The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Rathfriland Manor

Provider: Manor Healthcare Ltd

Date of Inspection: 3 July 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:	Manor Healthcare Ltd
Responsible Individual: -	Mr Eoghain King
Registered Manager:	Mrs Rachel McCaffrey

Service Profile –
This home is a registered nursing home which provides nursing care for up to 54 patients. Care is provided for up to 30 patients over the age of 65 for general nursing and up to 24 patients who have a dementia. Patients' bedrooms are located over two floors and patients have access to communal dining and lounge areas to relax in.

2.0 Inspection summary

An unannounced inspection took place on 3 July 2025 from 9.40am to 5.25pm 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 18 April 2024; 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 and the service was well led. One area for improvement was identified in relation to the recording of wound care.

As a result of this inspection all five areas for improvement from the previous care inspection were assessed as having been addressed by the provider. Full details, including the new area for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

Patients spoke positively when describing their experiences of living in the home. Refer to Section 3.2 for more details.

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 patients, 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 they were happy living in the home and that they were treated well by staff who were caring and supportive. Patients' comments included, "The staff are the best," and, "It's very good here. All are so kind and good to me". Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

We received two questionnaire responses from relatives. They indicated that they were very satisfied with the care provision in the home and one commented, "We are very happy with the care my mother receives in Rathfriland Manor. She gets regular checks when she's in her bedroom and assistance with all of her needs". The second thought the care was good and kind and was happy that staff checked in at night and answered call bells when needed.

Staff told us that they were happy working in the home and enjoyed engaging with the patients. They felt that they worked well together and were supported by management to do so. There was one response from the staff online survey. The respondent was very satisfied that the care was safe, effective and compassionate and that the home was well led. In the response they told us that they enjoyed working in Rathfriland Manor; felt the patients were well cared for and looked after and felt that the staff were well supported by management and well trained.

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.

Checks were made to ensure nurses maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

Regular staff meetings with management were held to enhance the communication in the home and allow staff to share their views.

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

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, pleasant and friendly. Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences. Patients spoke fondly on their interactions with staff.

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 patients 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.

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. However, where a patient had more than one wound, each wound did not have a separate care plan to guide staff or separate wound evaluation to monitor progress with each one. This was discussed with the manager and identified as an area for improvement.

Patients had good access to food and fluids throughout the day and night. 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. Tables had been attractively set and patients enjoyed music in the background during the meal. Food was only served when the patients were ready to eat their meal. Food served appeared appetising and nutritious. Staff were aware of the actions to take should a patient choke on their food.

Patients in receipt of one to one care had care plans in place to direct the staff member on the detail of the care required and supervision level to be provided.

Activities were conducted daily in each of the four units in the home. They included games, quiz, bingo, exercises, reminiscence, hair dressing and pampering. External entertainers visited the home and on the day of inspection a donkey was brought around for patients to see and engage with. Patients in the Shannon Unit shared ideas which could enhance the activity provision in the home. Their ideas were shared with the manager for their review and action as appropriate.

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 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. Risk assessments and care plans were reviewed regularly to ensure that they remained up to date. Care records were stored securely.

Supplementary care records were maintained to evidence care delivery in areas, such as, personal care delivery, food/fluid intake, continence management and records were kept of any checks staff made on patients.

Nurses completed daily progress notes to monitor and evaluate the care delivered to the patients in their care.

3.3.4 Quality and Management of Patients' Environment Control

Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. There were no malodours in the home.

Fire safety measures were in place to protect patients, visitors and staff in the home. Corridors and fire exits were clear of clutter and obstruction should the need to evacuate occur and fire extinguishers were easily accessible. Staff had attended fire training and fire safety checks were regularly conducted.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. The manager confirmed that, in addition to this, they conducted a daily walk around the home to monitor the environment and practices. Personal protective equipment was readily available throughout the home.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Rachel McCaffrey has been the registered manager of the home since 1 February 2016. Staff commented positively about the manager and described her as supportive and approachable.

In the absence of the managers there was a nominated nurse-in-charge (NIC) to provide guidance and leadership. The NIC was clearly identified on the duty rota.

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.

The number of complaints to the home was low. There was a robust 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

An area for improvement has been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	1	0

The area for improvement and details of the Quality Improvement Plan were discussed with Rachel McCaffrey, Registered 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 12 (1) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that where a patient has more than one wound, each wound is assessed, care planned and evaluated separately. Ref: 3.3.2

(3 July 2025)	**Response by registered person detailing the actions taken:** With immediate effect, all residents with more than one wound are assessed, care planned and evaluated separately .

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

The Regulation and Quality Improvement Authority

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