The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Cairnmartin Court Care Home

Provider: Healthcare Ireland (Belfast) Ltd

Date of Inspection: 11 November 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:	Miss Amanda Mitchell
Registered Manager:	Mrs Michelle Newe
Service Profile – This home is a registered nursing home which provides nursing care for up to 33 patients who have a dementia. The nursing home is situated on the first floor of the building and patients have access to communal living and dining areas. There is a separate registered residential care home which occupies the ground floor of the building and the registered manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 11 November 2025 from 9.35am to 4.15pm 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 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 all of the areas for improvement from the previous care inspection was assessed as having been addressed. A new area for improvement has been identified in relation to nutritional record keeping. Details can be found in the main body of the report and in the quality improvement plan (QIP) 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 told us that they were happy living in the home and that they were treated well by staff. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. We received five questionnaire responses from patients. They described the care they received as, 'Excellent', 'great' and 'wonderful'. One simply wrote, "Happy with everyone".

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.

Relatives consulted during the inspection told us that they were very happy with the care delivery in the home. One told us, "We have no concerns at all. Staff are very friendly and encourage us to bring in any belongings from home. (name) is very settled here". We received one questionnaire response from a relative. The respondent commented, "The care is first class. The staff are kind, gentle and caring".

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. There was evidence of robust systems in place to manage staffing. Since the last inspection, the staffing level had increased with the introduction of a twilight shift. Overall training compliance was at 96 percent.

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.

Regular staff meetings with management were held to enhance the communication in the home and allow staff to share their views. Minutes of these meetings were available for all staff to review.

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.

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.

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. Where patients required topical preparations as part of their care plan, records of this administration had been recorded well. Pressure relieving equipment, such as pressure relieving mattresses, had been set appropriately in accordance with the patients' weights. Nursing evaluations of care made reference to skin integrity.

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. However, a deficit was identified in record keeping when a nutritional need changed, for example, when the levels of modified food/fluids changed. All relevant documentation had not been consistently updated to record the change. In addition, some of the care plan evaluations did not identify the change and continued to make reference to the previous requirement. This was discussed with the manager and identified as an area for improvement.

Continence needs were assessed on admission and care plans developed to guide staff on how to meet these needs. The care plans included normal bowel patterns and identified any continence aids the patient required.

Accidents in the home were reviewed on a monthly basis for any patterns and trends in an effort to potentially reduce any future falls from occurring.

In addition to the activities therapist, there was an activities champion allocated daily on the duty rota to assist with activity provision. Activities were provided daily in the home in the morning and afternoon. Activities included games, pampering, bowling, book reading, sensory activities, movies, relaxation, 1-1 chats, reminiscence and arts and crafts. There was a hairdressing room situated in the building which patients could avail off. Photographs were displayed of patients enjoying activities. Records were kept of each patient's engagements with activities. Residents' meetings were held and planned in advance. Activities formed part of the agenda on these meetings to seek patients' views and look for alternatives if preferred.

There was an information notice in each patient's bedroom on how best to support them with their daily needs and how best to communicate with them. The 'About Me' notice also identified the people important to the patient.

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. 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.

Nurses completed daily progress notes to monitor and evaluate the care delivered to the patients in their care.

3.3.4 Quality and Management of Patients' Environment

There was a sign book and hand hygiene available on entry to the home. 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.

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.

Hazards such as chemicals and thickening agents were not accessible to patients and had been stored securely.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. Hand hygiene provision and personal protective equipment was readily available throughout the home.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. The registered manager had returned from a period of planned leave. Mrs Michelle Newe has been registered as manager of the home since 15 March 2022. Staff commented positively about the manager and management team describing them 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.

The RQIA registration certificate was appropriately displayed and accurately reflected the registration status of the home.

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 logged and 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

An area for improvement has been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	1	0

The area for improvement and details of the Quality Improvement Plan were discussed with Michelle Newe, Registered Manager and the senior 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 12 (1) (a) (b) **Stated:** First time **To be completed by:** With immediate effect (11 November 2025)	The registered person shall ensure that all relevant care plans and evaluations consistently reflect any changes made to a patient's nutritional needs. Ref: 3.3.2
	Response by registered person detailing the actions taken: Following the inspection feedback, the Inspectors findings was shared with all Registered Nurses and also included on the agenda for team meetings. Registered Nurses were reminded of their responsibility to promptly update care plans and evaluations to reflect any changes in residents nutritional needs. The Registered Manager has a robust system in place to monitor all resident 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. Any changes to a residents assessed needs will be discussed at the Safe Care Huddle and the residents plan of care updated to reflect these changes.

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

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