The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Oakridge Care Home

Provider: Spa Nursing Homes Ltd

Date of Inspection: 23 June 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:	Spa Nursing Homes Ltd
Responsible Individual:	Mr Christopher Philip Arnold
Registered Manager:	Mrs Irene Nazarath – not registered

Service Profile –
This home is a registered Nursing Home which provides nursing care for up to 58 patients. The home is divided into three units over two floors. The Tollymore unit on the ground floor provides general nursing care and the Murlough and Tyrella units which are on the first floor provide care for people with living with dementia.

There is a Residential Care Home in the same building and the registered manager for this home manages both services.

2.0 Inspection summary

An unannounced inspection took place on 23 June 2025 between 9.15 am and 7.15 pm by two care inspectors.

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 care inspection on 5 September 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

There was a calm atmosphere in the home. Patients were presented well and observed to be relaxed in their environment.

Review of the previous areas for improvement issued in September 2024 evidenced that eight areas had been addressed by the provider.

However, enforcement action resulted from the findings of this inspection as RQIA had concerns in relation to the delivery of care, the management team's systems to monitor the quality of care, staff knowledge of safeguarding and implementation of this procedure, record keeping and maintenance of the environment.

A meeting with the Intention to issue four Failure to Comply notices in respect of The Nursing Homes Regulations (Northern Ireland) 2005, Regulation 10 (1), 13 (8), 14 (4), and 27 (4) (a)(c). was held with the Responsible Individual on 4 July 2025.

Based on the information provided to RQIA, during this meeting, the decision was made to issue one Failure to Comply notice (Ref: FTC00249) in relation to Regulation 10(1) and to manage the remaining areas of concern through the quality improvement plan (QIP) with five areas for improvement stated for a second time.

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.

Details of our enforcement procedures and notices issued can be found on our web site www.rqia.org.uk

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, "this is great, I find staff approachable", "the food is ok here", and "staff are alright here", "there's some entertainment sometimes a singer comes in", and "everything is ok here, the staff are nice". Others advised that the breakfast on this day was late and they felt there was not always enough staff on duty. This information was passed to the management team for information and action as required. Some patients said they liked to spend time in their own room and that if they needed staff, they could just ask for help and staff would assist.

Patients who were unable to express their opinions appeared well presented. However, observation of care delivery, evidenced that there was limited or no choice for patients in how they spent their day. This is discussed further in Section 3.3.2.

Staff commented that they felt teamwork was good, they felt well supported by management and that they were happy in their job,

There were no surveys or questionnaires from staff or relatives and patients following the inspection.

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 said there was good team work and that they felt well supported in their role. Review of the staff rota demonstrated that the home was staffed as planned however, some care and domestic staff advised that there was an issue with skill mix on shift. Some domestic staff said that there were often not enough staff on duty to effectively clean the home. Review of the rota indicated that the planned domestic staffing was achieved but observation of the environment confirmed that there were areas of the home not effectively cleaned. This was shared with the manager for consideration and is discussed further in Section 3.3.4.

Review of staff training records evidenced insufficient compliance levels with mandatory training for staff and the system to monitor this was not driving or sustaining improvement. Discussion with staff also evidenced a gap in knowledge evidencing that training which had been undertaken was not embedded into practice. For example, staff were unable to describe or demonstrate their role in safeguarding, safe Moving and Handling and dementia care.

Observation of care delivery evidenced that the staff and management team did not consider the impact the lack of knowledge had on the patients' experience of living in the home. This area for improvement was not met and has been stated for a second time.

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. However, observation of care delivery evidenced that staff were not prompt in recognising patients' needs, specifically for those who had difficulty in making their wishes or feelings known.

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 records which are used to advise the kitchen staff of the correct diets had not been updated and provided inaccurate information. An area for improvement was identified.

Prior to the mealtime staff held a safety pause, in accordance with current best practice guidelines, in two of the units to consider those patients who required a modified diet. In the third unit, the staff said that there was no practice of safety pause and there was no clear system in place to ensure that all patients received their meal. This was discussed with manager for review and action.

At the lunchtime meal, there were 10 patients identified that did not eat their meal and for two of these patients, staff were unable to confirm if a meal had been served or not. Staff did not initiate a supportive role for these patients, for example, to offer prompting and some patients' meals had gone cold meantime. Staff did not offer encouragement when a meal was declined and were unable to provide satisfactory explanations for the delays. Through discussion, concerns were identified regarding staffs' understanding of the impact of their actions on patients' experience and their quality of life. This was particularly concerning given that two of the units observed provide care for patients with a dementia diagnosis who may be unable to make their own needs known.

Throughout the home there was insufficient evidence that patients were offered choice or that consideration had been given to the experience of the patients living in the home. For example, in Tollymore, the breakfast meal was not served until 10.00 am, patients said that they were upset by breakfast being late and said they were hungry. When asked about this, staff and management were unable to offer an explanation. In Murlough, patients were observed sitting in communal areas with limited stimulation or interaction from staff. Prior to the tea time meal, staff were observed 'queuing' patients along the corridor/foyer in their wheelchair from 4:15 pm. When staff were asked for the rationale for this practice they said it was preparation for the tea time meal which they confirmed was not served until 5:15pm. This practice left patients who had dementia, queued outside the dining room for at least one hour waiting for their meal with no stimulation or interaction from staff. This is not acceptable practice. An action has been included in the FTC notice and a further area for improvement was identified.

The monthly calendar for planned activities was on display in the communal areas and although there were gaps in this schedule of the planned activity, the Activity Coordinator was engaging well with patients; meaningfully interacting with them and making them laugh. She supported some patients in the morning in feeding the birds in the garden. Other examples of activities provided in previous weeks included, baking, gardening and live music. However, review of records indicated that, where patients spent much of their time in their bed, there was limited variation in their activities each day. For example, activities recorded included only 'TV', 'music', and 'reminiscence'. Activities and meaningful engagement are not solely the responsibility of the activity therapist and there was no evidence in the records reviewed or in observations of the care delivery that care staff were providing patients with conversation, company and engagement as they assisted patients with daily tasks or sat with them in the lounge.

An action has been included in the FTC notice.

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. Nursing assessments had been completed to identify preventative measures and patients were observed to be wearing appropriate footwear. However, when asked, staff were unsure of how to safely transport patients in a wheelchair. This has been included as an action in the FTC notice.

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.

However, concerns were identified regarding the management of care records. For example, care records evidenced that nursing staff had not recorded any review of care needs when a patient returned to the home from hospital; and care plans were not updated to reflect changes in care needs in a timely manner. Nursing staff informed RQIA that they did not routinely document a review of patient's needs following a hospital stay unless they were informed of a specific change to assessed need. However, review of one record evidenced that this was not the case as changes had not been updated in the patient care plan. This has been included as an action in the FTC notice.

Patients care records were not held confidentially. In Tollymore, patients' confidential records were accessible from the nurse's station which was unlocked and in the confidential waste bin, in the foyer outside the nurse's station, which was also unlocked. An action has been included in the FTC notice.

Review of a sample of patient records evidenced that there was an improvement in the recording of care records relating to the management of patients' skin. For example, some patients require support to change their position regularly in order to protect their skin from damage. Records recorded the frequency of repositioning, that the care had been delivered by two members of staff and that skin was regularly checked.

However, at times a patient may be assessed to benefit from being checked on by staff regularly for example, throughout the night, particularly for those who are unable to make their needs known. Records to evidence regular checks through the day or night demonstrated significant gaps in recording. An area for improvement was identified.

There was also evidence that some staff recorded delivery of care on behalf of other care staff which would not be in accordance with best practice. An area for improvement was identified.

3.3.4 Quality and Management of Patients' Environment

The home was warm and comfortable. Patients bedrooms were decorated with personal items such as paintings and photographs and artwork made by patients was displayed in communal areas.

Review of the home's environment evidenced that there was some improvement since the last inspection. For example, the external entrance had been restored, new drawers and beds had been replaced and some other new furniture for patients in communal rooms.

However, there was limited evidence of oversight or monitoring of the quality of the environment and a number of issues were identified which required replacement or repair. One bedroom in Tollymore Unit had damp staining evident on the wall; chairs were observed throughout the home with no seat cushions; inappropriate storage was noted in Tollymore Unit's dining room, there were broken wheelchairs which also looked dirty; broken tiles were noted in an en-suite bathroom in Murlough Unit, a water leak in one bedroom had caused damage to the cupboard; delamination was noted on a set of drawers in another bedroom and wallpaper was noted to be torn in the patients' communal areas. There was an insufficiently robust system in place for staff to report maintenance issues, faults or required repairs or to evidence managerial oversight. This was discussed during the meeting with RQIA on 4 July and an action included in the FTC notice.

An area for improvement relating to the cleanliness of some furniture items and patient equipment was stated for a second time.

During the previous care inspection in September 2024 it was evidenced that remedial actions listed within the home's Fire Risk Assessment (FRA) had not all been completed and an area for improvement had been identified. During this inspection it was evidenced that this area for improvement remained unmet. There was no evidence available to confirm that remedial works to the fire doors had been addressed despite the monthly fire door checks recording that there were deficits in the fire doors since at least January 2025; and there was no timeframe indicated as to when this work would be completed. The main front door to the home is a designated external fire exit door. This door was wedged/propped open, the internal release bar was broken and a bolt lock had been fitted to the inside of the door to facilitate closure. It was concerning that if or when this door was bolted closed this means of escape would be blocked placing patients at risk in the event of a fire. In addition, there were a number of fire doors identified as needing attention in a recent audit, however, there was insufficient evidence that the management team had oversight of this or that there was a time bound action plan to drive and sustain improvement where necessary. Additionally, there were two internal fire doors propped open. This was discussed during the meeting with the Responsible Person on 4 July and assurances were provided that the front door bolt had been removed and a time bound plan was in place to address the fire safety matters. A Failure to Comply notice was not issued in this regard and an area improvement relating to the fire risk assessment has been stated for a second time. A new area for improvement was identified in relation to the propping open of fire doors.

Staff were observed to be engaging in hand hygiene and using personal protective equipment (PPE) appropriately.

Concerns about the management of general risks to health, safety and wellbeing of patients and visitors to the home were identified. Cleaning chemicals were found unsupervised and accessible in a communal area, the kitchen was found to be accessible and a nursing station was left unlocked, in which medicines were accessible. An area for improvement has been stated for a second time and a new area for improvement relating to medication storage was identified.

3.3.5 Quality of Management Systems

There has been a recent change in the management of the home since the last inspection with Mrs Irene Nazareth, previously the home's deputy manager, appointed on 2 June 2025.

The post of registered manager is a key one. A permanent, registered manager contributes significantly to the stability of the home and the delivery of safe and effective care delivery. An application to register the manager was discussed during the meeting with RQIA on 4 July and included as an action in the FTC notice.

Staff commented positively about the manager and described her as supportive and approachable.

There was some improvement in the systems for reviewing the quality of care, other services and staff practices. For example, they had developed the audit system since the last inspection and there was an increase in the frequency of audits and deficits were being identified. However, there was limited evidence that these processes improved the environment and/or the quality of services provided by the home as there were aspects of the home not being monitored, such as the environment; and improvements were not being made where deficits were identified.

The Responsible Individual provided assurances at the meeting that there were plans in place to employ two new Deputy Nurses and improve the oversight of management arrangements in the home.

Concerns were identified regarding the lack of progress with the areas for improvement identified during the previous inspection on 5 September 2024. RQIA are not assured that the governance, management and leadership in the home have been effective in identifying, driving or sustaining improvements. Review of the reports of the monthly visits undertaken in accordance with Regulation 29, evidenced that the deficits found during this inspection had not been identified; and where an action plan was in place, there was limited evidence of managerial oversight to ensure progress with the action plan.

Actions to address this were included in the FTC notice.

Review of the accident and incidents audit identified at least two incidents which were not reported to RQIA as required and this area for improvement has been stated for a second time.

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	5*	6*

* the total number of areas for improvement includes three under Regulations and two under Standards that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with the management team 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:** Second time **To be completed by:** 23 June 2025	The registered person shall ensure that all areas of the home to which patients have access are free from hazards to their safety. Ref: 3.3.4
	Response by registered person detailing the actions taken: The Registered Person carries out daily walkabouts to check that all hazards are locked away. This has also been addressed with all grades of staff. The domestic staff now have a carry cart for chemicals to carry and keep beside them. The Nursing staff are aware that thickener must be stored in a locked cupboard and not left on top of the medicine trolley. These areas continue to be monitored in the home.
Area for improvement 2 **Ref:** Regulation 27 (4) (a) **Stated:** Second time **To be completed by:** 31 July 2025	The registered person shall ensure recommendations made in the fire risk assessment are addressed in the recommended timeframe. Ref: 3.3.4
	Response by registered person detailing the actions taken: The Registered Person can confirm all areas in the action plan from the Fire RIsk Assessment has been addressed.Some actions were outside the recommended timescale on the report due to waiting on external contractor to complete the work but are now completed. The Fire Risk Assessment was graded as Tolerable.
Area for improvement 3 **Ref:** Regulation 30 (1) (d) (f) **Stated:** Second time **To be completed by:** 23 June 2025	The registered person shall give notice to RQIA without delay of the occurrence of any notifiable incident. All relevant notifications should be submitted retrospectively. Ref: 3.3.5
	Response by registered person detailing the actions taken: The Registered Person has completed relevant notifications retrospectively on advice form RQIA Inspector. The Registered Person will ensure that all incidents that are notifiable are completed in a timely manner.
Area for improvement 4 **Ref:** Regulation 27 3 (b) **Stated:** First time	The registered person shall ensure that fire doors in the home are not propped open. Ref: 3.3.4

To be completed by: 23 June 2025	**Response by registered person detailing the actions taken**: The Registered Person can confirm that all fire doors are closed and not propped open, this has been addressed with all staff. The Registered Person can confirm that the front door is now key padded and wired to the fire alarm so when the alarm is activated the keypad will deactivate.
Area for improvement 5 **Ref:** Regulation 13 4 (a) **Stated:** First time **To be completed by:** 23 June 2025	The registered person shall ensure that all medication is securely stored when not in use. Ref: 3.3.4
	Response by registered person detailing the actions taken: The Registered Person can confirm that all medication is securely stored when not in use within locked cupboards and the medication trolley when not in use is locked and chained to the wall.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref**: Standard 39.9 **Stated:** Second time **To be completed by** 23 July 2025	The registered person shall ensure that mandatory training requirements are met to enable staff to meet the needs of patients safely and effectively. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Registered Person has addressed with all staff completion of mandatory training requirements and records are available for each training module. The Registered Person continues to monitor this area of compliance.
Area for improvement 2 **Ref:** Standard 46.2 **Stated:** Second time **To be completed by:** 23 June 2025	The registered person shall ensure that the environment in the home is managed to minimise the risk and spread of infection. This area for improvement specifically related to the cleaning of the environment and patient equipment within the home. Ref: 3.3.4
	Response by registered person detailing the actions taken: The Registered Person will ensure that the environment in the home is managed to minimise the risk of the spread of infection. The Registered Person is checking all decontamination records to ensure these are all recorded. The Registered Person on the daily walkabout will check all equipment to ensure it is clean.

Area for improvement 3 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 23 June 2025	The registered person shall ensure that when a care record in relation to patient dietary requirements has been commenced or reviewed that this is shared with the kitchen staff. Ref: 3.3.2
	Response by registered person detailing the actions taken: The Registered Person can confirm that the kitchen staff have a list of all resident's dietary requirements and any changes to assessed needs the kitchen staff will be updated.
Area for improvement 4 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 23 June 2025	The registered person shall ensure that where a patient is disorientated to time, that there is evidence of sufficient effort made to encourage good nutrition between planned mealtimes. Ref: 3.3.2
	Response by registered person detailing the actions taken: The Registered Person has been overseeing mealtimes especially for those who have cognitive decline to ensure that residents are given the appropriate support and encouragement to eat. A selection of snacks is available from the kitchen for residents who refuse a meal.
Area for improvement 5 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** 23 June 2025	The registered person shall ensure that supplementary care records relating to patient checks are accurately maintained in accordance with the care plan and are completed contemporaneously. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Registered Person has been working with staff on recording of supplementary records to ensure they are accurately recorded in accordance with the care plan and are completed contemporaneously. The Registered Person will continue to monitor chart recording.
Area for improvement 6 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** 23 June 2025	The registered person shall ensure that supplementary care records are accurately maintained and are completed by the staff member(s) delivering the care. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Registered Person has addressed with staff their responsibility for recording of records of care that they deliver and will continue to monitor this.

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

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