguarding systems and protocols; and how to escalate concerns. The inspections evidenced that all of the services were largely compliant with safeguarding processes.

There was evidence that staff had attended safeguarding training relevant to their role. It was positive to note that, following the concerns with PCI, shared in November 2025, the arrangements for safeguarding had been reviewed and the arrangements for reporting revisited with staff. In Sunnyside House, there was one incidence where one member of staff was unable to differentiate between the thresholds of when something was a potential complaint of poor practice or if it required review under Adult Safeguarding; it was agreed this would be addressed with the individual member of staff.

In Lawnfield House, the records did not provide complete assurance that the PSNI had been notified in regard to allegations of theft. The need to ensure that clear and accurate records are maintained of all decisions taken was discussed. An AFI was made to ensure good compliance with record keeping.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the organisational safeguarding policy. Following the concerns identified in PCI, a new safeguarding champion had recently been appointed for the registered services. Staff were able to identify the safeguarding champion and were aware of the recent changes in the organisation. Signage was in place throughout the services to advise who the safeguarding champion was.

The inspections evidenced that all of the services were largely compliant with safeguarding processes.

3.0 Conclusion

As stated within Section 1.0, this composite report has brought together the outcomes of the ten inspections undertaken to services registered and operated by the Presbyterian Council of Social Witness. Areas for improvement have been

identified for each individual service and these will be followed up in subsequent inspections. Having considered the findings of all the inspections undertaken, a number of themes have been identified for the Organisation as a whole to consider for further action.

Governance and management arrangements

1. PCSW should give consideration to undertaking an organisational wide review of the implementation of the induction process for managers and ensure that it is:
    - Implemented consistently across services
    - initiated at the commencement of the manager's appointment
    - includes managers who have been promoted from more junior roles within PSCW

2. PCSW should give consideration to undertaking an organisational wide review of the arrangements for manager supervision and appraisal to ensure that it is provided to managers consistently across all registered services.

3. PCSW should give consideration to undertaking an organisational wide review of the arrangements for the completion of the monthly monitoring visits to ensure they are effective in monitoring the quality of services and driving the necessary improvements.

4. Due to the frequent turnover of managers and its potential impact on the quality of service delivery, PCSW should consider implementing measures to improve managerial support and retention.

Management of concerns

1. It is advised that a meaningful timeframe is set for the completion of the ongoing review of polices.

2. PCSW should meet with the staff in Aaron House Day Care Setting to discuss their concerns with regard to the whistle blowing process and provide reassurance.

The lived experience of residents / service users

1. It is advised that PCSW ensure the refurbishment plans for services are invested in and the necessary improvements are made to décor and repair of the environment to ensure the services remain pleasant places for the service users to live.

2. It is advised that the storage of cleaning chemicals and arrangements for COSHH should be review across all services to ensure they are stored securely in line with COSHH regulations.

Staffing arrangements

1. PCSW should give consideration to undertaking an organisational wide review of the implementation of the induction process for staff to ensure that:
    - it implemented consistently across services
    - managers understand the significance of and importance of a robust induction for staff, including agency staff.

2. PCSW should give consideration to undertaking an organisational wide review of the staff supervision to ensure staff receive this support.

The Regulation and Quality Improvement Authority

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James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews