The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Annadale**

Provider: **Annadale Private Nursing Home Ltd**

Date of Inspection: **15 September 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:	Annadale Private Nursing Home Ltd
Responsible Individual:	Mrs Briege Agnes Kelly
Registered Manager:	Mr Thomas Mthetho

Service Profile –
This home is a registered nursing home, which provides general nursing care for up to 38 patients with a physical disability under and over 65 years; and to general nursing care for patients over 65 years. There are a range of communal lounge areas throughout the home and a communal dining room.

2.0 Inspection summary

An unannounced inspection took place on 15 September 2025, from 9.30 am to 5.00 pm 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 1 August 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

It was established 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 a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Areas for improvement were required to ensure the effectiveness and oversight of the care planning and managing a safe environment.

As a result of this inspection all areas for improvement were assessed as having been addressed by the provider. 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. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

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 living in the home was 'very pleasant' and that staff provided care respectfully. Patients said that they felt they were offered choice and that staff engaged positively with them, making them laugh. Some patients told us that they enjoyed the food in the home.

Patients also told us that they felt staff responded quickly when they used their buzzer.

Patients explained that they could go out to church, local shops, clubs or other activities in the community.

Visitors in the home told us that that they thought patients were 'very well cared for'.

Patient and relative questionnaires returned confirmed they felt there was good car experienced in the home.

Patients told us that they were encouraged to participate in regular residents' meetings which provided an opportunity for them to comment on aspects of the running of the home. For example, planning activities and menu choices.

Patients told us that staff offered choices to patients throughout the day including 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.

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 and that they felt well supported in their role and that they were satisfied with the staffing levels. It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way; and to provide patients with a choice on how they wished to spend their day. For example, some patients who preferred to spend the afternoon in their own room said they were appreciative that staff were proactive and came to 'check in' on them and see if they needed anything. One identified patient said this was not his experience and this was fed back to the manager for review and action.

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

Staff engaged well with mandatory training and were observed to work well together as a team and to engage positively with patients.

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 knowledgeable of individual patients' 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. For example, where a patient benefited from support with a mealtime task, staff were skilled in facilitating independence and offering support in a dignified manner.

It was observed that 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.

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.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, the staff sought advice from specialist services to prevent patients falling, encouraged appropriate footwear and encouraged patients to use their walking aid or utilise the buzzer system if the required assistance.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. through to full assistance from staff and their diet modified.

Observation of the lunch time meal, review of records and discussion with patients and staff confirmed that there were systems in place to manage patients' nutrition and mealtime experience. It was discussed with the manager ways to enhance the review of all aspects of patients' mealtime experience; including those who choose to eat in their bedrooms.

The dining experience was an opportunity for patients to socialise and the atmosphere was calm, relaxed and unhurried. It was observed that patients were enjoying their meal and their dining experience. There was a staff member identified to direct the mealtime to ensure patients received the correct meal. It was evident that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. Staff were skilled in offering assistance or support with dignity and respect.

The importance of engaging with patients was well understood by the manager and staff. The home have a designated activity coordinator who plans activities with care staff and patients. Patients spoke positively of the activities organised for them for example, live music, high teas and bingo. They told us that staff knew and understood their preferences and helped patients to participate in planned activities; and that they knew about the activities in advance. Others who chose to remain in their bedroom with their chosen activity such as reading, listening to music or watching their preferred T.V programmes. Staff engaged in a meaningful way with patients who chose to not engage in groups; checking in on them or making conversation with them when they were nearby.

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.

Arrangements were in place to meet patients' social and religious needs within the home.

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 not always held confidentially; both the nurses station and the managers office were accessible and unlocked on a number of occasions. An area for improvement was identified.

On the whole, 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.

Review of care records identified that care plans specific to one to one care were lacking in detail; they did not sufficiently direct the care required and therefore could not be meaningfully reviewed. Details were discussed with the manager and an area for improvement was identified.

Patients weights were monitored and appropriate action taken such as referral to others Dietitian or G.P if intervention as required by other professionals.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. For example, patients' bedrooms were personalised with items important to the patient. Communal areas were well decorated, suitably furnished, warm and comfortable. Bedrooms were personally decorated, often with a number of sentimental items such as ornaments, paintings, photographs, bedding and soft furnishings.

There were 'homely' touches throughout such as flowers, 'homely' ornaments and décor and newspapers and magazines available for patients to access.

There is an ongoing refurbishment plan to improve the décor of the home. Patients commented that they felt the home was clean.

Both in communal areas and in patient bedrooms there were prescribed creams accessible. An area for improvement was identified.

Review of records confirmed that environmental and safety checks were carried out, as required on a regular basis, to ensure the home's was safe to live in, work in and visit. For example, fire safety checks, nurse call system checks and equipment checks.

Review of records confirmed 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.

Staff were observed washing their hands at appropriate times and to use PPE inappropriately. Discussion with the manager confirmed that hand hygiene audits were carried out routinely.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mr Thomas Mthetho has been the manager in this home since 1 November 2023.

The manager has taken part in 'My Home Life'; a programme for management teams to develop their processes and leadership in the home improve the care experience for those in the home.

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 evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

Where deficits were identified through these systems, the manager had clear action plans and an identified person to drive the improvement. Once completed, the manager demonstrated oversight of this completion.

There was a record of compliments from relatives expressing gratitude for the care provided for their loved ones.

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	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Thomas Mthetho, 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 (4)(a) **Stated:** First time **To be completed by:** 15 September 2025	The Registered Person shall ensure medication is securely stored when not in use. Ref: 3.3.4
	Response by registered person detailing the actions taken: The creams and ointments in residents' rooms are now stored securely in the cupboard. All other prescribed medications continue to be stored in locked treatment rooms.
Area for improvement 2 Ref: Regulation 19 (5) Stated: First time **To be completed by:** 15 September 2025	The Registered Person shall ensure that patient records are held confidentially; the nurses station and managers office will be secure when not in use. Ref: 3.3.3
	Response by registered person detailing the actions taken: The manager's office and the nurses' station are now locked when not in use. All residents' care records are kept confidentialy in locked cupboards.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 15 September 2025	The Registered Person will ensure care plans provide sufficient detail to direct care required. This is in relation to on to one care. Ref: 3.3.3
	Response by registered person detailing the actions taken: All care plans related to the one to one care are now updated to reflect the current care needs of the resident. This is reviewed and updated with each care review.

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

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