

Inspection Report

Name of Service: Magherafelt Manor Nursing Home

Provider: Kathryn Homes Ltd

Date of Inspection: 15 August 2025

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

1.0 Service information

Organisation:	Kathryn Homes Ltd
Responsible Individual:	Ms Tracey Anderson
Registered Manager:	Mrs Siobhan Conway
<p>Service Profile – This home is a registered nursing home which provides nursing care for up to 37 patients. The home is divided into two separate units on the ground floor; the Sycamore suite provides care for people living with dementia and the Hawthorn suite which provides general nursing care. Patients have access to communal lounges, dining rooms and outdoor space.</p> <p>There is a residential care home which occupies the first floor and the registered manager for this home manages both services.</p>	

2.0 Inspection summary

An unannounced inspection took place on 15 August 2025, from 9.45 am to 4.45 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 pharmacy inspection on 17 December 2025 and the last care inspection on 10 July 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection found that safe, effective and compassionate care was delivered to patients and that the home was 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.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained.

As a result of this inspection four areas for improvement were assessed as having been addressed by the provider. One area for improvement 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 who were able to share their opinions on life in the home said they were well looked after. Some patients may have difficulty telling us about their experiences. Patients who had communication difficulties looked relaxed in their environment and during interactions with staff.

Patient comments included "the staff are very good in here" and "I'm looked after very well".

Relatives spoken with told us "this is a lovely home, all the staff are lovely" "X couldn't be in a better place" and "we have no issues at all".

Staff spoken with said that Magherafelt Manor was a good place to work. Staff said that they were satisfied with staffing levels, teamwork was "brilliant", the manager was approachable and they thoroughly enjoyed working in the home. Two staff told us they "loved it" when asked to describe working in the home.

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 robust systems in place to manage staffing.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

Staff said there was good teamwork, that they felt well supported in their role, and that they were satisfied with the staffing levels.

There was a system in place to monitor that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC).

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.

Patients looked well cared for and were seen to enjoy warm and friendly interactions with the staff. Staff were observed to be chatty, friendly and polite to the patients at all times.

Some patients may have difficulty telling us about their experiences. Patients who had communication difficulties looked relaxed in their environment and during interactions with staff, and gave non-verbal cues to their wellbeing, such as smiling or hand gestures.

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.

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 and care records accurately reflected the patients' assessed needs. However, review of repositioning documentation identified that the records were not always completed contemporaneously and that some patients were not repositioned as prescribed in their care plans. An area for improvement was identified.

Examination of care records and discussion with the staff confirmed how the risk of falling and falls were managed; and how referrals were made to other healthcare professionals if needed. Review of records confirmed that staff took appropriate action in the event of a fall, for example, they commenced neurological observations and sought medical assistance if required.

However, it was observed in the records reviewed that body maps were not consistently recorded in line with best practice guidance. An area for improvement was identified.

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.

Observation of the lunchtime meal confirmed that enough staff were present to support patients with their meal and that the food served smelt and looked appetising. The dining experience was an opportunity for the patients to socialise and the atmosphere was calm, relaxed and unhurried. It was observed that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. The daily menu was displayed in both dining rooms.

The importance of engaging with patients was well understood by the manager and staff. There was a wide range of activities provided for patients by activity staff. The planned activity schedule was displayed in both units of the home. The range of activities included social, community, cultural, religious, spiritual and creative events. Patients' needs were met through a range of individual and group activities. The staff, patients and relatives fondly discussed the recent garden party.

A review of activity records identified gaps in the recording of activities to patients; this was discussed with the manager and activity staff and although activities had been delivered to the patients and the staff member kept their own records; due to time constraints this had not been recorded in the patients electronic care records. An area for improvement was identified.

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, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care.

Wound care records were reviewed for an identified patient, deficits were identified in the records reviewed; inconsistencies were noted with the care planning of the wound and gaps were noted in dressing changes. An area for improvement was identified.

3.3.4 Quality and Management of Patients' Environment

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. The home was clean, warm and comfortable. Patients' bedrooms were tidy and personalised with items of importance to each patient, such as family photos and sentimental items from home.

Review of records confirmed that environmental and safety checks were carried out, as required on a regular basis, to ensure the home's was safe to live in, work in and visit.

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

There has been no change in the management of the home since the last inspection. Mrs Siobhan Conway has been the Registered Manager of the home since March 2015.

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

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment.

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	5*

*The total number of areas for improvement includes one standard that is carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Siobhan Conway, 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 Care Standards for Nursing Homes, December 2022	
Area for improvement 1 Ref: Standard 23 Stated: First time To be completed by: 15 August 2025	<p>The Registered Person shall ensure that where a patient requires repositioning that this is completed in accordance with their care plan and reflected contemporaneously within supplementary recording charts.</p> <p>Ref: 3.3.2</p> <p>Response by registered person detailing the actions taken: Home Manager and Deputy Manager are checking the Repositioning daily. Repositioning folder in place for Staff Nurse to check and sign at the end of each shift. evidencing that this has been completed correctly.</p>
Area for improvement 2 Ref: Standard 22 Stated: First time To be completed by: 16 August 2025	<p>The Registered Person shall ensure that falls are managed in line with best practice guidance.</p> <p>This is stated with specific reference to the completion of body maps.</p> <p>Ref: 3.3.2</p> <p>Response by registered person detailing the actions taken: Falls documentation is reviewed by the Home/Deputy Manager and staff are completing the falls documentation/body map in line with the post falls guidance.</p>
Area for improvement 3 Ref: Standard 11 Stated: First time To be completed by: 22 August 2025	<p>The Registered Person shall ensure activity records are kept up to date to evidence activities offered and or delivered to patients; this should also include patient participation and engagement with activities where appropriate.</p> <p>Ref: 3.3.2</p> <p>Response by registered person detailing the actions taken: All activity records are reviewed by the Home/Deputy Manager and completed by the activity therapist following activities.</p>
Area for improvement 4 Ref: Standard 4.8 Stated: First time To be completed by:	<p>The Registered Person shall ensure care documentation for the management of wounds accurately reflect the assessed needs of the patient.</p> <ul style="list-style-type: none"> • All wounds should have detailed individualised care plan • The frequency of dressing changes should clearly reflect the assessed need of the wound

16 August 2025	<ul style="list-style-type: none"> Any change in the wound should be accurately documented and appropriate care documentation updated to reflect the change. <p>Ref: 3.3.3</p>
<p>Area for improvement 5</p> <p>Ref: Standard 18</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect (17 December 2024)</p>	<p>Response by registered person detailing the actions taken: Wound chart and dressing regime audited by the Home/Deputy manager. All wound care documentation is updated by the Staff Nurse on duty and reviewed by the Home/Deputy Manager.</p> <p>The Registered Person shall ensure that the reason for and the outcome of administration are recorded on every occasion, when medicines are administered on a 'when required' basis for the management of distressed reactions.</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>

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