The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Rathfriland Manor

Provider: Manor Healthcare Ltd

Date of Inspection: 3 June 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:	Manor Healthcare Ltd
Responsible Individual:	Mr Eoghain King
Registered Manager:	Mrs Rachel McCaffrey
Service Profile – This home is a registered nursing home which provides nursing care for up to 54 patients. Care is provided for up to 30 patients over the age of 65 for general nursing and up to 24 patients who have a dementia. Patients' bedrooms are located over two floors and patients have access to communal dining and lounge areas to relax in.	

2.0 Inspection summary

An unannounced inspection took place on 3 June 2026 from 9.30am to 5.00pm by two care inspectors.

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 3 July 2025; 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 the service was well led.

Patients spoke positively when describing their experiences of living in the home. Refer to Section 3.2 for more details.

As a result of this inspection the area for improvement from the previous care inspection was assessed as having been addressed and two new areas for improvement were identified. Details can be found in the main body of the 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 were well presented in their appearance and were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. One told us, "We are well cared for here". Another commented, "I am happy with the care here and comfortable". We received no questionnaire responses from patients or relatives.

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 was no responses from the staff online survey.

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. All appropriate recruitment safety checks had been verified prior to staff commencing in post. Newly employed staff completed a structured induction at the commencement of their employment which included mandatory training. A robust system was in place to ensure that all staff were compliant with pre-determined mandatory training requirements.

Staff told us that they were satisfied that the number and skill mix of staff on duty met the needs of the patients. Patients raised no concerns in relation to the staffing arrangements.

Observation of the delivery of care 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.

Minutes of staff meetings were available to all staff to aid in the communication within the home.

Checks were made to ensure nurses maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

3.3.2 Quality of Life and Care Delivery

Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences. Interactions between staff and patients were noted to be caring and compassionate. Patients spoke fondly about the staff.

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. Patients told us that they had choice in where and how they spent their day, what they wore and what they had to eat.

Staff confirmed that they received a detailed handover at the commencement of their shift and the information shared included important aspects of patients' needs, especially changes to care.

Patients who required special attention with skin care were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs. Where a patient had a wound, wound care records directed staff on how to treat the wound and wound evaluation records monitored the progress of the treatment. Where a patient had more than one wound; each wound was treated, monitored and documented separately. An area for improvement in this regard has now been met.

Patients had dehydration risk assessments completed and identified fluid targets within their care records to maintain hydration. Patients' weights were monitored monthly, or more frequently if required, for weight loss or weight gain. Nutritional care plans were in line with the recommendations from dieticians and/or speech and language therapists. Food and fluid intakes had been recorded well.

Patients had good access to food and fluids throughout the day and night. Patients were safely positioned for their meals and the mealtimes were appropriately supervised. Staff communicated well to ensure that every patient received their meals in accordance with their assessed needs. Food was only served when the patients were ready to eat their meal. The meals served appeared appetising and nutritious. Staff sat with patients when providing assistance and assistance was given in an unhurried manner. Patients enjoyed their meal and spoke positively of the quality of their meal.

Activities for patients were provided incorporating both group and one to one activities. Birthdays and annual holidays were celebrated. Records were kept of all activity engagements with patients. Relatives were invited to attend a planned coffee morning each month.

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 the patients' needs. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate. Risk assessments and care plans were reviewed regularly to ensure that they remained reflective of patient need. Care records were stored securely in an archive storeroom.

Supplementary care records were maintained to evidence the care delivered to patients. The records included personal care delivery, food and fluid intake, repositioning, checks made on patients and continence care.

Nurses completed daily progress notes to monitor and evaluate the care delivered to the patients in their care. We discussed ways of enhancing the recording of the daily evaluations.

3.3.4 Quality and Management of Patients' Environment

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. Storage and communal rooms were maintained clean and tidy. There were no malodours in the home.

Externally the home was well maintained. There were enclosed garden areas where patients could sit outside.

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 recent fire extinguisher and evacuation training. Fire safety checks were regularly conducted.

There were inappropriate items identified within patients' bedrooms in the dementia unit which could be potentially harmful to patients. This was discussed with the manager and identified as an area for improvement. No patients came to any harm.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. Personal protective equipment and hand hygiene facilities were readily available throughout the home.

Some topical preparations in use did not have the date recorded when they were opened. This is important to ensure that they are not used outside of manufacturers' guidelines. An area for improvement was identified.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Rachel McCaffrey has been registered as manager of the home since 1 February 2016. Staff commented positively about the manager and described her as supportive and approachable.

In the absence of the manager there was a nominated nurse-in-charge (NIC) to provide guidance and leadership. The NIC was clearly identified on the duty rota.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. The manager had a suite of audits to complete.

The number of complaints to the home was low. There was a system in place to manage any complaints received. A compliments book was available with cards and emails of thanks. All compliments received were shared with staff.

Staff were aware of what constituted as a safeguarding incident and 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

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	1	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Rachel McCaffrey, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

A completed Quality Improvement Plan from the inspection of this service is not currently available. However, it is anticipated that it will be available soon.

If you have any further enquiries regarding this report please contact RQIA through the e-mail address info@rqia.org.uk

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** With immediate effect (3 June 2026)	The registered person shall ensure that the identified items, which could be harmful to patients, are not accessible to patients in the dementia unit. Ref: 3.3.4
	Response by registered person detailing the actions taken:
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** With immediate effect (3 June 2026)	The registered person shall ensure that topical preparations are dated on opening to make sure that they are disposed of in accordance with manufacturer guidelines. Ref: 3.3.4
	Response by registered person detailing the actions taken:

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

The Regulation and Quality Improvement Authority

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