

Inspection Report

Name of Service:	Mullaghboy
Provider:	Mullaghboy Limited
Date of Inspection:	3 December 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:	Mullaghboy Limited
Responsible Individual:	Mr Robert Maxwell Duncan
Registered Manager:	Mrs Lesley Johnston
Service Profile – Mullaghboy is a registered nursing home which provides nursing care for up to 33 patients who require general nursing care, including patients living with a terminal illness. Patient bedrooms are located over two floors. Patients have access to communal spaces, a dining room and outdoor space.	

2.0 Inspection summary

An unannounced inspection took place on 3 December 2025, from 9.30 am to 6.00 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 4 December 2024; 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 that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

This inspection resulted in no areas for improvement being identified; three areas for improvement from the inspection undertaken on 4 December 2024 were addressed by the provider and three areas for improvement, relating to the management of medicines have been carried forward for review at a future inspection. Full details 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 told us they were happy with the care and services provided. Comments made included "well looked after" and "the staff are so kind, very patient".

Patients told us that staff offered choices to patients throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Staff spoke in positive terms about the provision of care, their roles and duties, training and managerial support.

Questionnaires returned from relatives confirmed that they were satisfied with the care and services provided in the home; comments shared in this feedback included; "very good, communication good" and "staff are excellent and very patient". There was no additional feedback received from the online staff questionnaires.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a system was in place to ensure staff were recruited correctly to protect patients.

The staff duty rota accurately reflected the staff working in the home over a 24-hour period and identified the nurse in charge when the manager was not on duty. Registered nurses taking charge of the home in the absence of the manager are required to have undertaken a competency and capability assessment prior to commencing in the role; review of a sample of these records confirmed these had been completed as required.

Review of records provided assurances that a system was in place to ensure all nursing staff were registered with the Nursing and Midwifery Council (NMC). There was also a system in place to monitor registration status of care staff with the Northern Ireland Social Care Council (NISCC).

There were systems in place to ensure staff were trained and supported to do their job. Mandatory training was progressing for staff and the manager confirmed that training compliance was kept under review.

Staff should have the opportunity to attend, at minimum, two supervisions and an appraisal annually to review their roles and enhance their professional development. A review of records confirmed that the provision of supervision and appraisal meetings was ongoing.

Staff were seen to attend to patients' needs in a timely manner, and patients' were offered choices throughout the day.

3.3.2 Quality of Life and Care Delivery

Staff said they met for a handover at the beginning of each shift to discuss any changes in the needs of the patients; a handover record was available and included detailed meaningful information pertaining to patients' individual needs.

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.

It was observed that 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 patient choice in how and where they spent their day or how they wanted to engage socially with others.

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.

An effective system was in place to identify which meal was for each individual patient, to ensure patients were served the right consistency of food and their preferred menu choice.

The food served was attractively presented, smelled appetising and a variety of drinks were served with the meal. Staff told us how they were made aware of patients' nutritional needs to ensure they were provided with the right consistency of diet; and where patients preferred to have their meal in their own room, this was readily accommodated with support provided as required in accordance with their assessed needs. A menu was available to inform patients of the meal and choice available and patients commented that they enjoyed their lunch.

The importance of engaging with patients was well understood by the manager and staff. Staff understood that meaningful activity was not isolated to the planned social events or games.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home. The activity schedule was on display. It was positive to see that the activities provided were varied, interesting and suited to both groups of patients and individuals.

Patients were well informed of the activities planned and of their opportunity to be involved.

Staff were observed sitting with patients and engaging in discussion. Patients who preferred to remain private were supported to do so and had opportunities to listen to music or watch television or engage in their own preferred activities.

Life story work with patients and their families helped to increase staff knowledge of their patients' interests and enabled staff to engage in a more meaningful way with their patients throughout the day, discussion with the manager and staff confirmed that this was ongoing.

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.

Care records were person centred and updated to ensure they continued to meet the patients' needs; where minor gaps were identified, these were discussed with the manager and assurance was provided that the gaps would be addressed.

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.

Patients care records were held confidentially.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. For example, patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

Fire safety measures were in place to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear.

3.3.5 Quality of Management Systems

Mrs Lesley Johnston has been managing the home since 28 March 2025.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. Discussion with the manager confirmed that the suite of audits were being further developed to enhance governance oversight within the home; this will be reviewed at a future inspection.

The manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and the quality of services provided by the home.

Compliments received about the home were kept and shared with the staff team.

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*	2*

* the total number of areas for improvement includes three which are carried forward for review at the next inspection.

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Lesley Johnston, Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 13 (4) Stated: First time To be completed by: 9 October 2025	The registered person shall ensure that the temperature of the medicine storage areas is monitored and recorded daily and that appropriate action is taken if the temperature recorded is over 25°C. Ref: 3.3.2
	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.
Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 1 Ref: Standard 18 Stated: First time To be completed by: 9 October 2025	The registered person shall review the management of distressed reactions to ensure that the reason for and outcome of each administration are recorded. Ref: 3.3.1
	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: 9 October 2025	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: 3.3.1
	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.

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