The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Mullaghboy

Provider: Mullaghboy Limited

Date of Inspection: 23 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:	Mullaghboy Limited
Responsible Individual:	Mr Robert Maxwell Duncan
Registered Manager:	Mrs Anne Dugan

Service Profile –
This home is a registered nursing home which provides nursing care for up to 33 patients who require general nursing care under and over 65 years of age, including patients living with a terminal illness.

Patients bedrooms are located over two floors. Patients have access to communal spaces, a dining room and outdoor space.

2.0 Inspection summary

An unannounced inspection took place on 23 January 2025, between 10.15 am to 6.00 pm 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; 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. 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. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As a result of this inspection one area for improvement was assessed as having been addressed by the provider. Two areas for improvement have been stated again. 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 told us they were happy with the care and services provided. Patients who were less able to share their views were observed to be at ease in the company of staff and to be content in their surroundings.

Patients told us that staff offered choices to them 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.

Staff spoke in positive terms about the provision of care, their roles, duties and managerial support. Comments made included "good teamwork" and "enjoy my job".

Relatives spoken with told us that they were happy with the care provided and that there was good communication from staff, however, comments were made pertaining to the lack of activities provided in the home. This is discussed further in section 3.3.2.

Following the inspection, there were no responses received from the staff questionnaires or patient/relative questionnaires.

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.

Recruitment records were not available for review, as the manager was on leave on the day of inspection; this will be reviewed at a future inspection.

Staff confirmed they were provided with an induction programme to support them in the tasks associated with their role and duties. Systems were in place to ensure staff were trained and supported to do their job. Mandatory training was progressing for staff and the manager confirmed that training compliance was kept under review.

Registered nurses taking charge of the home in the absence of the manager are required to have undertaken a competency and capability assessment; review of a sample of these records confirmed these had been completed as required.

Staff should have the opportunity to attend, at minimum, two individual supervisions and an appraisal annually to review their roles and enhance their personal development. Discussion with staff confirmed that appraisal system was in place, however no records were available to evidence individual formal supervision; an area for improvement was identified.

The staff duty rota accurately reflected the staff working in the home on a daily basis. Review of the duty rota did not consistently identify the nurse in charge when the manager was not on duty. This was discussed with the management who provided assurance this will be addressed; this will be reviewed at a future inspection.

Patients said 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. Staff told us that the patients' needs and wishes were important to them. It was clear through observation of the interactions between the patients and staff that the staff knew the patients well.

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 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.

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.

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

Observation of the lunch time meal, review of records and discussion with patients and staff evidenced that there were robust systems in place to manage patients' nutrition and mealtime experience. It was clear that staff made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

The previous inspection had identified two areas for improvement pertaining to activity provision. Discussion with patients, staff and relatives reported a lack of activities and meaningful things to do. Observation noted there was no activity information display available to inform the patients and/or visitors to the home of any available activities. It was positive to note that the home had hairdressing services that attended the home on a regular basis. The provision of activities rests with care staff at present. Staff said they generally have limited opportunities to assist patients with meaningful activities as the majority of their time is devoted to ensuring care needs are met. The two areas for improvement identified at the previous inspection have been stated for a second time.

3.3.3 Management of Care Records

Patients' needs were assessed by a suitably qualified member of staff 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.

Discussion with staff and the management confirmed that the home is in the process of reviewing and updating the patient record system to an electronic platform. Gaps were noted in the review of one patients record during the transition phase, this was discussed with the management for review and action as appropriate and is discussed further in section 3.3.5.

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.

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. Bedrooms and communal areas were suitably furnished, warm and comfortable.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear.

On review of the homes environment, excess storage of equipment was identified in one bathroom, this was discussed with the management for review and action as appropriate. This will be reviewed at a future inspection.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Anne Dugan has been the manager in this home since April 2005.

Patients, relatives and staff commented positively about the management team and described them as supportive and approachable.

Review of a sample of records evidenced that the manager had processes in place to monitor the quality of care and other services provided to patients. Due to the gaps in one patient's record as discussed in section 3.3.3, a discussion took place with the management to review the system for the auditing of care records. This will be reviewed at a future inspection.

There was evidence that the management team responded to any concerns, raised with them or by their processes, and took measures to improve practice and the quality of services provided by the home.

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	0	3*

* 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 Lesley Johnston, Nurse in charge, as part of the inspection process. Feedback was also provided to the manager during a telephone call on the 24 January 2025. The timescales for completion commence from the date of inspection.

Quality Improvement Plan
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)

Area for improvement 1 **Ref:** Standard 11 **Stated:** Second time **To be completed by:** 14 January 2025	The registered person shall make arrangements to ensure that staff are in such numbers to allow designated staff sufficient time to plan and deliver daily activities in order to provide structure to the patient's day. These should be developed in consultation with the patients and reviewed at least twice yearly to ensure this meets patients' changing needs. Individual activity assessments should be completed and reviewed as required to inform and compliment patient centred care plans. A contemporaneous record of activities delivered, the names of persons leading each activity and the patients who participate must be retained. Ref: 3.3.2
	Response by registered person detailing the actions taken: As far as possible staff will be given allocated time for activities each afternoon.Each resident has an individual activity assessment which is centred around their interests.Records of activity and the mname of who is leading will be maintained.
Area for improvement 2 **Ref:** Standard 11 **Stated:** Second time **To be completed by:** 14 January 2025	The registered person shall ensure that the programme of activities is displayed in a suitable format in an appropriate location in order that patients know what is scheduled. Ref: 3.3.2
	Response by registered person detailing the actions taken: Anew notice board has been erected in the main hall way.
Area for improvement 3 **Ref:** Standard 40 **Stated:** First time **To be completed by:** 14 January 2025	The registered person shall ensure staff have recorded individual supervision at least twice per year. Ref: 3.3.1
	Response by registered person detailing the actions taken: Supervision sessions regularly take place but recording of this will be improved for each member of staff.

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

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