

Inspection Report

Name of Service: Ardmaine Care Home

Provider: Healthcare Ireland No 2 Ltd

Date of Inspection: 30 September and 1 October 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:	Healthcare Ireland No 2 Ltd
Responsible Individual:	Ms Amanda Mitchell
Registered Manager:	Ms Oonagh Grant – not registered
Service Profile: This is a registered nursing home which provides nursing care for up to 65 patients. The home is divided into two units. Bronte unit accommodates patients living with dementia and is located on ground floor level. Mourne unit provides general nursing care and is located on the first floor. There are a range of communal spaces, including dining rooms, lounges, and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 30 September 2025 from 10 am to 4.45 pm, and on 1 October 2025 from 10 am to 2.10 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 care inspection on 17 and 18 July 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

While we found care to be delivered in a compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery.

Some patients described their experience of living in Ardmaine Care Home as positive and said that staff were very good and available when they needed support. Staff were observed to be respectful and polite in manner towards patients, visitors, and each other.

Some patients and relatives raised concerns about the meals provided in the home, and what they perceived to be a lack of engagement from staff. Some staff said that there was not enough care staff on duty to provide anything above “basic care.” Comments from patients, relatives, and staff were shared with the management team who acknowledged that they were aware of some of the views shared and had plans to address these.

As a result of this inspection one area for improvement was assessed as having been addressed by the provider. One area for improvement identified at the last care inspection was stated for a second time. 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 spoken with gave mixed responses about their experiences living in Ardmaine Care Home. Some patients said they were happy with the care provided and described staff as "very good" and "very kind", and said that staff respond when they buzz or ask for help, "They [staff] are always around to help." One patient said, "I like it here," and two patients told us that the food was "lovely" on that particular day.

Other patients gave mediocre descriptions of their experience, saying that staff were "Okay, they do what you need", and that the food was "not great." While some patients acknowledged that they could choose from two meal options at lunch and dinner, they also said that if they did not like either option "you get what you're given", or "it's tough luck." One patient said that hot meals were sometimes served cold. These comments were shared with the management team, who informed us that they were aware of some issues with the food and planned to review the menus and to complete consultation with patients and relatives to obtain their views and suggestions.

Some patients said that they enjoyed getting their nails done as an activity, but otherwise they were unsure what activities took place. Other patients said, "I read books or go out with family", "there is nothing to do...I watch television and play music", and "there's not much to do...I colour in and do my own thing".

Relatives spoken with also gave mix responses in relation to, meals provided, the provision of activities, staff and staffing and the delivery of care. One relative said that their loved one was “well cared for...staff are very caring and do their best to get things right”, and “we are very happy... our [loved one] always looks clean and tidy...staff are lovely”.

Other relatives said that staff were polite but that they did not fully engage with patients during interventions. For example, one relative described staff assisting their loved one to the toilet without properly explaining to the patient what they were doing. Another relative said, “Staff are friendly and helpful when you ask them for something, but you nearly always have to ask.” Comments were discussed with the management team who acknowledged that sometimes staff did not communicate well with patients. They accepted that clear communication was essential in care delivery and agreed to address this through staff meetings and training. Staff communication with patients is discussed further in section 3.3.2.

Relatives also confirmed that they knew how to raise issues or concerns and knew who the manager was. The themes that emerged from discussions with relatives were shared with the management team.

No patient or relative questionnaires responses were received following the inspection.

Staff said that while they enjoyed working in the home, they felt more care staff were required each day. This is discussed further in section 3.3.1 of this report.

No staff survey responses were received 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 and regular staff training.

Review of staff duty rotas confirmed the discussion with patients, relative and staff, that the planned staffing levels were not always adhered to. The management team did provide evidence of ongoing staff recruitment and that staffing levels were kept under review. It was agreed that the manager would continue to monitor and review planned staffing levels and RQIA will review staffing arrangements again at the next inspection.

It was noted that some staff names on the duty rota did not fully match the names used for their professional registration. This was brought to the attention of the manager and will be reviewed at the next care inspection.

There were systems in place to monitor relevant staffs' professional registration. The manager reviewed nurses' registration with the Nursing and Midwifery Council (NMC) monthly and this system was working well. However, the registration status of some care staff with the Northern Ireland Social Care Council (NISCC) was unclear from review of the records.

A member of the management team was able to clarify the registration status for some of the identified staff during the inspection. RQIA requested that the manager provide written assurances about the remaining identified staff following the inspection. RQIA did not receive this information within the requested timeframe. 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. Throughout the day staff confirmed and were observed to attend safety briefings and conduct 'safety pauses' prior to mealtimes to ensure good communication across the team about changes in patients' needs.

Staff were observed to be prompt in responding to requests for assistance from patients. Staff were polite and respectful during interactions. As noted in Section 3.2 some relatives raised concerns about communication with staff and we confirmed that the management team were aware of their concerns and had agreed to address this.

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 care records accurately reflected the patients' assessed needs.

Examination of care records and discussion with nurses confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. For example, patients were referred to the Trust's Specialist Falls Service, their GP, or for physiotherapy.

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 lunchtime meal was observed. The dining room was nicely set prior to the patients arriving and a menu displayed two choices for lunch and dinner. Staff were observed to hold a 'safety pause' before serving any food, with the nurse taking the lead as mealtime coordinator, and staff wore the appropriate personal protective equipment (PPE). The mealtime was unhurried and there was background music.

Some patients came to the dining room while some patients stayed in their bedrooms or lounges for their meals. The communal dining experience should be an opportunity for patients to socialise. While the atmosphere was calm and unhurried, it was very quiet with limited conversation between staff and patients. When staff did interact with patients, for example, when placing on clothes protectors or placing a meal in front of a patient, there was very little communication. For example, the staff member either did not speak, or would speak quietly, sometimes from behind the patient. Skilled communication in dementia care is essential and requires clear, simplified language, face-to-face, good eye contact, and touch where appropriate. Patients should be given time to respond to ensure they have heard the instruction

from staff. This observation in addition to comments made by relatives about staff carrying out interventions without speaking indicated that staff required improvement in their communication approaches with patients. An area for improvement was identified.

Trays were set for meals to be taken to those patients in the lounges or bedrooms. It was noted that some meals were appropriately covered until they reached the patient, and others went uncovered. An area for improvement was identified.

Discussion with patients highlighted mixed experiences in relation to food quality and choice. Some patients said that there was limited choice, in that if they did not like the options on the menu, they felt that they could not get an alternative. During the lunchtime serving some patients were offered a choice of drinks while other patients just had their drinks poured without any choice offered. Some patients said that food was sometimes served cold and some relatives said that the choice and quality of food was not good at times. In addition a significant number of main meals were returned to the kitchen either untouched or with just a small amount eaten.

Review of records evidenced that the home had received complaints about food. This was discussed with the manager who was aware of some expressions of dissatisfaction and said that they planned to review the menu. An area for improvement was identified.

Staff provided assistance to patients who required full support to eat their meals. However, staff were observed to support patients while they stood above the patient and one patient who was not fully alert was being fed their meal. This is contradictory to best practice in the management of the mealtime experience, dysphagia and choking risks. An area for improvement was identified.

There was an activities programme available on display on noticeboards in both units and advertised games, music, and one to one sessions. The home had one full time activity coordinator employed and recently introduced an activity and wellness software package called OOMPH. The manager explained that this software package would help support care staff in delivering activities in the absence of the activity coordinator.

A crafts session took place during the inspection and patients who participated said they enjoyed it. Some patients said that there was not much organised activity happening or they were not interested in the sessions on offer. Some patients told us that they occupied their own time with interests and hobbies such as reading, listening to music, or watching television. The provision of activities will be reviewed again at the next care inspection.

Patients and relatives confirmed that visiting arrangements were in place and working well. Some patients told us that they enjoy going out with family.

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 patients' needs and included any advice or recommendations made by other healthcare professionals.

Current patients' care records were held confidentially on each unit. However, it was found that some patient records intended for archiving were left unsecured in a communal part of the home. This was brought to the attention of the management team who provided assurances that these records would be secured immediately. An area for improvement was identified.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care. 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.

3.3.4 Quality and Management of Patients' Environment

The home was clean and tidy. Patient bedrooms were clean and personalised with items of interest or importance to the patient.

There was evidence of poor upkeep with some areas of the environment requiring redecorating and/or repair or replacement. For example, a significant number of chairs in the communal lounges were torn, equipment such as crash mats were torn, bedframes were damaged, walls, radiator covers, and window sills required repair and/or painting, and an identified carpet was badly stained. These shortfalls were not in keeping with environmental standards and could influence the quality of life for patients. An area for improvement was identified.

Three communal toilets on the ground floor were found to be out of order and the visitor's toilet on the ground floor was also in need of repair. An area for improvement was identified.

An identified bedroom was found to have a strong malodour. A relative told the inspector that they had reported the issue to the manager several weeks prior. An area for improvement was identified.

The home had a refurbishment plan in place. RQIA were concerned that despite deficits being identified by the home's management and escalated to the provider in April 2025, the refurbishment plan was insufficiently robust to drive the necessary improvements and the majority of actions remained incomplete. An area for improvement was identified.

On the first day of the inspection, the lift machinery room was found to be unlocked and therefore accessible to patients with the potential to cause them harm. This was brought to the attention of the management team. However, this room was again found unlocked on the second day of inspection. An area for improvement was identified.

While there was a range of communal areas for patients to use, the cinema room was found to be used as a store room and therefore no longer suitable for patients to use. An area for improvement was identified.

It was noted that there was a lack of dementia friendly signage around the home. For example, directions to the dining room from the lounge, or patient identifiers on bedroom doors. Given the size and layout of the home, this could make it more difficult for patients to navigate their way around without the assistance of staff. An area for improvement was identified.

Staff were trained in IPC and correct use of PPE. Despite training in IPC and hand hygiene, a member of staff was seen to wear gel nails. A previously identified area for improvement was stated for a second time. In addition, other poor IPC practices were observed. For example, staff wearing gloves outside of care delivery interventions, or were seen to move through several areas of the home wearing gloves, and handling used linen and incontinence pads inappropriately. A new area for improvement in relation to IPC was identified.

There was ample supply of PPE and cleaning supplies in the home. Housekeeping staff discussed their cleaning schedule and confirmed that regular touch points were cleaned daily.

Fire safety measures were reviewed. Records confirmed that staff were provided with fire safety training and fire drills were held regularly to ensure all staff participated in at least two a year. Fire doors and exits were free from obstruction and fire-extinguishing equipment was accessible.

The most recent fire risk assessment was undertaken on 24 October 2024. A number of recommendations were made by the assessor at that time. Some recommendations had been addressed by the provider. However, three identified deficits that were escalated to the attention of the provider and required immediate action, remained unaddressed. This was discussed with an RQIA estates inspector and an area for improvement was identified.

3.3.5 Quality of Management Systems

Since the last inspection, there had been changes to the management arrangements. Ms Oonagh Grant took up post as manager on 28 July 2025. The manager is not yet registered with RQIA.

Care homes are required to display their certificate of registration. The most recent certificate was issued to the home on 28 July 2025. This certificate was not on display. An area for improvement was identified.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the management team responded to any concerns raised with them or by their processes.

There was evidence of communication with staff through regular staff meetings.

A representative on behalf of the provider, reviews the quality of services provided, by visiting the home each month. Written reports of each visit were maintained and evidenced consultation with patients, relatives, and staff, and an action plan to drive improvements.

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	10*	7

*The total number of areas for improvement includes one that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Oonagh Grant, 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 13 (7) Stated: Second time To be completed by: 1 October 2025	The registered person shall ensure that all staff remain bare below the elbows in all areas of the home where care is provided. Ref: 2.0 and 3.3.4 Response by registered person detailing the actions taken: Staff have received supervision regarding bare below elbows. Hand hygiene audits are being enhanced. Management will monitor compliance within walk around audits and senior management within Reg 29 visits
Area for improvement 2 Ref: Regulation 20 (1) (c) (ii) Stated: First time To be completed by: 31 October 2025	The registered person shall ensure that the system in place to monitor staffs' registration with the Northern Ireland Social Care Council (NISCC) is sufficiently robust and gives clear indication of the registration status of all relevant staff working in the home. Ref: 3.3.1 Response by registered person detailing the actions taken: A robust system has been implemented with least monthly checks completed with management sign off. Care staff will be reminded in a timely manner of registration update requirements including fee payments. Anyone who fails to complete re registration will stop working immediately. Senior management will monitor compliance during Reg 29 visit.

<p>Area for improvement 3</p> <p>Ref: Regulation 12 (1) (a) and (b)</p> <p>Stated: First time</p> <p>To be completed by: 30 September 2025</p>	<p>The registered person shall ensure that staff adhere to best practice when supporting patients to eat and drink safely.</p> <p>Ref: 3.3.2</p> <hr/> <p>Response by registered person detailing the actions taken: Mealtime experience audits have been enhanced. These are being completed at mealtimes to ensure that safety pause is followed, meal distribution coordinator is allocated at each mealtime, promoting a positive dining experience. Home Manager to review on daily walkabout. Senior Management will continue review in this area during Reg 29 visits</p>
<p>Area for improvement 4</p> <p>Ref: Regulation 19 (1) (b)</p> <p>Stated: First time</p> <p>To be completed by: 30 September 2025</p>	<p>The registered person shall ensure that patient records are held securely at all times.</p> <p>Ref: 3.3.3</p> <hr/> <p>Response by registered person detailing the actions taken: All records have been removed from area and stored securely Compliance with GDPR is being monitored through , management walk rounds and within Reg 29 visits.</p>
<p>Area for improvement 5</p> <p>Ref: Regulation 27 (2) (b) (c) and (d)</p> <p>Stated: First time</p> <p>To be completed by: 31 December 2025</p>	<p>The registered person shall ensure that remedial action is taken to address the deficits identified in the home's environment. This is in relation to, damaged seating, bedframes, falls equipment, stained carpet, damaged walls, radiator covers, and windowsills.</p> <p>Ref: 3.3.4</p> <hr/> <p>Response by registered person detailing the actions taken: There are ongoing environmental audits, any deficits identified should be reported through our maintenance platform. This is monitored by regional manager, senior management and estates manager. An action plan will be forwarded to the lead inspector by end of November. Actions completed to date include replacement seating and replacement flooring.</p>
<p>Area for improvement 6</p> <p>Ref: Regulation 27 (2) (j)</p> <p>Stated: First time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person shall ensure that there are a sufficient number of communal toilets operational and accessible to patients. Broken or damaged toilets should be repaired without unnecessary delay.</p> <p>Ref: 3.3.4</p> <hr/> <p>Response by registered person detailing the actions taken: All broken/damaged toilets have been addressed, and any further repairs will be addressed in a timely manner through our maintenance platform.</p>

<p>Area for improvement 7</p> <p>Ref: Regulation 18 (j)</p> <p>Stated: First time</p> <p>To be completed by: 27 November 2025</p>	<p>The registered person shall ensure that the malodour in the identified bedroom is investigated and eliminated for the comfort and dignity of the patient.</p> <p>Ref: 3.3.4</p> <hr/> <p>Response by registered person detailing the actions taken: Flooring has been replaced. This has addressed the malodour.</p>
<p>Area for improvement 8</p> <p>Ref: Regulation 13 (1) (a)</p> <p>Stated: First time</p> <p>To be completed by: 27 November 2025</p>	<p>The registered person shall ensure that an up to date refurbishment plan is developed. The plan should identify the person(s) responsible for addressing each identified area and should be time bound.</p> <p>A copy of the refurbishment plan must be submitted to RQIA with the returned quality improvement plan (QIP).</p> <p>Ref: 3.3.4</p> <hr/> <p>Response by registered person detailing the actions taken: This will be sent to the lead inspector by the end of November.</p>
<p>Area for improvement 9</p> <p>Ref: Regulation 14 (2) (c)</p> <p>Stated: First time</p> <p>To be completed by: 1 October 2025</p>	<p>The registered person shall ensure that the lift machinery room is secured at all times to prevent unauthorised access and potential harm to patients.</p> <p>Ref: 3.3.4</p> <hr/> <p>Response by registered person detailing the actions taken: All staff has been reminded of their responsibilities in regard to securing stores to reduce access to areas of potential harm to residents. Management monitor during walk rounds and senior management will monitor during reg 29 visits</p>
<p>Area for improvement 10</p> <p>Ref: Regulation 27 (4) (a)</p> <p>Stated: First time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person shall ensure that the outstanding actions stated on the fire risk assessment undertaken on 24 October 2024 are addressed without delay.</p> <p>Ref: 3.3.4</p> <hr/> <p>Response by registered person detailing the actions taken: These have been addressed and a further Risk Assessment has been completed 23rd October 2025.</p>

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
<p>Area for improvement 1</p> <p>Ref: Standard 25.5</p> <p>Stated: First time</p> <p>To be completed by: 31 October 2025</p>	<p>The registered person shall review staffs' knowledge and skills in relation to communication approaches with patients. Shortfalls should be addressed through training, supervision, and monitoring of staff practice.</p> <p>Ref: 3.3.2</p> <p>Response by registered person detailing the actions taken: This initially is being addressed through debrief meetings and staff meetings. Face to face training is being organised within December 2025 and January 2026 for all staff. There will be ongoing monitoring by management to ensure there is positive practice in this area.</p>
<p>Area for improvement 2</p> <p>Ref: Standard 12</p> <p>Stated: First time</p> <p>To be completed by: 30 September 2025</p>	<p>The registered person shall ensure that all meals leaving the dining room are covered with food protectors until they reach the patient, and the patient is ready to eat.</p> <p>Ref: 3.3.2</p> <p>Response by registered person detailing the actions taken: Kitchen, Nursing and Care staff has been reminded with their role and responsibility to comply. As above there will be an enhanced monitoring on mealtime experience and the monitoring of food leaving the dining area.</p>
<p>Area for improvement 3</p> <p>Ref: Standard 12</p> <p>Stated: First time</p> <p>To be completed by: 1 December 2025</p>	<p>The registered person shall undertake a review of food quality and menu choices. This review should evidence consultation with patients and relatives.</p> <p>Ref: 3.3.2</p> <p>Response by registered person detailing the actions taken: A full review of the menu and catering service is occurring. Food Quality and choice is also being monitored within Dining Experience Audits. A survey is being completed with residents and relatives in this area individually and will be carried into planned meetings in December 2025. There will be ongoing close monitoring by management.</p>
<p>Area for improvement 4</p> <p>Ref: Standard 44.3</p> <p>Stated: First time</p>	<p>The registered person shall ensure that all rooms in the home are used for their registered purpose. This is with specific reference to the cinema room.</p> <p>Ref: 3.3.4</p>

<p>To be completed by: 31 October 2025</p>	<p>Response by registered person detailing the actions taken: This cinema room has been cleared of inappropriate items being stored. There will be ongoing review within environmental audits by management. The registered purpose of this room is being reviewed.</p>
<p>Area for improvement 5</p> <p>Ref: Standard 43.1</p> <p>Stated: First time</p> <p>To be completed by: 28 November 2025</p>	<p>The registered person shall review the environment and put measures such as signage and/or pictures in place to promote orientation and way finding for patients with dementia in particular and visitors.</p> <p>Ref: 3.3.4</p> <p>Response by registered person detailing the actions taken: Additional signage was put in place at time of inspection. A further review is occurring within environmental audit and feedback will be sought from residents and relatives</p>
<p>Area for improvement 6</p> <p>Ref: Standard 46</p> <p>Stated: First time</p> <p>To be completed by: 1 October 2025</p>	<p>The registered person shall ensure that staff adhere to best practice in infection prevention and control (IPC). This is with specific reference to the use of gloves and handling of linen and continence aids.</p> <p>Ref: 3.3.4.</p> <p>Response by registered person detailing the actions taken: Infection Prevention and Control related audits are increased within governance schedule. Staff are reminded of their responsibilities in this area. Further training , for example Donning & Doffing training is planned. Improved systems of ongoing monitoring by nursing staff and by management within the Home. Monitoring will occur within Reg 29 visits also</p>
<p>Area for improvement 7</p> <p>Ref: Standard 35.26</p> <p>Stated: First time</p> <p>To be completed by: 1 October 2025</p>	<p>The registered person shall ensure that the most recent RQIA registration certificate is on display at all times.</p> <p>Ref: 3.3.5</p> <p>Response by registered person detailing the actions taken: Addressed at time of inspection.</p>

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