The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Iveagh House Private Nursing Home

Provider: Spa Nursing Homes Ltd

Date of Inspection: 14 October 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:	Spa Nursing Homes Ltd
Responsible Individual:	Mr Christopher Philip Arnold
Registered Manager:	Miss Chloe Burns – Not registered
Service Profile – Iveagh House Private Nursing Home is a registered nursing home which provides general nursing care for up to 33 patients. Patients' bedrooms are located over three floors and patients have access to communal dining and lounge areas.	

2.0 Inspection summary

An unannounced inspection took place on 14 October 2025 from 9.45am to 3.00pm 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 15 May 2025.

As a result of this inspection all of the previous areas for improvement were assessed as having been addressed by the provider and no new areas for improvement were identified. Details can be found in the main body of this report.

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 lovely here," and, "I couldn't say a bad word about the place; the staff are very good". Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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 were no responses from the staff online survey and we received no questionnaire responses from patients or their visitors.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Staff felt that they were supported during induction to the home and were trained well to perform their duties. Training included person centred care, adult safeguarding, deprivation of liberty and first aid. There was a system in place to ensure that staff completed their training.

Staff told us that, while patients' basic needs were met, they would like more time to spend with the patients. Staff views were shared with the management team for their review and action as appropriate.

Observation of the delivery of care during the day 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.

Patients raised no concerns in relation to the staffing arrangements in the home.

Staff celebrated a 'Happy Week' the preceding week where management arranged for a staff breakfast and a staff lunch and entertainment.

3.3.2 Care Delivery and Record Keeping

A nurse assessed patients' needs 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. 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.

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.

Pressure management risk assessments were completed to identify risk levels of skin breakdown. Where risks were identified, care plans were in place to direct staff on how to manage the risk. Care plans identified the equipment required to maintain skin integrity and were air mattresses were in use, these had been set at the correct setting for the patient. Body maps were used to identify affected areas where skin integrity had been breached.

Patients had good access to food and fluids throughout the day and night. Nutritional assessments were completed to monitor for weight loss and/or weight gain. A review of a random sample of these evidenced that they had been completed accurately. Weight management was audited monthly. Care plans in place were consistently reflective of the recommendations of the speech and language therapists and/or dieticians. A system was in place to ensure all patients received their meals.

Accidents in the home had been well managed. A review of accident records evidenced that the correct actions were taken and correct persons notified following a fall in the home. Accidents occurring in the home were reviewed monthly for patterns and trends to identify if any future falls could be prevented.

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. Restrictive practices in use were audited monthly.

The home had been decorated for Halloween and patients were preparing for a Halloween party. The manager confirmed that intergenerational work had recommenced. Patients were settled in their environment. One told us, "I love it here; the staff are very good".

3.3.3 Quality and Management of Patients' Environment Control

The home was warm, clean and comfortable. There were no malodours. There was evidence of recent refurbishment in the home. All doors had been repainted, as had the reception area and the stairwells. Identified bedroom floors had been replaced and new lighting was in the process of being fitted. Externally within the central garden trees had been trimmed; paving had been cleaned and painting had commenced.

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. All staff had completed a fire drill and the manager confirmed that they aim for all staff to be involved in two fire drills per year.

Infection prevention and control audits were conducted monthly and monitored the environment and staff practices. Where deficits were identified, an action plan was developed and reviewed to ensure completion.

3.3.4 Quality of Management Systems

Miss Chloe Burns has been managing the home since 9 September 2024. Staff commented positively about the management team and described them as supportive, approachable and available to provide guidance.

A review of records evidenced the system in place to review the quality of service provision in the home over a range of areas. The manager had a monthly suite of audits to complete.

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.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Chloe Burns, Manager and Louise Riley, Regional Support Manager, as part of the inspection process and can be found in the main body of the report.

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