

Inspection Report

Name of Service:	Castleview
Provider:	Tona Enterprises Ltd
Date of Inspection:	2 March 2026

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

1.0 Service information

Organisation	Tona Enterprises Ltd
Responsible Individual:	Mr Robert Maxwell Duncan
Registered Manager:	Mrs Jacqueline Felicitas
Service Profile – This is a registered nursing home which provides nursing care for up to 35 patients. Patients have access to communal lounges, a dining room and a garden space.	

2.0 Inspection summary

An unannounced inspection took place on 2 March 2026, from 9.45 am to 3.45 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 29 August 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection evidenced 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.

As a result of this inspection one previous care area for improvement was assessed as having been addressed by the provider. A medicine related area for improvement was carried forward for review at a future inspection. This inspection resulted in no new areas for improvement being identified. 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 who were able to share their opinions on life in the home said they were well looked after. Some patients may have difficulty telling us about their experiences. Patients who had communication difficulties looked relaxed in their environment and during interactions with staff. Patients were observed to give non-verbal cues to indicate their wellbeing, such as smiling or hand gestures.

Patient comments included "It's not too bad, I have no concerns", "I am content enough", "I like it here" and "The staff are very good".

Staff spoken with said that Castlevue was a good place to work. Staff said that they were satisfied with staffing levels, teamwork was good, the management team was approachable and they thoroughly enjoyed working in the home.

A visiting healthcare professional commented on how communication with the home was good and that the staff were observed very attentive to the patients.

One questionnaire was returned from a family member, they praised the home for the care delivered to their loved one. We did not receive any response from the staff online survey within the timescale specified.

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.

Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels.

The staff duty rota accurately reflected the staff working in the home on a daily basis.

There was a system in place to monitor that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC).

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

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.

Patients looked well cared for and were seen to enjoy warm and friendly interactions with the staff. Staff were observed to be chatty, friendly and polite to the patients at all times.

Staff were observed to be prompt in recognising patients' needs, staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

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 the staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. Review of records confirmed that staff took appropriate action in the event of a fall, for example, they commenced neurological observations and sought medical assistance if required.

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.

Observation of the lunchtime meal confirmed that enough staff were present to support patients with their meal and that the food served smelt and looked appetising. The dining experience was an opportunity for the patients to socialise and the atmosphere was calm, relaxed and unhurried. It was observed that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. The daily menu was displayed and the patients commented positively about the food served.

The importance of engaging with patients was well understood by the manager and staff. There was a range of activities provided for patients by staff. The patients confirmed that activities took place in the home, an activities planner was available for review. The range of activities included social, community, cultural, religious, spiritual and creative events.

Some recent events included a quiz, music and singing, games and jigsaws. Art and crafts with a St Patrick's Day theme was also planned. Patients' needs were met through a range of individual and group activities. Activity records were maintained which included patient engagement with the activity sessions. It was positive to see that the activities provided were varied, interesting and suited to both groups of patients and individuals.

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.

Patients care records were held confidentially.

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.

3.3.4 Quality and Management of Patients' Environment

Examination of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. The home was clean, warm and comfortable. Patients' bedrooms were tidy and personalised with items of importance to each patient, such as family photos and sentimental items from home. The manager advised of an ongoing refurbishment and redecoration plan for the home.

Review of records confirmed that environmental and safety checks were carried out, as required on a regular basis, to ensure the home's was safe to live in, work in and visit.

Review of records and observations confirmed that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last care inspection; Mrs Jacqueline Felicitas has been the registered manager of Castleview since 1 April 2005.

Staff commented positively about the manager and described her as supportive and approachable.

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. 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/or the quality of services provided by the home.

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	0	1*

*The total number of areas for improvement includes one standard which is carried forward for review at a future inspection.

No new care areas for improvement were identified at this inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 30 Stated: First time To be completed by: Immediate and ongoing 21 May 2025	The registered person shall ensure that the current, maximum and minimum temperatures of the medicine refrigerator are monitored and recorded daily and that the thermometer is reset. Appropriate action must be taken if the temperature recorded is outside the recommended range of 2-8°C. Ref: 2.0
	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.

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