The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Abbey View Care Home

Provider: MD Healthcare Ltd

Date of Inspection: 8 May 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 (acting)
Registered Manager:	Ms Georgeana Tarabuta
Service Profile – This home is a registered nursing home which provides nursing care for up to 25 patients. Patients' bedrooms are located over two floors and patients have access to communal social and dining areas within the home.	

2.0 Inspection summary

An unannounced inspection took place on 8 May 2025 from 9.30am to 5.00pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to patients and the service was well led. However, an area for improvement was identified in relation to the management of falls and details of this can be found in the main body of the report and in the quality improvement plan (QIP) in Section 4. There were no areas for improvement from the previous care inspection to review.

Patients spoke positively when describing their experiences of living in the home. Relatives were equaly complimentary of the care delivered. Refer to Section 3.2 for more details.

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 told us that they were happy living in the home and that they were treated well by staff who were caring and supportive. Patients' comments included, "We really appreciate all they do for us"; "The care is excellent here," and, "The staff are very respectful". Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Relatives consulted during the inspection were complimentary in regards to the care their loved ones were receiving. One told us, "They absolutely love being here. No complaints at all. Very happy with the care". Another commented that their loved one had, "Come on leaps and bounds" since moving into the home. We received two questionnaire responses from patients' visitors. Both were complimentary. One commented that their loved one, "Often expresses how content they feel", and the second one simply described the care as, "Brilliant".

Staff told us that they were happy; there was enough staff on duty to provide care and they felt that they worked well together and were supported by management to do so. There were no responses from the staff online survey.

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. Staff were further supported through staff supervision and appraisals.
Checks were made to ensure nurses maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

Patients said that there was enough staff on duty to help them. Staff said there was good teamwork and that they felt well supported in their role. Staff told us that they were satisfied

with the staffing levels. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

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 patients 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 and staff confirmed that patients' rising and retiring times were in accordance with the patients' preferences. Each patient had a personal care care plan and supplementary care records were available to evidence the personal care delivered to each patient on a daily basis. Inconsistencies were identified in relation to the management of falls. There was gaps in record keeping and patients had not been consistently monitored following a fall in keeping with best practice and the home's fall's policy and procedure. Staff confirmed that they had not received any recent training on falls management. This was discussed with the manager and identified as an area for improvement.

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 dieticians. Care plans were updated and information shared well when changes to nutritional requirements were made. Patients were safely positioned for their meals and the mealtimes were well supervised. Food served appeared appetising and nutritious. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs. Food and fluid intakes were recorded well to identify daily intakes.

The home's management team confirmed that they were actively seeking to recruit a replacement activities therapist. In the interim, care staff were fulfilling this role.

Patients complimented the care. One recently admitted patient informed us that they were, "Made to feel very welcome" when they arrived. Another commented, "The staff are all very nice; I have no complaints at all. I can choose my own clothing to wear and food to eat and I can get up or go to bed whenever I want".

Relatives told us that staff communicated well with them and were positive in describing their loved one's care. One told us, "The staff always keep us up to date with any changes and we are happy that we can talk to staff if we had any concerns". Comments on returned questionnaires included, "Staff are friendly and caring to mum and with her visitors", and, "There is always someone close by".

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 the patients' needs. 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. Risk assessments and care plans were reviewed regularly to ensure that they remained up to date. Care records were stored securely.

Supplementary care records were maintained to evidence personal care delivery, food/fluid intake, continence management and records were kept of any checks staff made on patients.

Nurses completed daily progress notes to monitor and evaluate the care delivered to the patients in their care.

3.3.4 Quality and Management of Patients' Environment

Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

Fire safety measures were in place to protect patients, visitors and staff in the home. Corridors and fire exits were clear of clutter and obstruction should the need to evacuate occur and fire extinguishers were easily accessible. Staff had attended fire training and fire safety checks were regularly conducted.

Monthly infection control audits were completed to monitor the environment and staffs' practices. Audits contained action plans which evidenced review to ensure that the identified actions had been completed. Personal protective equipment was readily available throughout the home.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Ms Georgeana Tarabuta has been the registered manager in this home since 22 August 2023.

Staff commented positively about the manager and described her as supportive, approachable and always available to provide guidance. The manager was supported by the deputy manager.

In the absence of the managers there was a nominated nurse-in-charge (NIC) to provide guidance and leadership. The NIC was clearly identified on the duty rota.

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.

The number of complaints to the home was low. There was a robust system in place to manage any complaints received. A compliments log was maintained to capture compliments received and this was 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

An area for improvement has been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	1	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Georgeana Tarabuta, Registered Manager and Mrs Heather Murray, Group Quality and Development 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 13 (1) (a) (b) **Stated:** First time **To be completed by:** 8 June 2025	The registered person shall ensure that the management of falls in the home is reviewed to ensure staff knowledge and consistency in practice. Ref: 3.3.2
	Response by registered person detailing the actions taken: The management of falls policy has been reviewed and updated. Staff have completed supervision sessions to ensure their knowledge and consistency in practice reflects the updated policy. This will be closely monitored by the Home Manager.

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

The Regulation and Quality Improvement Authority

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