

Inspection Report

Name of Service: Mahon Hall

Provider: Ann's Care Homes

Date of Inspection: 26 June 2025

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

1.0 Service information

Registered Provider:	Ann's Care Homes
Responsible Individual:	Mrs Charmaine Hamilton
Registered Manager:	Ms Cristina Citea - acting
Service Profile – This home is a registered nursing home which provides nursing care for up to 44 patients. Patients' bedrooms are located over two floors in the home and patients have access to a range of communal spaces such as lounges, dining rooms and an enclosed garden/patio area.	

2.0 Inspection summary

An unannounced inspection took place on 26 June 2025 from 9.35 am to 5.30 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 determine if the home is delivering safe, effective and compassionate care and if the service is well led.

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. Refer to Section 3.2 for more details.

It was evident from discussions with patients and relatives that staff promoted patient's dignity and well-being and that staff were knowledgeable and well trained to deliver safe and effective care.

While we found care to be delivered in a compassionate manner, a number of areas for improvements were identified to ensure the effectiveness and oversight of certain aspects of care delivery, including; management of weight loss, notifiable events, food and fluid intake records and personal care records.

As a result of this inspection three areas for improvement were assessed as having been addressed by the provider. One area for improvement has been stated again and a further area for improvement has been carried forward and will be reviewed at the next inspection. 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 spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "They (the staff) are very decent, the whole lot of them", "They are all very good. I feel safe when they move me and dress me", "It's one big family atmosphere here" and "I am very happy here and it is all down to the staff."

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.

Relatives commented positively about the overall provision of care within the home. Comments included: "The staff couldn't be any better. The activities are very good", "The majority of staff are friendly and approachable. Anything I ask I am told" and "We are very happy with the care."

Staff spoken with said that Mahon Hall was a good place to work and said the teamwork was very good. Staff commented positively about the manager and described them as supportive and approachable. Comments from staff included, "It is very easy to talk to everyone" and "I am happy here and we have a good work/life balance."

We did not receive any questionnaire responses from patients or their visitors or any responses from the staff online survey 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.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and 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 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 patient 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.

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. A restrictive practice register was monitored and reviewed monthly.

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.

Where a patient was at risk of falling, measures to reduce this risk were put in place. In addition, falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented.

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; although examination of records confirmed that weight loss care plan directions regarding the frequency of weighing some patients were not consistently adhered to. An area for improvement was identified.

Nutritional care plans were in line with the recommendations of the speech and language therapists and/or the dieticians. Patients were safely positioned for their meals and the mealtimes were well supervised. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Observation of the morning meal, review of records and discussion with patients, staff and the manager indicated that there were systems in place to manage patients' nutrition.

The food served looked appetising and nutritious. Patients told us they enjoyed the meal and the food was good. However, plastic glasses provided to patients were visibly stained and worn. This was discussed with the deputy manager who agreed to address this matter.

The importance of engaging with patients was well understood by management and staff and patients were encouraged to participate in their own activities such as watching TV, reading, resting or chatting to staff. Arrangements were also in place to meet patients' social, religious and spiritual needs. An activity planner displayed highlighted events such as movie days, sing a long's, cookery club, craft time entertainment and quizzes.

Patients were observed listening to music and watching TV. Patients spoken with told us they enjoyed living in the home and that staff were friendly.

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.

Care records, for the most part, were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Personal hygiene records for an identified patient were not fully reflective of their current assessed needs and contained conflicting information. An area for improvement was stated for a second time.

Nursing staff recorded regular evaluations about the delivery of care. Some of these entries were found to be repetitive and not person centred. This was discussed with the manager who gave assurances that additional supervision and support would be given to staff in this area.

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.

Prescribed nutritional supplements consumed by an identified patient were not accurately and consistently recorded as part of their food and fluid intake records. Assurances were given that this would be monitored to ensure compliance with record keeping standards and expectations.

Patient's looked well-presented and cared for although gaps in recording of up to seven days were noted in personal care records. An area for improvement was identified.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and patients' bedrooms were personalised with items important to the patient. Communal areas were suitably furnished, warm and comfortable. Armchairs and bedside tables were observed to be missing from a number of bedrooms. This was discussed with management who arranged for this to be replaced immediately.

A number of shortfalls were identified throughout the laundry relating to the cleanliness of cupboards, broken equipment, storage of linen and labelling of patient's clothing. Details were provided to the management team who provided assurances that these matters would be addressed without delay. This will be reviewed at a future care inspection.

Fire safety measures were in place to protect patients, visitors and staff in the home.

There was evidence that systems and processes were in place to manage infection prevention and control (IPC) which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

A small number of shortfalls in individual staff practice with IPC practices were discussed with the manager who agreed to monitor this through their audit processes and arrange additional training and supervisions if required.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Ms Cristina Citea has been the acting manager in this home since 18 March 2025.

A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly at the time. However, at least three notifiable events had not been submitted to RQIA as required. The deputy manager agreed to audit the accidents and incidents and notify RQIA retrospectively. An area for improvement was identified.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. The manager completed audits to quality assure care delivery and service provision within the home.

There was a system in place to manage any complaints received.

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

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

*The total number of areas for improvement includes one that has been stated for a second time and one which is carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Cristina Citea, 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 Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 13 (1) (a) (b) Stated: First time To be completed by: 26 June 2025	<p>The registered person shall ensure that care plans are followed. This is stated in relation to the frequency of a patient weights being completed.</p> <p>Ref: 3.3.2</p> <p>Response by registered person detailing the actions taken: The Registered Manager has conducted a full review of weight management by completing a base line weights audit. The analysis was used to cross reference care plans and associated risk assessments ensuring they are reflective and inclusive of frequency to weigh. Supervision was completed with registered nurses and will be further discussed at meeting 14.8.25. Compliance will be monitored by Registered Manager.</p>
Area for improvement 2 Ref: Regulation 30 (1) (d) (f) Stated: First time To be completed by: 26 June 2025	<p>The registered person shall give notice to RQIA without delay of the occurrence of any notifiable incident. All relevant notifications should be submitted retrospectively.</p> <p>Ref: 3.3.5</p> <p>Response by registered person detailing the actions taken: Following the inspection, the identified notifications were submitted retrospectively. Going forward the Registered Manager will use the scope of notification guidance to complete Reg 30s in a timely manner.</p>
Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 1 Ref: Standard 28 Stated: First time To be completed by: 3 April 2025	<p>The registered person shall ensure that liquid medicines and inhalers are administered in accordance with the prescriber's instructions.</p> <p>Ref: 2.0</p> <p>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</p>
Area for improvement 2 Ref: Standard 4 Stated: Second time	<p>The registered person shall ensure that care plans regarding personal hygiene are person centred and reflect the current needs of the patients.</p> <p>Ref: 2.0 and 3.3.2</p>

<p>To be completed by: 26 June 2025</p>	<p>Response by registered person detailing the actions taken: The Registered Manager has completed supervision with all registered nurses to cover standard 4 and reiterated in accordance with nurses NMC guidelines, that prescribed care plans and associated risk assessments are to be reflective of current assessed needs information. Compliance will be monitored through care plan auditing, Traccas and documentation will be spot checked during walkabout and evidenced on the relevant form. This will be further discussed at registered nurse meeting 14.8.25.</p>
<p>Area for improvement 3 Ref: Standard 4.9 Stated: First time To be completed by 26 June 2025</p>	<p>The registered person shall ensure that personal care records are consistently maintained and completed contemporaneously. Ref: 3.3.3</p> <p>Response by registered person detailing the actions taken: As per area of improvement No.2, the Registered Manager has completed supervision with all registered nurses covering standard 4. Reiterated in accordance with NMC guidelines, contemporaneous nursing records are kept of all nursing interventions, activities and procedures carried out in relation to each resident. The outcomes of such actions are recorded. Any variance from the care plan, reasons and outcomes are also documented. Compliance will be monitored through care plan auditing, Traccas and documentation will be spot checked during walkabout and evidenced on the relevant form. This will be further discussed at registered nurse meeting 14.8.25.</p>

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