The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Redburn Clinic

Provider: Spa Nursing Homes Ltd

Date of Inspection: 9 December 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:	Mr Michael Bagood
Service Profile – This home is a registered nursing home which provides general nursing care for up to 27 patients. The home is also registered to care for patients with a physical disability. Patients' bedrooms are located over three floors and patients have access to communal lounges and a dining area.	

2.0 Inspection summary

An unannounced inspection took place on 9 December 2025 from 9:45 am to 3:20 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 16 January 2025; 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.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

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.

As a result of this inspection, the area for improvement identified at the last inspection was assessed as having been addressed by the provider. 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 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 they were happy with the care and services provided. Comments made included "the food is brilliant and staff treat me well" and "I have no complaints".

Patients told us that staff offered choices to patients 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.

Questionnaires returned from patients during the inspection indicated that they were very happy with the care. The comments included "Knowing staff are here 24-7 makes a big difference to me as I feel safe and secure" and "the care is excellent".

Staff spoke in positive terms about the provision of care, their roles and duties, training and managerial support.

Families spoken with told us that they were very happy with the care provided and that there was good communication from staff.

Following the inspection, no response was received from patients, relatives or staff questionnaires.

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.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels.

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

Any member of staff who has responsibility of being in charge of the home in the absence of the manager should have a competency and capability assessment in place. Review of records established that not all staff with this responsibility had an assessment in place. An area for improvement was identified.

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.

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.

It was observed that 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.

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 regularly and their care records accurately reflected their needs.

Patients who required care for wounds had this clearly recorded in their care records and records evidenced the wounds were dressed by the nursing staff as planned.

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.

The dining experience was an opportunity for patients to socialise, music was playing, and the atmosphere was calm, relaxed and unhurried. It was observed, that patients were enjoying their meal and their dining experience. It was evident that staff had made an effort to ensure patients were comfortable and had a pleasant experience.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home. Staff were observed sitting with patients and engaging in discussion. Patients who preferred to remain private were supported to do so and had opportunities to listen to music or watch television or engage in their own preferred activities.

The activity schedule was on display. Activities planned for the week included chair exercises, games, reminiscence and hand massage. A number of patients were observed to be singing Christmas songs on the morning of the inspection and enjoying it.

3.3.3 Management of Care Records

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment, care plans and risk assessments should be developed in a timely manner to direct staff on how to meet the patients' needs. However, review of two patients' care records evidenced that some of the care plans and risk assessments had not been developed in a timely manner. This was identified as an area for Improvement.

Patients care records were held confidentially. Nursing staff recorded regular evaluations about the delivery of care.

Review of identified care records evidenced that care plans were not regularly reviewed, this is necessary to ensure patients' care records reflect the care being delivered especially as patients' needs may change over time. This was identified as an area for improvement.

We discussed the management of patients' who vape within the home. Review of an identified patient record, evidenced that risk assessments and care plans were not in place to direct the management of this. This was identified as an area for improvement.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. For example, patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

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. Mr Michael Bagood has been the registered manager since 14 May 2024.

Relatives and staff commented positively about the management team and described them as supportive, approachable and able to provide guidance.

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 the quality of services provided by the home.

Compliments received about the home were kept and shared with the staff team

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	4

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Michael Bagood, Manager and Mrs Linda Graham, Regional 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 41.7 **Stated:** First time **To be completed by:** 31 December 2025	The registered person shall ensure competency and capability assessments are completed for all staff who take charge of the nursing home in the absence of the manager. Ref: 3.3.2
	Response by registered person detailing the actions taken: The Registered Manager has completed nurse in charge competency assessments on all staff who work within the home.
Area for improvement 2 **Ref:** Standard 4.1 **Stated:** First time **To be completed by:** 9 December 2025	The registered person shall ensure that there is a system in place to monitor the completion of care records following a patient's admission to the home. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Registered Manager will ensure all care files are audited following a resident admission to the home to ensure all care records are completed within the specified timeframe.
Area for improvement 3 **Ref:** Standard 4.7 **Stated:** First time **To be completed by:** 31 December 2025	The registered person shall ensure that patients' care plans are reviewed regularly. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Registered Manager has addressed with the nursing team the importance that all care plans are reviewed regularly. The Registered Manager will continue to monitor this area with the nursing team.
Area for improvement 4 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 31 December 2025	The registered person shall ensure that there are detailed care plans and risk assessments in place for patients who vape. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Registered Manager can confirm that there is a detailed care plan and risk assessment in place for resident's who vape.

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

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