The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Hockley Private Nursing Home**

Provider: **Elim Trust Corporation**

Date of Inspection: **27 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:	Elim Trust Corporation
Responsible Individual:	Mr Edwin Michael
Registered Manager:	Mrs Mary Jane Sagayno
Service Profile – Hockley Private Nursing Home is a registered nursing home which provides general nursing care for up to 54 patients. The home is divided into two units; The Lodge and The Mews. Patients have access to communal lounge and dining areas.	

2.0 Inspection summary

An unannounced inspection took place on 27 May 2025, between 10.00 am and 4:40 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 on 11 June 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

It was evident 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.

While we found care to be delivered in a safe and compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery.

As a result of this inspection two 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 they were happy with the care and services provided. Comments made included "staff are nice and always available" and "things are going great, the food here is great and my room is always kept nice and clean".

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV.

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.

Staff spoke in positive terms about the provision of care, their roles and duties, training and managerial support.

Families spoken with told us that they were very happy with the care provided and that there was good communication from staff.

Questionnaires returned from relatives indicated that they were very happy with the care, the comments included "Care at Hockley Lodge is excellent" and "staff are always on hand and go the extra mile". No staff questionnaires were received within the timescale specified.

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 systems in place to manage staffing.

A range of mandatory and additional training was completed by staff on a regular basis. However, review of training records evidenced that not all staff had taken part in an annual fire drill. This was identified as an area for improvement.

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.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

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.

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 manage this aspect of care. Review of the restrictive practice audits evidenced that they required further detail in regards to the type of restraint in place. This was discussed with the manager and assurances were given that this would be addressed. This will be reviewed at the next inspection.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position however, examination of the repositioning records evidenced gaps in the recording of repositioning and care plans lacked detail in relation to the repositioning regime. This was identified as an area for improvement.

Wound care records were reviewed, in the one record reviewed, the recommended frequency of dressing changes in the care plan was different to the frequency of dressing changes being carried out. This was identified as an area for improvement.

Examination of care records and discussion with staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed.

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 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. 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.

Care plans were in place for patients who required their diets to be modified. However, choking risk assessments reviewed were incomplete or lacked detail of the patients' diet and the care required. An area for improvement was identified.

The importance of engaging with patients was well understood by the manager and staff. Staff understood that meaningful activity was not isolated to the planned social events or games. Individual notebooks with photographs of each patient were kept as a keepsake for either the patient or next of kin.

Patients were well informed of the activities planned and of their opportunity to be involved. The activity schedule was on display. It was positive to see that the activities provided were varied, interesting and suited to both groups of patients and individuals. Activities planned for the week crafts, snakes and ladders and hand massage. During the inspection patients were observed playing a game of bingo facilitated by the activity co-ordinators, patients appeared to enjoy each other's company.

Staff were observed sitting with patients and engaging in discussion. Patients who preferred to remain private were supported to do so and had opportunities to listen to music or watch television or engage in their own preferred activities.

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 person centred, regularly reviewed and updated to ensure they continued 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.

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 well decorated, suitably furnished, warm and comfortable. A programme of refurbishment was in place and a number of carpets were being replaced throughout the home. A small number of patient chairs was worn and the manager advised that new chairs had been ordered.

Observation of the environment identified concerns that had the potential to impact on patient safety; we observed some tins of thickening agent accessible in both dining rooms and a kitchenette left unsupervised with access to food and fluids. This was identified as an area for improvement.

Review of records and observations 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.

3.3.5 Quality of Management Systems

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	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Mary Jane Sagayno, 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 27 (4) (f) **Stated:** First time **To be completed by:** 30 June 2025	The Registered Person shall ensure that all staff participate in a fire evacuation drill at least once a year. Ref: 3.3.2
	Response by registered person detailing the actions taken: Fire drill is carried out during fire training and by fire warden in house. The attendance of the fire drill is being monitored by management team to ensure compliance.
Area for improvement 2 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** 27 May 2025	The registered person shall ensure as far as reasonably practical that all parts 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: Communication was sent to all the staff to ensure safety around the Home is being observed. All food thickeners are locked away when not supervised. Management will monitor compliance.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 30 June 2025	The registered person shall ensure that where a patient has been assessed as requiring repositioning: • care plans and repositioning charts are consistent in relation to the recommended frequency of repositioning • the frequency of repositioning is accurately recorded within the care plan. Ref: 3.3.2
	Response by registered person detailing the actions taken: Repositioning record is audited monthly by management to ensure consistent record is kept. Nurse in charge will make sure that all repositioning is recorded on the computer before the end of the shift. Checklist is in place.

Area for improvement 2 **Ref:** Standard 4.8 **Stated:** First time **To be completed by:** 30 June 2025	The registered person shall ensure that wound care is completed in keeping with the recommended dressing frequency documented in the patient's care plan. Ref: 3.3.2
	Response by registered person detailing the actions taken: This area of improvement was communicated to all registered nurses to ensure frequency of dressing is consistent with the careplan. Management will audit the record monthly and will liaise with staff for further concern.
Area for improvement 3 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 30 June 2025	The registered person shall ensure that choking risk assessments are recorded accurately and reflect the current needs of the patient. Ref: 3.3.2
	Response by registered person detailing the actions taken: Choking risk assessments reflecting the current need of all residents on modified diet are now in place. Management will monitor that this will be in place and reviewed as needed.

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

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