

Inspection Report

Name of Service: Willow Brook

Provider: Presbyterian Council of Social Witness

Date of Inspection: 13 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 (PCSW)
Responsible Individual/Responsible Person:	Mrs. Caroline Yeomans (Acting)
Registered Manager:	Mr. Francis Mooney (Acting)
Service Profile: Willow Brook is a domiciliary care agency, supported living service which provides personal care and housing support to service users living in their own homes in Coleraine. It is located within the Northern Health and Social Care Trust (NHSCT) area.	

2.0 Inspection summary

An unannounced inspection took place on 13 January 2026 from 10.45 am to 6.20 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 (PSCW).

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 29 April 2024 were also reviewed as part of this inspection.

Enforcement action resulted from the findings of this inspection. A number of breaches of regulations and standards were identified. This gave rise to serious concerns regarding governance arrangements and managerial oversight, staffing arrangements, staff selection and recruitment, and monthly monitoring arrangements.

As a result of this inspection a total of nine new areas for improvement were identified. Details of these can be found in the main body of the report and in the Quality Improvement Plan.

Two previous areas for improvement were not met and have been restated; three previous areas for improvement were assessed as met.

A Serious Concerns meeting was held on 5 February 2026 with the acting Responsible Individual and their representatives to discuss these shortfalls.

During the meeting the acting Responsible Individual provided a full account of the actions taken/to be taken in order to drive improvement and ensure that the concerns raised at the inspection were addressed.

Following the meeting, RQIA has given the acting Responsible Individual and the Acting Manager a period of time to demonstrate that the improvements have been made in a sustained manner and advised that a further inspection may be undertaken to ensure that the concerns have been effectively addressed.

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 agency 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 Willow Brook. This included the previous Quality Improvement Plan issued, registration information, and any other written or verbal information received from service users', their representatives, staff and the commissioning Trust.

Throughout the inspection process, inspectors seek the views of those receiving the service, their representatives and those working in the agency and examine a sample of records to evidence how the agency is performing in relation to the regulations and standards.

Information was provided to service users, their representatives, staff and other stakeholders on how they could provide feedback on the quality of the service. This included telephone calls, questionnaires and an electronic survey.

3.2 What people told us about the service

Service users consulted on the day of inspection provided mixed feedback. One service user advised that they had discussed with their multidisciplinary team the desire to obtain more independent accommodation. This service user confirmed that staff had been supportive of their wishes and aiding them in preparing for their recent review.

Other service users told us that they were satisfied with the service that they receive from Willow Brook. They told us that staff were "good" and they helped them. Service users were observed communicating their wishes and needs to staff who were responsive.

Service users' representative feedback was varied. One service user's representative advised that they were content with the quality of care however expressed concerns regarding lack of consistency and, consequently, continuity of care.

Another service user's representative described the acting Manager as "fabulous" but emphasised that they are temporary. Staff were commended on their practice but concerns were shared by service users' representatives regarding what they felt to be "inadequate staffing".

Service users' representatives also expressed concerns regarding a perceived lack of activities promoting socialisation amongst service users and a "lack of meaningful community engagement". One service user's representative felt Willow Brook "has changed a lot ... I do not feel it has changed for the better".

Staff who provided feedback on the service commented that the care was "very good" and "support staff give 110%". Staff described their colleagues as "brilliant" and advised that the support team goes "above and beyond".

However, some staff told us that they had inadequate time to complete all tasks expected of them and that staff felt "stretched". Staff also described how improvements were needed in regard to allocation of tasks among the staff team.

Commissioner feedback confirmed that they felt Willow Brook was meeting the assessed needs of service users. Northern Health and Social Care Trust (NHSCT) representatives described the service having previously been "very good" at organising and facilitating activities and promoting social engagement but was aware that such provision had declined.

All feedback was shared with the acting Manager during and/or following the inspection for consideration and action, as appropriate.

3.3 Inspection findings

3.3.1 Governance and management arrangements

RQIA were informed by Dermot Parson, 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 no change to the day to day operational management of the agency since the last inspection. Mr Francis Mooney has been the acting Manager for Willow Brook since 8 November 2023 and is supported by a regional manager.

Discussion with the acting Manager confirmed that they had not received an induction upon commencement in post nor had they been in receipt of regular supervision or appraisal to support them in their role. We were advised that the recent appointment of a new regional manager has created a sense of support for the acting Manager, which was previously felt by them to be lacking. Staff supervision and appraisal are further discussed in section 3.3.4.

Service users responded positively by clapping and smiling when advised the acting Manager was due to attend to facilitate the inspection.

Staff described the acting Manager as, “very understanding”, “a good listener and approachable” however staff did share concerns that his presence within the service was inconsistent. Additionally, staff felt that concerns raised were not responded to in a timely manner and that internal communication required improvement.

Review of the staff duty rota evidenced that the acting Manager’s working hours within the setting are not recorded. On arrival, staff were unable to advise if the acting Manager was expected to be on duty that day. An area for improvement was identified.

Discussion with the acting Manager and acting RI during and/or following the inspection evidenced that the acting Manager was also providing regular managerial support to another registered service operated by PCSW which negatively impacted his availability and presence within Willow Brook; the need for consistent and meaningful managerial presence at all times within the setting has been stressed.

A review of monthly monitoring reports did not provide assurance that care delivery and service provision was being consistently and robustly quality assured. For instance, there was no evidence that training deficits identified in the September 2025 report had been addressed.

In addition, review of the September 2025 and October 2025 reports highlighted that some deficits initially identified in the July 2025 report remained unresolved. It was also noted that several deficits highlighted during this inspection had not been identified and/or addressed within these monthly reports.

The aforementioned shortfalls are particularly disappointing in view of the fact that RQIA highlighted similar deficits with the Responsible Individual during an enhanced feedback meeting on 29 May 2024 following an unannounced care inspection of this agency on 29 April 2024. An area for improvement was identified.

3.3.2 Management of Concerns

There were processes in place relating to management of complaints. The complaints log was found to be up-to-date and contained information about outcomes. Service users spoken with told us they were aware of how to make a complaint and stated staff had assisted them with these when required. One service user expressed dissatisfaction regarding the management of a complaint they made, this was discussed with the acting Manager who agreed to address this.

Staff who spoke with the Inspectors had a clear understanding of their responsibility in identifying and reporting any actual or suspected incidences of abuse. They could also describe their role in relation to reporting poor practice and their understanding of the agency’s policy and procedure with regard to whistleblowing.

Some staff 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; this feedback was anonymously shared with the acting Manager and acting RI during and/or following the inspection for consideration and action, as appropriate.

Review of incident records identified that they were managed appropriately. There was evidence that incidents were audited on a regular basis, to establish any patterns/trends. It was good to note that these were reviewed as part of the monthly quality monitoring process.

3.3.3 The lived experience of Service Users

Inspectors received consent to enter one property in which three service users resided. The property was observed to be inviting, clean and homely. Service users told us that the staff had supported them in purchasing new living room furniture. There was an open planned living room and kitchen area, in which we observed service users coming together to enjoy mid-morning refreshments.

Interactions observed between service users and staff illustrated promotion of autonomy, with choice provided. One service user produced a dessert which they advised they had made along with staff; the service user advised that they enjoyed learning new recipes with support of staff and that they would cook or bake on a regular basis. Staff demonstrated a good understanding of each service user's needs and identified risks, with fluids and foods prepared in line with their assessed International Dysphagia Diet Standardisation Initiative (IDDSI) levels.

Positive, person-centred interactions were observed between service users and staff. Staff demonstrated a strong understanding of each service user's individual communication methods, accurately interpreting non-verbal cues and gestures. This enabled meaningful engagement and ensured the service user's needs and preferences were effectively understood and responded to.

One service user consented to show an Inspector their bedroom. It was positive to see the individual's own personal preferences and interests reflected in their bedroom, for example framed photographs of their family and football merchandise of their favourite team displayed.

One service user's representative told us that they felt the physical environment was in "good condition" however, expressed concerns regarding the lack of responsiveness of the housing association in addressing remedial works.

Some service users' representatives expressed concerns regarding the lack of communal spaces available for service users within Willow Brook to meet up and socialise.

Service users' activities included attendance at local day care settings, day opportunities and/or engagement with local community groups. One service user told us that they volunteered locally and advised that they enjoyed this. Another service user told us about a trip taken with staff to Portrush.

Staff stated that there had been a significant reduction in activities for service users. Staff felt that this was a direct result of the current staffing levels available. Staff described how their ability to support service users' engagement in the local community had been negatively impacted due to changes regarding transport arrangements within the setting, and that staff consultation regarding these changes was inadequate.

Similar feedback had been received from service users' representatives who expressed concerns that service users nor their representatives had been consulted prior to implementation of the changes relating to transportation.

Some service users' representatives also expressed concerns regarding social isolation. They advised that the provision of service users' outings, which would have been planned in consultation with them, had significantly reduced and their absence had a detrimental impact on the quality of life of service users.

One service user's representative advised that service users "do not have the opportunity to meet up", while another stated, "the social aspect has certainly gone and that is a disappointment".

This feedback was shared with the acting Manager and acting RI for consideration and action, as appropriate.

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 service users.

Review of governance records received after the inspection, highlighted concerns in relation to the safe and effective selection and recruitment of staff. Specifically, it was noted that the agency's selection and recruitment processes did not enable the acting Manager to consistently obtain and review a full and complete employment history of all prospective staff. This limits the acting Manager's ability to assure himself that staff are suitable for the role they have applied for, and that any unexplained gaps of employment may be identified and explored; this deficit has the potential to place service users at risk of harm. An area for improvement was made.

Concerns were also identified in regard to the absence of a robust induction process for staff, which does not provide assurances that staff are appropriately supported to understand the service, its operational requirements, and their role and responsibilities. An area for improvement was identified.

Review of governance records and feedback from staff evidenced the lack of an effective system to ensure that all staff, undergo an appraisal in a timely manner. The acting Manager stated that time pressures was a significant factor contributing to the lack of staff appraisals. An area for improvement was identified.

Staff supervisions were also found to be non-compliant with the agency's own policy and procedures. The acting Manager stated that a wall calendar was used to schedule staff supervisions in the absence of a robust and effective system. The provision of staff supervision in a timely and consistent manner is critical to provide guidance, support professional development, and uphold accountability. An area for improvement was identified.

A review of training records also identified significant deficits in relation to staff training. This was particularly concerning in the case of one identified staff member providing unsupervised personal care to service users with assessed needs, including dysphagia and deprivation of liberty (DoLS), without having completed the mandatory training required to safely meet those needs. This has the potential to place service users at risk of significant harm. An area for improvement was identified.

There was a system in place whereby staff completed competency assessments to ensure that they were competent in their roles and responsibilities. Competency assessments included examination of employees' capabilities to act as the person in charge in the absence of the manager. All staff, with exception of two employees who were in probation, were found to have competency assessments in place.

It was noted that one identified staff member had not completed mandatory training nor had a competency assessment in place prior to being left in charge of the service. An area for improvement was identified.

In addition, discussion with staff and review of the staff rota highlighted that staffing arrangements were insufficiently robust in relation to the safe and effective management of service users presenting with complex needs and/or behaviours.

It was noted that despite a previous incident involving one service user absconding from the premises, there was no contingency plan in place to address foreseeable risks associated with managing such needs in a safe, responsive and person centred manner. An area for improvement was identified.

3.3.5 Adult safeguarding

It was established that systems and processes were in place to safeguard service users and ensure that they feel safe within their own homes. 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 organisational safeguarding policy. Staff were able to identify the safeguarding champion 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 service to reflect this.

There were records in place to evidence that any safeguarding concerns recorded had been appropriately reported. However, it was noted that the system for ensuring that relevant staff were appropriately updated in regard to ongoing adult safeguarding referrals was lacking; the Regional Manager advised that safeguarding procedures were being reviewed internally to permit appropriate staff greater access so as to be fully advised regarding the progression of safeguarding referrals made. This will be reviewed at a future inspection.

3.3.6 Quality of Care records

Service user care records were stored securely and accessible to authorised personnel in accordance with data protection regulations.

Service users' needs were assessed when they were first referred to the agency and before care delivery commenced. Following this initial assessment, care plans were developed to direct staff on how to meet service users' needs. There was evidence of consent forms regarding the sharing of information.

Whilst care plans were in place to direct staff on how to meet service users' needs, it was identified that these were not kept under regular review and as such contained inaccurate information. For example, one service user's care records had not been reviewed since 2023. Another individual had a risk assessment and management plan contained inaccurate information regarding supervision levels. An area for improvement has been identified.

The management of restrictive practices was also considered. Feedback from staff and review of care records evidenced that restrictive practices were employed without appropriate documentation; multidisciplinary collaboration; and due consideration to the potential impact on other service users.

In addition, the acting Manager was unable to provide sufficient assurances that they possessed an adequate understanding of restrictive practices, including the circumstances in which they may arise and the governance arrangements required to oversee them. An area for improvement was stated for a second time.

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	7*	4

* the total number of areas for improvement includes two that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Francis Mooney, Acting 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 Domiciliary Care Agencies Regulations (Northern Ireland) 2007	
Area for improvement 1 Ref: Regulation 15(4) Stated: Second time To be completed by: 09 February 2026	The Registered Person shall, so far as is practicable, ensure that the prescribed services which the agency arranges to be provided to any service user meets the service user's needs specified in the service user plan prepared in respect of him. This relates specifically to the Restrictive Practice Log. Ref: 3.3.6 Response by registered person detailing the actions taken: Restrictive Practice Log is updated and maintained as part of the monthly audit schedule. This document details the intricacies of the restriction as well as how this is managed. The Registered Manager and staff team are to receive additional training on 1st April with MCA training being delivered by NHSCT. The clients in Willow Brook now have access and support of a NHSCT aligned Social Worker which will allow for Care Reviews to occur to ensure compliance.
Area for improvement 2 Ref: Regulation 16(1)(a) Stated: Second time	The Registered Person shall ensure that suitably qualified and competent persons are available to be consulted during any period of the day in which a person is working for the purposes of the agency.

To be completed by: Immediate from the date of the inspection	Ref: 3.3.4 Response by registered person detailing the actions taken: The Registered Manager is substantively based at Willow Brook. The Team Leader who is suitable qualified would be in position in his absence. As of 18 th March 2026 there now a new Registered Manager (Acting) in post on a six month secondment to provide governance and oversight as well as culture and direction to Willow Brook and the induction and probation of the same will be kept under review by the Regional Manager.
Area for improvement 3 Ref: Regulation 23(1)(4) Stated: First time To be completed by: 13 March 2026	The Registered Person shall ensure that actions contained within the quality monitoring reports are meaningfully reviewed and timely resolution sought. Where actions are consistently repeated there must be evidence that these have been escalated internally for consideration. 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. Service Managers are aware that if there are outstanding reasons as to why actions highlighted in the MMV are not completed by the following month then the rationale behind this should be documented and escalated where necessary.
Area for improvement 4 Ref: Regulation 13(a)(b)(c)(d) Stated: First time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure that recruitment and selection processes comply with Regulations and records are obtained in line with Schedule 3 for all applicants. Ref: 3.3.4 Response by registered person detailing the actions taken: Recruitment & Selection processes are centralised within the HR Department in Assembly Buildings, with the Registered Manager being involved in the recruitment process through using our online recruitment platform. The Registered Manager is involved in the shortlisting and interviewing of candidates. Prior to commencement employment the HR department will send the Registered Manager a pre-populated recruitment checklist including due diligence pre-employment checks for the Registered Manager to review and approve before a start date is generated. The Recruitment Checklist would then remain in the service within the Employee File in the event of future review.
Area for improvement 5	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.

Ref: Regulation 16(5)(a)(b)(i)(ii)(iii)(iv) Stated: First time To be completed by: Immediate from the date of the inspection	Ref: 3.3.4 Response by registered person detailing the actions taken: As per organisational decision, a reviewed Induction Process will be developed within CSW to ensure meaningful inductions. A cross-departmental Working Group has commenced as of 11th March, comprising of Regional Managers, Service Managers, HR representatives and led by our Compliance Manager to scope and develop a new meaningful induction template for all care services. Once these inductions are completed by deadline for 31st May 2026 CSW staff will also be meaningfully reinducted.
Area for improvement 6 Ref: Regulation 16(1)(a) Stated: First time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure, having regard to the size of the agency and the number and needs of the service users that there is at all times an appropriate number of suitably skilled and experienced persons scheduled on rota. Ref: 3.3.4 Response by registered person detailing the actions taken: The service rota is kept under constant review and ensures that there is an adequate skill mix of experienced staff on shift at all times. There is minimal agency use within the service so staff and service users have the familiarity expected within a supported living environment and support personalisation is able to take place. The Service Manager has oversight of the service rota in collaboration and support from the Team Leader, both of which would ensure the rota is signed off when any changes are made/completed to ensure a good skill mix in service.
Area for improvement 7 Ref: Regulation 15(2)(c) Stated: First time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure that service user's plans contain all necessary information to adequately and safely respond to identified needs and presenting risks. Ref: 3.3.6 Response by registered person detailing the actions taken: Care Plans are kept under review dependent on client need. Organisationally for our supported living services we have changed our Reg 23 monthly monitoring visit template to ensure that internal Care Plan reviews are completed every 6 months to ensure these are kept up to date and relevant. In addition to this, should there be a change in the tenant's circumstances or following an incident etc the Care Plan would be updated to reflect this.

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 Ref: Standard 8.1 & 10.4 Stated: First time To be completed by: Immediate from the date of the inspection	The registered person shall ensure that the manager's hours and the capacity in which these were worked are clearly identified on the staff rota. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Registered Manager's working capacity and hours are recorded on the service rota. This is signed when any changes are made/on completion and reviewed monthly as part of our Reg 23 visits.
Area for improvement 2 Ref: Standard 13.3 Stated: First time To be completed by: 13 April 2026	The Registered Person shall ensure that each employee receives appropriate supervision and that there is appropriate means to enable monitoring of compliance in respects to supervision. Ref: 3.3.4
	Response by registered person detailing the actions taken: CSW Policy has now been reviewed and updated to align all care staff to receive quarterly supervisions. Managers will continue to receive monthly supervision. To ensure compliance, all supervisions are recorded on the Staff Quality & Governance Matrix include pre-populated dates for the remainder of the year to ensure protected time for the staff member. This is audited by the Regional Manager as part of the quality monitoring visits under Reg 23.
Area for improvement 3 Ref: Standard 13.5 Stated: First time To be completed by: 13 April 2026	The Registered Person shall ensure that each employee of the agency receives an appraisal in keeping with best practice. Ref: 3.3.4
	Response by registered person detailing the actions taken: All staff will receive an annual appraisal in line with their starting date with the service. All appraisals are recorded on the Staff Quality & Governance Matrix and include those dates pre-populated for the remainder of the year to ensure protected time for the staff member. This is audited by the Regional Manager as part of the quality monitoring visits under Reg 23.
Area for improvement 4 Ref: Standard 12.3 & 12.4 Stated: First time To be completed by: Immediate from the date of the inspection	The Registered Person shall ensure that mandatory training requirements are met for all employees of the agency, this includes any additional or bespoke training required to meet the needs of service users. Ref: 3.3.4
	Response by registered person detailing the actions taken: The Registered Manager has overall responsible for the training compliance within their service. Using our online training platform, managers should ensure that the service remains at 95% compliance rate or above at all times. This is reviewed by the Regional Manager through the quality monitoring visits and if this

	falls below this 95% compliance percentage then an action plan is put in place to ensure remedial completion. Where bespoke training needs are identified the Manager would discuss this with both the Regional Manager and the Training Manager to ascertain the best method for implementing this training into the service.
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