The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Somerton Private Nursing Home**

Provider: **Somerton Private Nursing Home**

Date of Inspection: **1 September 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:	Somerton Private Nursing Home
Responsible Persons:	Mr Henry Enda McCambridge Mr Paul Henry McCambridge
Registered Manager:	Mrs Dhimi Daniel
Service Profile – This home is a registered nursing home which provides nursing care for up to 26 patients who live with dementia. Patients have access to communal living and dining areas and externally there is a well maintained garden with seating.	

2.0 Inspection summary

An unannounced inspection took place on 1 September 2026 from 9.25am to 4.30pm 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 14 November 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led. Areas for improvement identified at the previous medicines management inspection on 12 February 2026 were not reviewed as part of this inspection and these are carried forward for review at the next inspection.

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 one area for improvement from the previous care inspection was assessed as having been addressed and one was stated for the second time. One new area for improvement was 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 content in their surroundings and in their interactions with staff. Patients communicated comfortably with one another and with staff. We received no responses from patients' questionnaires.

Relatives were complimentary on the care their loved ones were receiving. During the inspection a relative told us, "The care is fabulous. The staff are lovely to all of the patients. I never have a worry". We received seven relative questionnaire returns from relatives. They described the care from staff as, 'excellent' 'reassuring' 'helpful' 'caring' 'kind' 'attentive' and 'pleasant'. One relative responded, "We are happy with the care provided to (xxx). They are treated with kindness, dignity and respect and we feel reassured knowing she is in such caring hands".

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 one response from the staff survey. The respondent confirmed that they felt care in the home was safe, effective and compassionate and that the home was well led. They commented, "Its a lovely home to work for and all the staff are providing care with great compassion. Residents appear to be happy and content in the home".

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. In addition to training, staff were also supported through staff supervisions and appraisals.

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.

Staff meetings were conducted to aid in the sharing of information. Minutes of the meetings were made available for staff, especially those unable to attend, to read and sign once read. The minutes included all attendees at the meeting and discussions which were had.

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. A handover sheet was available for staff to be used as an aide memoire.

Pressure management risk assessments were completed and reviewed monthly to ensure that skin integrity was maintained. 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. Pressure relieving equipment, such as, air mattresses in use had been correctly set in accordance with the patient's weight.

We reviewed the use of prescribed topical preparations to assist in managing skincare. An area for improvement was made to ensure that record keeping was completed in full, for example, all patient details completed on any relevant document, the indications for use recorded, the site of application identified, frequency of use, and the start and end date, if applicable, to be recorded.

Continence care plans clearly identified the patients' continence needs and aids required. Toileting charts recorded when patients were assisted to the toilet and if pads in use were wet, dry or changed. Bowel management was recorded utilising Bristol Stool Scores.

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 monitored.

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. The meals served appeared appetising and nutritious. Staff sat with patients when helping with their meal and assistance was given in an unhurried manner. Patients enjoyed their meal and spoke positively on the quality of their meal. Staff were aware of the actions to take should a patient regularly refuse food.

Hourly checks were maintained on all patients to ensure their safety; especially for those who chose to stay in their bedrooms. Some patients required more frequent checks in place which were also recorded. Care staff reported any concerns to the registered nurses on duty.

Each patient had their own activity records on file recording each engagement, type of activity and outcome. Activities for patients were provided incorporating both group and one to one engagement. Activities included arts and crafts, games, doll therapy, exercises, walks, reminiscence and busy boards. Birthdays and annual holidays were celebrated. Patients' families could log into a Facebook page where they could see videos and pictures of the patients enjoying activity engagements. In addition, there were photographs displayed of patients engaging in activities at the reception area of the home. An orientation board was displayed showing patients the day, date, time and weather. This was maintained up to date.

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. We discussed the benefits of re-writing care plans when significant changes were made. Risk assessments and care plans were reviewed regularly to ensure that they remained reflective of patient need. Care records were stored securely.

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. While improvements in the recording of these evaluations were noted from the previous care inspection, several night duty entries were completed up to half way through the shift and not accounting for the remainder of the shift. This was discussed with the manager and an area for improvement previously stated in this regard was stated for the second time.

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. Access to rooms containing hazards had been restricted. There were no malodours in the home.

Externally the home was well maintained. There was an attractive patio area within an enclosed garden where patients could sit outside alongside multiple potted plants.

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 safety training and fire safety checks were regularly conducted. A recent fire risk assessment had taken place and the only action identified was managed in a timely manner.

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.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Dhimi Daniel was registered as manager with RQIA on 15 January 2018. 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 completed a competency and capability assessment on taking charge prior to taking on the role and 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. Accidents were reviewed monthly for any patterns or trends in an effort to prevent any future falls from occurring.

The use of restrictive practices, such as alarm mats or bedrails, was monitored monthly to ensure that the practice remained relevant to the patient and the correct records were in place.

There were no recent or ongoing complaints relating to the home. There was a system in place to manage any complaints received. All compliments received were shared with staff including multiple online relatives' feedback.

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

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	4*

*The total number of areas for improvement includes one that has been stated for a second time and three which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Paul McCambridge, Registered Person and Mrs Lilykutty Peter, Nurse in Charge, 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 12 (1) (a) (b) **Stated:** First time **To be completed by:** With immediate effect (1 September 2026)	The registered person shall review the management of topical preparations to ensure that all associated care records are completed in full and creams, for example, are administered as prescribed. Ref: 3.3.2
	Response by registered person detailing the actions taken: Staff have been reminded of their resoponsibilities and appropriate checks are being undertaken to ensure that topical medicine are administered as prescribed and that records are completed accurately and in full. The registered manager will continue to monitor compliance through audits
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 12 February 2026	The registered person shall review the management of thickening agents to ensure that records of prescribing and administration are accurately maintained. The recommended consistency level should be recorded on all records. Ref: 2.0
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 12 February 2026	The registered person shall ensure that records of disposal are accurately maintained. Ref: 2.0
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.

Area for improvement 3 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 12 February 2026	The registered person shall ensure that safe systems are in place for the management of medication changes. Ref: 2.0
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 4 **Ref:** Standard 12 **Stated:** Second time **To be completed by:** With immediate effect (1 September 2026)	The registered person shall ensure that nursing staff evaluate care in a meaningful manner that is person centred. Ref: 2.0 and 3.3.3
	Response by registered person detailing the actions taken: Nursinng staff have been reminded of the importance of evaluating care in a meaningful, person centered manner to ensure that evaluations are completyed appropriately and consistently. Audits will be undertaken to monitor compliance.

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

The **Regulation** and **Quality Improvement** Authority

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