The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: The Somme

Provider: Board of Directors

Date of Inspection: 17 September 2026

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Registered Provider:	Board of Directors
Responsible Individual:	Mr Gary William Stewart Cassells
Registered Manager:	Mrs Ruth Rogers

Service Profile –
This home is a registered nursing home which provides general nursing care for up to 50 patients under and over 65 years of age. The Somme also provides care for patients living with a physical disability other than sensory impairment over and under the age of 65 years.

The home is a single storey building which is divided into four units; Wilson Liddell Unit, Bates Unit, Eakin Unit and Rogers Unit. There is a large communal dining room and a selection of lounges, sitting areas and enclosed outside courtyards.

2.0 Inspection summary

An unannounced inspection took place on 17 September 2026 from 9.30am to 5.20pm 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 16 October 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led. There were no additional areas for improvement identified during the last medicines management inspection on 9 December 2025.

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 areas for improvement from the previous care inspection were assessed as having been addressed by the provider and four new areas for improvement were identified. Details can be found in the main body of this report and in the Quality Improvement Plan within Section 4.0.

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. Patients chatted freely and one told us, "I am happy here. Staff are very good and we get plenty to eat and drink. I am comfy". Another commented, "This is a great place; staff are fantastic". We received seven patient / relative questionnaires. Care delivery was described as, "Very Good", "A high standard and practiced with kindness and compassion", "Excellent" and "Generally very good".

While the majority of responses both verbally and via questionnaire feedback complimented the care provision in the home, some concerns were raised in relation to the staffing arrangements. All concerns raised were shared with the manager for their review and actions as appropriate.

Relatives were complimentary on the care their loved one was receiving. During the inspection a relative told us, "We are very happy with the care. (name) is always well presented and we can come and go as we please". Another commented, "There is good care delivered here. We are happy".

Staff told us that they felt well trained to perform their duties and that teamwork in the home was good. Staff thought that the manager and management team were approachable and they would not have any concerns about raising concerns if they felt that they needed to. Some staff raised concerns regarding the staffing arrangements. Concerns raised were shared with the manager for their review and action as appropriate. There were no responses from the staff 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.

Recruitment safety checks had all 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 staff were compliant with pre-determined mandatory training requirements. However, staff had not received training on end of life care. This was identified as an area for improvement.

Some staff were off the opinion that the staffing levels were not sufficient to meet the needs of the patients. Patients also shared concerns in relation to the staffing arrangements. This was discussed with the manager and an area for improvement was made to review the morning routines in the home in order to ensure that patients' needs were met and in a timely manner. Observation of the delivery of care evidenced that staff responded to requests for assistance promptly in a caring and compassionate manner.

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. 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 handover at the commencement of their shift and the information shared included important aspects of patients' needs, especially changes to care. Handover sheets were available 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 and care records accurately reflected the patients' assessed needs. Care plans identified each patient's mobility requirements and how to safely move and handle each patient, where appropriate.

Patients' weights were monitored monthly, or more frequently if required, for weight loss or weight gain. Nutritional assessments were completed and the nutritional care plans were in line with the recommendations from dieticians and/or speech and language therapists. Food and fluid intakes had been monitored well.

Patients had good access to food and fluids throughout the day and night. They could take their meals in their preferred area; the dining room, bedroom or one of the lounges. Patients were safely positioned for their meals and the mealtimes were appropriately supervised. A system was in place to ensure that patients received the correct food and drinks in accordance with their nutritional 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.

Activities' therapists worked well together to provide both group and one to one activity engagements with patients. A programme of upcoming activities was shown on the new electronic display board at reception which also included the menu for an upcoming Autumn dining evening where patients could invite family members. Activities included karaoke, darts, arts and crafts, ball games, quiz, jigsaws, movies, musical therapy and hairdressing. Cadets had visited the previous day to chat to patients and share a slide presentation of Normandy. A private Facebook page had been set up to share photos and comments on patients' activities. Patients had enjoyed the 110th Anniversary of the Battle of the Somme Dignitaries Meal where special guests had attended. Throughout the year there was intergenerational work with a local nursery and musical entertainers had been booked to come to the home to entertain patients. Activities staff were in the process of arranging entertainers to come to the home, for example, schools and choirs to help patients celebrate Christmas. Daily records were kept of all activity engagements.

The manager confirmed that patients had recently completed a quality assurance survey and that, when the findings were collated, the results would be displayed for patients and relatives to see along with an action plan where required.

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.

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. However, several of the evaluation entries were completed up to half way through the shift and not accounting for the remainder of the shift. In addition, several entries were phrased in broad terms without specific detail. This was discussed with the manager and identified as an area for improvement.

Care records were stored securely.

3.3.4 Quality and Management of Patients' Environment

On entry to the home there was a large reception area with seating and a receptionist on duty to assist visitors. Visitors recorded their entry in a sign in book and there was a hand hygiene facility available. Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. Patients had access to call bells when remaining in their rooms to summon staff if they required assistance. Storage and communal rooms were maintained clean and tidy. Access to rooms containing hazards had been restricted. There were no lingering malodours in the home. The home was in a good state of repair and staff identified any environmental issues within a maintenance log book to alert maintenance staff to remedy.

Corridors and fire exits were clear of clutter and obstruction should the need to evacuate occur and fire extinguishers were easily accessible. Fire drills had been completed to aid in preparation for evacuations. Staff had attended additional fire safety training and fire safety checks were regularly conducted. A fire risk assessment had been completed in March 2026.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. However, during the inspection we observed several staff not to be bare below the elbow wearing watches and/or wrist jewellery. Being bare below the elbow is necessary for performing effective hand hygiene. An area for improvement was identified. 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 Ruth Rogers has been registered as manager of the home since 21 November 2023. Staff commented positively about the manager and described her as supportive and approachable and always available to provide any advice or guidance.

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. In addition to the NIC, there was an on-call manager nominated to deal with any issues if/as they arose.

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. We discussed the importance of completing timebound action plans when deficits were identified. This will be reviewed again at a subsequent inspection.

The number of accidents in the home was low. Accidents were monitored monthly for pattern and trends in an effort to potentially prevent any future falls from occurring. Details of any remedial actions taken were recorded.

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.

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. Patients and relatives were satisfied that if they raised any concerns, these would be dealt with by the manager or person in charge and in a timely manner.

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	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Ruth Rogers, Registered 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time **To be completed by:** 17 October 2026	The registered person shall review the morning routines to ensure that patients' needs are met and in a timely manner. Ref: 3.3.1
	Response by registered person detailing the actions taken: We are currently undertaking a review of our current moring arrangments , Including dependency levels staff deployment residents individual preferences and routines . Staff meetings have been scheduled to discuss and feedback will also be sought from residents relatives and staff to identify areas where we can improve our service
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 20 **Stated:** First time	The registered person shall ensure that staff are trained in palliative / end of life care in accordance with their roles and responsibilities. Ref: 3.3.1

To be completed by: 30 November 2026	**Response by registered person detailing the actions taken:** All relevant staff have been scheduled to complete palliative care training . This was a management oversight The nurse manager had accidently removed palliative care training from essential list on e learning platform . Management will have oversight of trainng compliance
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** With immediate effect (17 September 2026)	The registered person shall ensure that nursing staff evaluate care in a meaningful manner that is person centred. Ref: 3.3.3
	Response by registered person detailing the actions taken: All nursing staff have been remnded of the importance of completing documentation at the time care is delivered entries are to be factual accurate . Care is to be reviewed reguarily to establish that the delivery of care is meeting the individual residents needs promotng their dignity quality of lifemanagment will audit care palns and evaluations monthly findings and actions will be shared at staff meetings
Area for improvement 3 **Ref:** Standard 46 Criteria (3) **Stated:** First time **To be completed by:** With immediate effect (17 September 2026)	The registered person shall ensure that training on infection control is embedded into practice and staff are bare below the elbow in the areas where care is provided. Ref: 3.3.4
	Response by registered person detailing the actions taken: The importance of Bare below the elbows requirement has been reinforced to staff management will carry out spot checks hand hygiene audits and infection control audits to ensure compliance with same .

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