The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Aughnacloy House**

Provider: **MD Healthcare Ltd**

Date of Inspection: **3 March 2026**

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:	MD Healthcare Ltd
Responsible Individual:	Mrs Lesley Catherine Megarity
Registered Manager:	Ms Constance Mitchell

Service Profile –
This home is a registered nursing home which provides nursing care for up to 71 patients. The home is divided into two units over two floors. General nursing care is provided on the ground floor and patients living with dementia are cared for on the first floor. Patients have access to communal lounges, dining rooms and garden space.

2.0 Inspection summary

An unannounced inspection took place on 3 March 2026 between 9.30 am to 6.00 pm by two care inspectors.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; 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 that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

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.

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 who were able to share their opinions on life in the home said or indicated that they were well looked after. Patients who were less able to share their views were observed to be at ease in the company of staff and to be content in their surroundings.

Patients told us that staff offered choices to them 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.

Relatives consulted spoke positively on the care their loved ones received. They told us that staff kept them up to date with all relevant information relating to the patients; that the environment was always clean, and that the staff were very pleasant and helpful.

No additional feedback was received from patients, relatives or staff following the inspection.

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. Discussion with the management confirmed that dependency levels were reviewed on a regular basis to determine staffing requirements. A review of the duty rota evidenced that the home was generally staffed as planned, however, after identifying the need for twilight shifts, it was noted the home's twilight shift in both units was not consistently covered. Staff also raised concerns regarding supervising patients and meeting their needs at these times. Discussion with the management confirmed that they are actively recruiting for this role. This was discussed with the management for review and action as appropriate; an area for improvement was identified.

Staff told us that the patients' needs and wishes were important to them. Staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through observation of the interactions between the patients and staff that the staff knew the patients well.

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 and received a handover report with pertinent patient details. Staff were allocated to identified areas within the home.

Staff were knowledgeable of individual patient's needs, their daily routine wishes and preferences. A discussion took place with the management to review the system in place to ensure staff are aware of the Deprivation of Liberty Safeguards (DoLS) in place; this will be reviewed at a future inspection.

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.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, 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.

Patients were observed to be well presented in their appearance and dressed in appropriate attire.

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. Staff were knowledgeable of individual patient's needs and were able to describe the actions they would take to report any skin issues identified to nursing staff. Patients who required assistance by staff to change their position regularly, were regularly assisted to change position and care records accurately reflected the patients' assessed needs.

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, identified that music was playing, and the atmosphere was calm, relaxed and unhurried. Some patients chose to remain in their bedroom for their meals and this was readily accommodated with support provided in accordance with their assessed need. The menu for the day was displayed in the home and patients confirmed that they were offered a choice at all meal times.

Staff took time to converse with patients in the dining room and ensure they had a meal that they enjoyed. A selection of condiments and drinks were available and patients comments included, “just beautiful (food)” and “plenty to eat”.

A review of records and discussion with patients and staff evidenced that there were robust systems in place to manage patients’ nutrition and mealtime experience.

The programme of social events was displayed on the noticeboard advising of future events. Activities for patients were provided which involved both group and one to one activities. Patients were observed enjoying a live music session, singing and sessions. A patient commented how much they enjoyed the music session.

Arrangements were in place to meet the patients’ social, religious and spiritual needs within the home.

3.3.3 Management of Care Records

Patients’ needs were assessed by a suitably qualified member of staff 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.

Care records in general, were person centred and regularly reviewed to ensure they continued to meet the patients’ needs. It was noted bespoke enhanced care arrangements were in place for a number of patients, and staff were observed supporting patients with their assessed care needs. Patients who required bespoke enhanced care did not have detailed individualised care plans pertaining to the bespoke care arrangement in place. This was discussed with the management for immediate review and action as appropriate; an area for improvement was identified.

The nursing staff complete patient daily progress notes to monitor and evaluate the care delivered to patients in their care. However, the daily nursing evaluation of care delivery during the shift had been completed half way through the day; there were no additional entries to evidence the care delivered later in the day. A discussion took place with the management team to ensure a meaningful review of patient care is recorded; an area for improvement was identified.

Patients care records were held confidentially.

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. Beds were neatly made up with clean bedlinen and there was evidence of a good supply of clean bedding and towels. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. There was evidence of ongoing refurbishment to include new flooring in identified areas. Observation identified that the carpet in the ground floor nurses station required either repair or replacement; discussion with the management confirmed that a refurbishment plan which included the carpet was in place. This will be reviewed at a future inspection.

Photographs of patients participating in social events that they had attended were on display in communal spaces within the home. A system was in place to ensure consent for patient photography had been reviewed.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records kept.

3.3.4 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Constance Mitchell has been the manager in this home since 12 February 2015.

Staff commented positively about the manager 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. The manager had a suite of audits to complete and any identified deficits were action planned for review and action as required.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Discussion with staff confirmed knowledge of safeguarding systems and protocols and how to escalate any concerns.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	3

Areas for improvement and details of the Quality Improvement Plan were discussed with the management, 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 **Stated:** First time **To be completed by:** 3 March 2026	The registered person shall review staffing requirements to ensure patients' needs are met taking account the deployment of staff and the size and layout of the home. Ref: 3.3.1
	Response by registered person detailing the actions taken: Staffing levels have been reviewed and are in line with patient dependency, and the size and layout of the home. A targeted recruitment drive to strengthen twilight shift cover has been successfully completed. Staff rotas are reviewed daily to ensure adequate staffing levels are maintained to meet the needs of residents. Staffing arrangements are subject to ongoing review to ensure safe and effective care.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 3 March 2026	The registered person shall ensure, where applicable, a bespoke enhanced care plan is in place which includes the specific care details relating to the patient. Ref: 3.3.3
	Response by registered person detailing the actions taken: A bespoke enhanced supervision care plan was implemented on the day of inspection for the identified resident. This plan clearly outlines the rationale for supervision, specific staff instructions, required safety measures (including management of risks in relation to other residents), and recording requirements for the 1:1 staff member. The registered person has ensured that bespoke enhanced care plans will be put in place for any resident requiring increased supervision, and these will be subject to ongoing review.

Area for improvement 3 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that nursing staff evaluate care in a meaningful manner that is person centred. Ref: 3.3.3
To be completed by: 3 March 2026	**Response by registered person detailing the actions taken:** The registered person has met with nursing staff to reinforce the importance of meaningful, person-centred evaluation of care. Guidance was provided to ensure care evaluations reflect all care delivered across the full shift, including evening entries. Care records are being monitored to ensure improvements are embedded and that documentation accurately reflects person-centred care.

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

The Regulation and Quality Improvement Authority

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