The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Shaftesbury Mews**

Provider: **Amore (Watton) Limited**

Date of Inspection: **15 May 2025 & 9 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:	Amore (Watton) Limited
Responsible Individual/Responsible Person:	Miss Sarah Elizabeth Perez
Registered Manager:	Ms Carina Douglas
Service Profile – This home is a registered nursing home which provides nursing care for up to 18 patients living with a learning disability or physical disability under and over the ages of 65. The home is comprised of three detached bungalows: Eden (Bungalow 1), Sleepy Hollow (Bungalow 2) and Sea Breeze (Bungalow 3). There is access to an activity room and communal garden.	

2.0 Inspection summary

An unannounced inspection took place on 15 May 2025 from 9.30am to 7.00pm by a care inspector and on 9 June 2025, from 11.00 am to 12.30pm, by a finance inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and determined if the home was delivering safe, effective and compassionate care and if the service 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.

A finance inspection was undertaken on 9 June 2025 to assess progress with three areas for improvement, identified by RQIA, during the last finance inspection on 13 April 2022. All three areas for improvement were assessed as having been addressed by the provider.

No new areas for improvement were identified during the finance inspection on 9 June 2025

Comments received from patients and staff are included in the main body of this report.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience.

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 and staff were spoken with during the inspection. Patients told us they were happy living in the home. Patients who were not able to voice their opinions verbally were seen to be relaxed and comfortable in their interactions with staff.

Staff told us team work was good and that they enjoyed working in Shaftesbury Mews.

One questionnaire was received following the inspection was discussed with the manager. No staff survey responses were returned within the indicated timeframe.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction. A review of training records evidenced that not all staff had up to date mandatory training such as manual handling and deprivation of liberty training (DoLS). Further training such as wound/ skin care and dementia training were also not completed. This was discussed with the manager and an area for improvement was identified.

There were systems in place to ensure that all relevant staff were registered with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

However, the NMC register did not fully identify the registration status of all staff. Assurances were provided during the inspection that all staff were registered. An area for improvement was identified.

The duty rotas reflected the staff working in the home over a 24-hour period. Staff absences were recorded on the rota and the person in charge in the absence of the manager was clearly highlighted.

Staff members were seen to respond to patients' needs in a timely manner and were seen to be warm and polite during interactions. It was clear through these interactions that the staff were aware of their patients' needs.

3.3.2 Quality of Life and Care Delivery

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including for 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 their needs.

It was observed that staff respected patients' privacy; they knocked on doors before entering bedrooms and bathrooms and offered personal care to patients discreetly.

The staff members were observed speaking to patients in a caring and professional manner; they offered patients choice and options throughout the day regarding, for example, where they wanted to spend their time or what they would like to do.

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. The cook had prepared the lunch and patients were observed enjoying their meal. Menus boards were not displayed in all of the bungalows and there were no alternative menu formats available for patients. This was discussed with the manager and an area for improvement was stated for a second time.

Activity schedules were developed by the home's activity staff member and were available to view. Some patients and staff told us that they felt there could be more activity in the individual bungalows particularly if the patients chose not to attend the activity room. This was discussed with the manager who agreed to review the activity arrangements this will be reviewed further at the next inspection.

Staff described how patients who were able to go out and about frequently and enjoyed bus trips with staff. Patients were seen enjoying being out in the garden and other patients were out on the bus. One patient was observed visiting friends in another bungalow.

3.3.3 Management of Care Records

A sample of care records reviewed evidenced some care plans lacked sufficient detail to direct the care required, for example, pain management and distressed reaction care plans. It was also evidenced that some risk assessments were not fully completed such as a falls risk assessment and smoking assessments.

These deficits had not been identified through the homes governance processes. An area for improvement was identified and an area for improvement in relation to care records such as pain management and distressed reactions was stated for a third time.

3.3.4 Quality and Management of Patients' Environment

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, communal areas such as lounges, laundry and the kitchen for each bungalow.

Patients' bedrooms were personalised with items of importance to each patient, such as photos, toys and games.

A door to the laundry in one bungalow was not locked and chemicals were accessible this was discussed with the staff and addressed immediately. An area for improvement was identified.

A door wedge was observed on the treatment room floor. Doors should not be wedged open. The use of wedges was discussed with the manager who agreed to address this.

A number of staff were observed wearing gloves when not providing care to a patient with no clear rationale for this. This was discussed with the manager and an area for improvement was identified.

3.3.5 Quality of Management Systems

Since the last inspection, there has been no change in the management arrangements. Mrs Carina Douglas has been the manager of the home since 10 January 2022.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was appointed as the adult safeguarding champion. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm.

It was established that the manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin and to their care manager. A review of records evidenced that two events, that required notification to RQIA, had not been submitted. This was discussed with the manager and an area for improvement was stated for a second time.

There was a system in the home for managing complaints however, records were not maintained. This was discussed with the manager and an area for improvement was identified.

A number of competency assessments in place for those staff who take charge of the home in absence of the manager required to be reviewed and updated. An area for improvement was identified.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed.

The reports however lacked sufficient detail to drive improvement and did not evidence shortfalls in regards to the documentation, ongoing refurbishment requirements nor feedback from the visitors to the home. This was discussed with the manager and an area for improvement was 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	4*	7*

* the total number of areas for improvement includes two regulations and one standard that has been stated for a second time and one standard which has been stated for a third time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Carina Douglas, 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 29 **Stated:** Second time **To be completed by:** 30 August 2025	The registered person shall ensure that, as part of the monthly monitoring visit, feedback of the service provision is sought from patients, relatives and staff and any deficits in service provision are quickly identified and monitored to make sure that they are addressed. Ref: 2.0 and 3.3.5
	Response by registered person detailing the actions taken: The importance of the completion of the same has been shared with the Site Leaders and Deputy Managers who complete the monthly reviews. An analysis of the completion of the last three months completed for the services is being undertaken to identify those who need further guidance and support in completing the same - further training and feedback to colleague will be completed by 22nd August 2025. The Operations Director for the region starts on the 28th July 2025 who will complete a Reg 29 visit to all registered services once per quarter, and the monhtly review of actions by the Associate Director of Quaity for the North will continue.

Area for improvement 2 **Ref:** Regulation 30 **Stated:** Second time **To be completed by:** 15 May 2025	The registered person shall ensure that all notifiable events are submitted to RQIA without delay. Ref: 2.0 and 3.3.5
	Response by registered person detailing the actions taken: SIte Leader who is currenlty registering for the service has been shared gudaince by RQIA around reportable incidents and is confident in her knowledge of the same. Site Leader is aware that if they are in doubt, to contact the Assodicate Director of Quality or Managing Director for guidance or RQIA directly. Both of the retrospective notifcations have now been sent.
Area for improvement 3 **Ref:** Regulation 21 (1) (b) **Stated:** First time **To be completed by:** 15 May 2025	The registered person shall ensure that a robust system is implemented and maintained in regards to the monitoring of staff registration with the Nursing and Midwifery Council. Ref: 3.3.1
	Response by registered person detailing the actions taken: Monthly tracker is now in place and owned by the site administrator but overseen by the Site Leader, this includes NMC registration and NISC registration. This will be reviewed during the Reg 29 visits. Priory are currently working on adding this on ITRENT which will allow for NISC, SSSC and DBS checks to be added for each colleague which will generate automatic reminders therefore will take out the requirement for manual recording, this will be in place by the end of the year.
Area for improvement 4 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** 15 May 2025	The registered person shall ensure all chemicals are securely stored to comply with Control of substances hazardous to health (COSHH) recommendations in order to ensure that patients are protected from hazards to their health. This is stated in reference to the access to the identified laundry room. Ref: 3.3.4
	Response by registered person detailing the actions taken: This has now been added to the daily manager walkround and is being checked during the health and safey walkround. We have colleague meetings planned for all Bungalows throughout July during which the above will be discussed.

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 18 **Stated:** Third Time **To be completed by:** 15 May 2025	The registered person shall ensure that care plans are in place with sufficient detail to direct staff when patients are prescribed: • insulin • medicines to manage chronic pain • medicines to manage distressed reactions Ref: 2.0 and 3.3.2
	Response by registered person detailing the actions taken: All RN's colleague bar one, have attended Diabetes training, a number of support colleague attended also. The Support plan relating to the use of the sliding scale has been added. All support plans that are in place to support with pain and distressed reaction have been updated and are currently being ratified by our quality improvement leads. The full review of the same will be completed by the end of July 2025. This will assist in identifing the need for further training for the colleague team which will be rolled out and lead by the Quality Team.
Area for improvement 2 **Ref:** Standard 12 **Stated:** Second time **To be completed by:** 30 August 2025	The registered person shall review the current dining experience and ensure the following in regard to mealtimes; • menus are displayed at mealtimes and in a suitable format • staff are aware of the daily food options • records are maintained of the choice of meals offered to patients and these records are retained in the home. This includes any alternatives offered. Ref: 2.0 and 3.3.2
	Response by registered person detailing the actions taken: New menu's are currently being devised with the input of the people we support and will be completed by the end of July 2025. This will include all options in picture form. The Chef is enrolling in her NVQ to enhance her knowledge. RN's are to be present during mealtimes to ensure adhereance to IDDSI guidelines.

Area for improvement 3 **Ref:** Standard 39 **Stated:** First time **To be completed by:** 1 September 2025	The registered person shall ensure staff receive training to meet their individual roles and responsibilities. This is stated in reference but not limited to • manual handling • deprivation of liberty safeguards • wound/ skin care • dementia care Ref:3.3.1
	Response by registered person detailing the actions taken: Dementia modules have been assigned to all colleagues and have been given a deadline for the 14th July for completion. We are currently looking to outsource training with Dementia UK. Wound/skin modules are being assigned for colleagues to completed, the same will be completed by the end of August 2025 and then will be build into the induction programme for colleagues. DOLS training is a mandatory course for colleagues, all colleagues to have completed the same by the end of August 2025. The support plan where there was noted concern relating to the on going assessments and detail has been amended and is to be ratified by the quality team.
Area for improvement 4 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 1 August 2024	The registered person shall ensure risk assessments are completed as required and are sufficiently detailed to meet the needs of the patients. This is stated in reference but not limited to falls risk assessment and smoking risk assessments. Ref: 3.3.2
	Response by registered person detailing the actions taken: Smoking risk assessment has been completed and the falls risk assessment has been completed also. This will be discussed during the colleague team meetings planned for July in relation to the importance of ensuring that risk assessments are kept up to date and are reflective of current risk. This will then be rountinely checked on Nourish.
Area for improvement 5 **Ref:** Standard 46 **Stated:** First time	The registered person shall ensure that staff receive further training on the appropriate use of gloves and this training is embedded into practice. Ref: 3.3.4

To be completed by: 1 July 2025	**Response by registered person detailing the actions taken**: This will be addressed via the daily manager walkrounds and in the meetings planned for July 2025. A tracker is now in place and colleagues who continue to breach guidance, will be addressed formally.
Area for improvement 6 **Ref:** Standard 16 **Stated:** First time **To be completed by:** 1 July 2025	The registered person shall ensure that a record of complaints is maintained to include communication with the complainant; result of any investigation; the action taken; whether the complainant was satisfied with the outcome of the outcome; and how this satisfaction was determined. Ref: 3.3.5
	Response by registered person detailing the actions taken: This is now in place and robust minutes are being maintained at site level. Colleagues are also using Nourish to record interactions or concerns raised so that we have evidence of the same. Corresspondance that is received from the Trust when they are leading on the same, is being kept in a central file in the site leaders office.
Area for improvement 7 **Ref:** Standard 39 **Stated:** First time **To be completed by:** 1 July 2025	The registered person shall ensure there is a robust system in place to ensure the competency and capability assessments for the staff who take charge of the home in the absence of the manager are reviewed on a regular basis. Ref:3.3.5
	Response by registered person detailing the actions taken: Compentences have been completed for all nurses who may/will be in charge of site. The compentency is currently being reviewed as it is noted that the same needs to be updated and then this will be roled out to all RN's. This will be completed by the 14th August 2025.

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