

Inspection Report

Name of Service: Bannview House Care Home

Provider: Healthcare Ireland (Belfast) Limited

Date of Inspection: 24 and 25 September 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 (Belfast) Limited
Responsible Individual:	Ms Amanda Mitchell
Registered Manager:	Laura Sands
<p>Service Profile: This home is a registered nursing home which provides nursing care for up to 63 patients. The home is divided into three units. The Downshire Unit which provides general nursing care and the Bronte and Scarva Units which provides care to people who have dementia. Patients have access to communal dining and lounge areas within each of the units.</p> <p>There is a residential care home which occupies part of the ground floor and the registered manager for this home manages both services.</p>	

2.0 Inspection summary

An unannounced inspection took place on 24 September 2025 from 9.45am to 4.45pm and on 25 September from 10.00am to 1.30pm 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 27 February 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, three areas for improvement from the previous care inspection was assessed as having been addressed; one was stated for the second time and one carried forward for review at the next inspection. New areas for improvement were identified in relation to staffing arrangements and record keeping. Details can be found in the main body of the report and within the Quality Improvement Plan in 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 content and settled in their environment and in their interactions with staff. Patients told us that they were happy living in the home. One commented, "It's very good here; I am happy. Staff are great. The foods good and you get a good choice of food". We received no questionnaire responses from patients or their relatives.

Relatives consulted during the inspection spoke positively on the care delivery. One told us, "I am very happy with the care here and have no concerns. The staff are very good".

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. Staff were recruited safely and staff confirmed that they were satisfied with the induction/training provision. However, several staff raised concerns in relation to the staffing levels and gave examples of how this impacted on care delivery. Staffs' concerns were shared

with the management team and an area for improvement was identified to review the staffing levels within the home in line with the concerns raised.

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.

Staff meetings with management were held to enhance the communication in the home and allow staff to share their views.

Observation of the delivery of care evidenced that patients' needs were met in a caring and compassionate manner.

3.3.2 Quality of Life and Care Delivery

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences. Patients spoke fondly on their interactions with staff.

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. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

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. Staff were also observed offering patients choice in how and where they spent their day or how they wanted to engage socially with others.

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about patients' needs, especially changes to care. Staff had access to a handover sheet containing all pertinent details of the patients in their 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 positional changes for pressure relief.

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 the patients' needs. Food was only served when the patients were ready to eat their meal. The meals served appeared appetising and nutritious. Food and fluid intake records had been maintained well and nursing staff had a good oversight of weight management.

Two activities' therapists oversaw the activity provision in the home. All activity engagements were recorded within patients' care records. A newsletter was sent to patients' relatives every three months and made available within each of the units.

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.

Supplementary care records were maintained to evidence care delivery in areas, such as, personal care delivery, food/fluid intake, continence management and records were kept of any checks staff made on patients. Although, an area for improvement was identified to ensure that the care delivered to patients was in keeping with the patients' care plans and any deviation of planned care rationalised within the daily evaluation of care; for example, oral care twice daily. Records should indicate where care was offered but refused.

Nurses completed daily progress notes to monitor and evaluate the care delivered to the patients in their care. However, several of the daily nursing evaluations had been completed half way through the shift; there were no additional entries to evidence the care delivered in the latter part of the shift. This was discussed with the manager and identified as an area for improvement.

3.3.4 Quality and Management of Patients' Environment Control

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. There were no malodours in the home. There was evidence that approximately two thirds of flooring identified for replacement had been replaced. The estates manager confirmed that the remaining flooring would be in place by Christmas. An area for improvement in this regard has been carried over for review to the next inspection.

Fire safety measures were in place to protect patients, visitors and staff in the home. 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 training and fire safety checks were regularly conducted.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. The manager confirmed that, in addition to this, they conducted a daily walk around the home to monitor the environment and practices. Personal protective equipment was readily available throughout the home.

3.3.5 Quality of Management Systems

Mrs Laura Sands has been the registered manager of the home since 5 January 2023. 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 robust system for reviewing the quality of care, other services and staff practices was in place.

The number of complaints to the home was low. There was a robust 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 spoken with said that if they had any concerns, they knew who to report them to and said they were confident that the manager or person in charge would address their concerns.

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*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with the management team, 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 18 (2)(c) Stated: First time To be completed by: 31 December 2024	The registered person shall ensure that the identified flooring in the home is replaced. A timebound refurbishment plan should be submitted with the returned QIP.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	

<p>Area for improvement 1</p> <p>Ref: Standard 12 Criteria 6</p> <p>Stated: Second time</p> <p>To be completed by: 25 October 2025</p>	<p>The registered person shall ensure that they review the systems in place when patients are receiving their choice of meals at mealtimes.</p> <hr/> <p>Response by registered person detailing the actions taken:</p> <p>Following the Inspection the menu has been reviewed for this season and shared with residents. Staff have been reminded that they must ensure the menu display is updated each day. The person allocated to update the menu is now recorded on the staff allocation rota and the Registered Manager completes daily checks that the menu has been updated as part of her daily walkaround of the home. If the Registered Manager is not available, this check will be completed by the Nurse in Charge.</p>
<p>Area for improvement 2</p> <p>Ref: Standard 4</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect (25 September 2025)</p>	<p>The registered person shall ensure that care delivered to patients is in line with their care plans. Any deviations from planned care should be recorded within nursing evaluations.</p> <p>This is in relation to oral health care.</p> <p>Ref: 3.3.3</p> <hr/> <p>Response by registered person detailing the actions taken:</p> <p>Following the Inspection the Registered Manager discussed with staff during Safe Care Huddles on 30.9.25 the importance of ensuring support offered with oral hygiene is accurately reflected in the care records.</p> <p>Oral care was discussed at the Registered Nurses meeting on 30.9.25 during which RQIA Inspection feedback was shared. Oral care is also included on the agenda for planned team meetings week commencing 17.11.25 to ensure improvements are sustained.</p> <p>The Registered Manager has put a robust system in place to monitor all resident oral care records on PCS. This audit system will enable any gaps in recording to be identified in a timely manner and addressed with individual staff members.</p> <p>All residents who require assistance with oral care have had their care records reviewed to ensure that care plans and risk assessments are person centred, accurate and that scheduled times for oral care are reflected.</p> <p>Any changes to a residents assessed needs will be discussed at the Safety Care Huddle and the residents plan of care updated to reflect these changes.</p>

<p>Area for improvement 3</p> <p>Ref: Standard 4</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect (25 September 2025)</p>	<p>The registered person shall ensure that nursing staff evaluate care in a meaningful manner that is person centred.</p> <p>Ref: 3.3.3</p>
	<p>Response by registered person detailing the actions taken:</p> <p>A Registered Nurse meeting took place on 30/09/2025, it was discussed at this meeting the importance of ensuring all daily progress notes contemporaneously evidence all care delivered throughout the shift as detailed within individual care plans. Staff are also reminded on daily walk arounds and at the daily nurses meeting.</p> <p>This will also be monitored through the audit process to evidence improvement is sustained. The Registered Manager will address any deficits identified with nursing staff.</p>

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