

Inspection Report

Name of Service: Iveagh House Private Nursing Home

Provider: Spa Nursing Homes Ltd

Date of Inspection: 22 October 2024

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:	Spa Nursing Homes Ltd
Responsible Individual:	Mr Christopher Philip Arnold
Registered Manager:	Miss Chloe Burns – Not registered
Service Profile – Iveagh House Private Nursing Home is a registered nursing home which provides general nursing care for up to 33 patients. Patients' bedrooms are located over three floors and patients have access to communal dining and lounge areas.	

2.0 Inspection summary

An unannounced inspection took place on 22 October 2024 from 9.30am to 4.00pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 17 May 2024.

While we found care to be delivered in a caring and compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery in relation to staffing arrangements and record keeping. Details and examples of the inspection findings can be found in the main body of the report.

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

As a result of this inspection three areas for improvement were assessed as having been addressed by the provider. Two areas for improvement will be stated for the third time and one stated for the second time. Full details, including a new area for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning Trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "It's grand here" and, "Plenty to eat and drink".

Patients told us that staff offered choices to patients throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options and where and how they wished to spend their time.

We did not receive any questionnaire responses from patients or their visitors or any responses from the staff online survey.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Patients spoke positively on their engagements with staff, however, patients, visitors and staff consulted all were off the opinion that there was not enough staff on duty. They shared comments, such as, patients waiting a long time for care, no staff available when patients/visitors looking for them and staff being 'rushed off their feet'. This was discussed with the manager and an area for improvement previously stated in this regard was stated for the third time.

Following a Trust investigation, an area for improvement had been made to ensure compliance with training on first aid and dysphagia. A review of training records evidenced that several staff were still to complete this training. This area for improvement has been stated for a second time. An additional area for improvement was made to ensure compliance with the home's identified mandatory training requirements as several of the identified topics had low compliance rates.

Staff did feel that newly employed staff received a good induction to the home. Supernumerary time was allocated to inductees and they were assigned a mentor to assist them in becoming more familiar with the home's policies and procedures. A booklet was recorded to capture the topics of induction covered.

A system was in place to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

3.3.2 Quality of Life and Care Delivery

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

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

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

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about their patients, especially changes to care, that they needed to assist them in their caring roles.

Patients may require special attention to their skin care. For example, some patients may need assistance to change their position in bed or get pressure relief when sitting for long periods of time. These patients were assisted by staff to change their position regularly and records maintained.

Patients had good access to food and fluids throughout the day and night. Nutritional risk assessments were completed monthly to monitor for weight loss or weight gain. Nutritional care plans were in line with the recommendations of the speech and language therapists and/or the dietitians. Patients were safely positioned for their meals and the mealtimes were well supervised. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs. The menu offered good choices at mealtimes.

A programme of planned activities was on display. Activities included bowls, baking, nail days, word search, exercises and hairdressing. An activities newsletter was published monthly and made accessible to patients and their relatives. The newsletter included pictures of recent activities and welcomed new staff and patients to the home. The newsletter also identified upcoming events such as entertainers coming to the home or religious services. Resident and relatives' meetings were hosted six monthly. Minutes were maintained of these meetings to evidence discussions had and decisions made.

Patients told us that they were happy living in the home. One said, "The staff are very good; I like it here. The food is excellent; we are baking later this morning". Another commented, "I am happy here. Prefer to stay in my room. The activities person calls to see me". A relative told us, "The staff are lovely here and the care that they give is very good".

Patients could enjoy visits from friends and relatives when they wished and were free to leave the home with their friends or relatives.

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. Patients care records were held confidentially.

Care records were regularly reviewed and updated to ensure they continued to meet the patients' needs.

Nursing staff recorded regular evaluations about the delivery of care. However, several evaluations did not evidence an oversight of the supplementary care records. For example, gaps in bowel management had not been identified and/or low fluid intakes had not been captured as part of the daily evaluations. This was discussed with the manager and an area for improvement previously made in this regard was stated for the third time.

3.3.4 Quality and Management of Patients' Environment Control

The home was clean and tidy and patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. The sun lounge had been recently redecorated and now offered tea/coffee making facilities. A new dresser and piano had been purchased for the sun lounge. Floors in the home had been deep cleaned.

Doors leading to rooms containing hazards were appropriately locked. There were no unattended chemicals accessible to patients. Radiator covers were now in place to protect patients from any accidental burns.

Fire safety measures were in place to protect patients, visitors and staff in the home. Corridors were free from clutter and fire exits were not obstructed should patients need to be evacuated. Fire extinguishers were easily accessible.

There was evidence that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.4 Quality of Management Systems

Since the last inspection there has been a change in the management of the home. Miss Chloe Burns has been managing the home since 9 September 2024. Staff commented positively about the manager and described them as supportive, approachable and always available to provide guidance.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place.

There was a system in place to manage any complaints received. A compliments log was maintained and any compliments received were shared with staff.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further. Patients and their relatives spoken with said that if they had any concerns, they knew who to report them to and said they were confident that the manager or person in charge would address their concerns.

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*	2*

*The total number of areas for improvement includes two that have been stated for a third time and one that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Chloe Burns, Manager, Dorothy Stafford, Regional Support Manager and Louise Riley, Regional Support 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 12 (1) (a) and (b) Stated: Third time To be completed by: With immediate effect (22 October 2024)	<p>The registered person shall ensure that registered nurses maintain an oversight of supplementary care records to make sure that the appropriate care has been delivered.</p> <p>Any actions taken as a result of review should be clearly documented within the daily evaluation notes.</p> <p>Ref: 2 and 3.3.3</p>
	<p>Response by registered person detailing the actions taken: The acting manager has addressed this area with the nursing team their accountability of oversight of charts. A new template has been introduced for clear overview of residents supplementary charts and reflection of these in daily records. The acting manager and regional support manager carry out spot checks and review of resident's daily progress notes to ensure compliance is maintained.</p>
Area for improvement 2 Ref: Regulation 20 (1) (c) (i) Stated: Second time To be completed by: 31 December 2024	<p>The registered person shall ensure that all staff receive training on first aid and dysphagia management.</p> <p>Ref: 2 and 3.3.1</p>
	<p>Response by registered person detailing the actions taken: The Acting Manager has addressed with staff the importance of training completion.</p> <p>. The acting manager can confirm 100% staff have completed first aid training and 97% staff have completed dysphagia training.</p>
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	

<p>Area for improvement 1</p> <p>Ref: Standard 41</p> <p>Stated: Third time</p> <p>To be completed by: 30 November 2024</p>	<p>The registered person shall review the staffing arrangements in the home, taking into consideration the deployment of staff and working practices, to ensure that patients' needs are met at all times.</p> <p>Ref: 2 and 3.3.1</p> <p>Response by registered person detailing the actions taken: The Acting Manager is conducting scoping exercise with staff, resident's and relatives to gather feedback and address any concerns raised. The Acting manager has updated the allocation sheets to provide structure to daily routine and has relocated staff for periods to the reception area for visibility and accessibility. The Acting Manager will continue to monitor this area.</p>
<p>Area for improvement 2</p> <p>Ref: Standard 39</p> <p>Stated: First time</p> <p>To be completed by: 31 December 2024</p>	<p>The registered person shall review the system in place to ensure that staff are compliant with mandatory training requirements.</p> <p>Ref: 3.3.1</p> <p>Response by registered person detailing the actions taken: The Acting Manager is monitoring staff compliance with mandatory training. The Acting Manager can confirm that all mandatory training is over 90%. Training adherence is reinforced through performance appraisals, with support provided where needed to ensure all staff meet requirements promptly.</p>

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