The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Rathmena House Care Home

Provider: MD Healthcare Ltd

Date of Inspection: 27 January 2025

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:	MD Healthcare Ltd
Responsible Individual:	Mrs Lesley Catherine Megarity
Registered Manager:	Ms Emma Turner – not registered
Service Profile – This home is a registered nursing home which provides care for up to 29 patients who require nursing care due to being over 65 years of age and/ or who have a physical or learning disability. The home is on one ground level and there is a communal lounge and dining area.	

2.0 Inspection summary

An unannounced inspection took place on 27 January 2025 between 9.30 am and 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; to assess progress with the areas for improvement identified, by RQIA, during the last inspection on 12&17 October 2023 and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that effective and compassionate care was delivered to patients and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

Patients said that living in the home was great. Patients unable to voice their opinions were observed to be to be enjoying the company of other patients and staff; smiling and engaging in conversations.

As a result of this inspection three 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 a future 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 patient's, 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.

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 said "this is a great place to live" and "we're like a family in here". Patients spoke of feeling like staff treated them like family saying "you can't get better than this". Patients told us they feel safe in the home and appreciated the atmosphere created in the home. Others said they felt there was enough staff and that staff were respectful in how they spoke to and cared for patients. Patients said they felt well cared for by the staff saying that staff knew them well and knew how to lift their spirits if they were having a difficult day.

Observation of care delivery and discussion with patients established that there was choice as to where the patients spent time and who was involved in their care. Patients spoke well of the organised activities and had choice as to whether they engaged or not. Discussion with patients confirmed that they were able to choose how they spent their day saying "it's great in here, I get to watch the sport". For example, patients could have a lie in and where they sat to eat their meals. There was evidence that patients' birthdays ere celebrated in the home.

Relatives told us "they're great in here" and commented that their loved one was treated like a family member by the staff. Relatives commented that staff were attentive to personal preferences of individuals; for example, specific attention was paid to personal care and grooming.

There were two questionnaires returned from relatives which were very positive about the care given to their loved ones and the compassion shown to visiting relatives. Some commented that staff "go the extra mile, it's just one big family". This positive feedback was shared with the manager who shared it with the staff for their encouragement.

3.3 Inspection findings

3.3.1 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.

Patients said that there was enough staff on duty to help them. Staff said there was good team work across the home and that they felt well supported in their role and that they were satisfied with the staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

Review of the duty rota and discussion with staff established that planned staffing levels were met and if there was a short notice change, staff worked as a team to cover this to facilitate consistency of staff for the patients.

Staff advised that they loved their job, advising that they felt well supported by management to ensure training was up to date. It was observed that staff know the patients well and have good communication with one another.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were observed to be prompt in recognising patients' needs and were proactive in meeting these needs. For example, where a person was unable to communicate verbally, staff provided options and engaged with the them to offer choice.

Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs. Where a person required additional support in transferring from one place to another in the home, staff treated them with dignity and compassion.

Patients were offered choice in how they spent their day; some read the newspaper, other read book or coloured in and watched TV. Some patients listened to music or browsed through a magazine and then later engaged in a group activity. Staff engaged with patients offering choices and facilitating preferences.

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, music was playing, and the atmosphere was calm, relaxed and unhurried. Patients were enjoying their meal and their dining experience; patients and staff were laughing and joking with one another. There was an appointed mealtime coordinator and there was good communication observed to ensure that individuals received the correct meal to reduce the risk of choking. Staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. Patients were asked their preferences for what they had to drink and what condiments they

wished to have with their meal. There were a small number of occasions when staff did not consistently take opportunities for hand hygiene. This was discussed with the manager who agreed to review.

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

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, patients had assessments for using mats which notify staff when stood on and patients had their rolators and zimmer frames close to them to allow for safer mobilising.

The importance of engaging with patients was well understood by the manager and staff. Life story work with patients and their families helped to increase staff knowledge of their patients' interests and enabled staff to engage in a more meaningful way with their patients throughout the day.

Observation of the planned activity where patients completed well known phrases confirmed that staff knew and understood patients' preferences and wishes. Staff supported patients to participate in planned activities or to remain in their bedroom with their chosen activity such as reading, listening to music or waiting for their visitors to come. There was a display of a variety of scheduled activities both in group and individual basis. For example, tasting competitions, quiz, board games. Activity staff knew the patients well and were able to engage them; pampering ladies who said this "can turn the day around" and bringing in newspapers for others who like to start their day with a local newspaper.

Activities records did not always evidence where patients had declined to engage; rather it noted only when they had engaged in a particular activity. This was discussed with the manager who agreed to review this as it is not in keeping with best practice for record keeping.

3.3.3 Management 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.

Generally, care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

When a patient has returned from hospital, there was limited evidence that care plans and risk assessments were accurately reviewed to ensure current care needs were known. An area for improvement was stated for a second time.

Patients may require special attention to their skin care. There was evidence that patients were assisted by staff to change their position in line with their prescribed care. However, the system for documenting skin checks was not robust; the repositioning records did not indicate the

frequency in which skin should be checked nor were these checks recorded. An area for improvement was identified.

The manager advised that a lockable cabinet has been ordered to hold patient records to ensure that patients care records are always held confidentially. This will be reviewed at a future inspection.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. Staff were observed to be cleaning communal equipment in-between use.

'Homely' touches such as photographs and painting were on display throughout the home. For example, photographs of seasonal parties and music events were on display. Both the dining room and living area were decorated in a homely way such as placemats and table condiments, and bookshelves in the lounge.

Patient's bedrooms were clean and tidy, and there was an array of personal items such as family photographs and personal ornaments.

Environmental and safety checks were carried out, as required on a regular basis, to ensure the home was safe to live in, work in and visit. For example, fire safety checks. The manager also detailed specific areas of the home where there are plans for updating the décor.

Shortfalls were identified in regard to the effective management of potential risk to residents' health and wellbeing; specifically, the supervision of a medication trolley and unsupervised food items. An area for improvement was identified.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection.

Patients, staff and relatives commented positively about the manager, describing her as supportive, approachable and able to provide guidance. It was positive to note that the manager is currently engaging in a programme called My Home Life. This programme seeks to support care homes in improving the quality of care delivered in the home, supporting managers and staff in how they manage training and education and how the community can be involved in the life of the home.

A robust system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the manager responded to any concerns, raised with them and took measures to improve practice.

Where an issue had been identified through the complaints process, records demonstrated that the manager had noted the completion of a solution or made a new timeframe for reviewing this.

There were systems in place to monitor staff compliance with mandatory training. The manager proactively supported staff to engage in these subjects in order to deliver safe care.

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	1	2*

* the total number of areas for improvement includes one standard which has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with the manager, Emma Turner, 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 14 (2) (a) (c) **Stated:** First time **To be completed by:** 27 January 2025	The registered person shall ensure that trolleys are not left unsupervised with potentially hazardous items accessible to patients. This includes but is not exclusive to medication and tea trolleys. Ref: 3.3.3 **Response by registered person detailing the actions taken:** This was addressed with the staff on the day of inspection. Supervision sessions have been completed with nursing staff and care staff to ensure that trolleys are not left unattended. This area will be closely monitored by the Manager and Deputy Manager.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for Improvement 1 **Ref:** Standard 4.7 **Stated:** Second time **To be completed by:** 27 January 2025	The registered person shall ensure patients care records are appropriately reviewed and updated on the patient's re-admission to the home; for example, following a hospital admission. Ref: 3.3.4 **Response by registered person detailing the actions taken:** This was rectified on the day of inspection; the resident's care plan was updated to reflect any changes made following the hospital admission for one resident. Discussions have been held

	with the nursing staff to highlight the importance of appropriately reviewing and updating a resident's care records on re admission back into the home, this will be closely monitored by the Home Manager and Deputy Manager through the auditing process.
Area for Improvement 2 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 27 January 2025	The registered person will ensure that repositioning records evidence the skin checks as prescribed in the patients care plan. These records should be accurately completed. Ref: 3.3.3 **Response by registered person detailing the actions taken:** Staff discussions commenced on the day of inspection, whilst staff confirmed they were checking each resident's skin at every opportunity, unfortunately there were gaps in the documentation which did not evidence this. There are no wounds or pressure damage currently in Rathmena House. Staff meeting completed to highlight the importance of evidencing that skin checks for each resident have been carried out. This will be closely monitored by the Home Manager and Deputy Manager through the auding process.

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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