The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Abbey View Care Home

Provider: MD Healthcare Ltd

Date of Inspection: 21 April 2026

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:	MD Healthcare Ltd
Responsible Individual:	Ms Jo Browne
Registered Manager:	Ms Georgeana Tarabuta
Service Profile – This home is a registered nursing home which provides nursing care for up to 25 patients. Patients' bedrooms are located over two floors and patients have access to communal social and dining areas within the home.	

2.0 Inspection summary

An unannounced inspection took place on 21 April 2026 from 9.25am to 4.45pm 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 8 May 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 the area for improvement from the previous care inspection was assessed as having been addressed. One new area for improvement was identified. Details can be found in the main body of the 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 that they were happy living in the home and that they were treated well by staff who were caring and supportive. Patients' comments included, "The care is very good. Staff take very good care of me. There is plenty of food and the food is of good quality. My room is always clean and tidy and I make my own choices during the day". Another commented, "I can't complain; carers are very good. Make my own choices for what I eat and what I wear".

Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. We received no questionnaire responses from patients or relatives.

A relative consulted told us, "We are so lucky to get here. The care is the best. Nothing is too much trouble. I can come and go as I please".

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. All appropriate recruitment safety checks had been verified prior to staff commencing in post. Newly employed staff completed a structured induction at the commencement of their employment which included mandatory training. A robust system was in place to ensure that all staff were compliant with pre-determined mandatory training requirements. Staff told us that they were satisfied that the number and skill mix of staff on duty met the needs of the patients. Patients raised no concerns in relation to the staffing arrangements.

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.

Minutes of recent staff meetings were available to all staff to aid in the communication within the home.

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.

3.3.2 Quality of Life and Care Delivery

Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences. Interactions between staff and patients were noted to be caring and compassionate. Patients spoke fondly about the staff.

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. Patients told us that they had choice in where and how they spent their day, what they wore and what they had to eat.

Staff confirmed that they received a detailed handover at the commencement of their shift and the information shared included important aspects of patients' needs, especially changes to care. All staff received a handover sheet which was updated daily and contained the pertinent patient details.

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.

Pressure management risk assessments were completed and patients at risk of pressure damage had care plans in place guiding staff on how to mitigate the risk. Patients who required special attention with skin care were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs.

Patients were well presented in their appearance. Staff were aware of the actions to take if a patient refused assistance with personal care needs. Privacy curtains were in place in bedrooms which accommodated more than one patient to protect patients' dignity.

Patients at risk of falling had dedicated falls care plans in place identifying measures to reduce the risk. When a patient had a fall, accident records reviewed evidenced that the correct actions had been taken following the fall and the correct persons notified. Staff consulted were aware of the actions to take should they find a patient lying on the floor. There was a low number of accidents in the home.

Patients had good access to food and fluids throughout the day and night. Dining room tables were attractively set for meals. Patients were safely positioned for their meals and the mealtimes were appropriately supervised. All staff communicated well to ensure that every patient received their meals in accordance with their assessed needs. Each staff member had a copy of the 'safety pause'; a document identifying each patient's nutritional requirements. Food was only served when the patients were ready to eat their meal. The meals served appeared appetising and nutritious. Dining aids, such as, plate guards were in use where required to promote independence. Patients enjoyed their meal and spoke positively of the quality of their meal.

A review of fluid balance and bowel management evidenced discrepancies in the recording. An area for improvement was identified to ensure, where required, the accurate recording of fluid intake / output and bowel management. Care plans should identify normal patterns and should direct staff on actions to take when outside of normal patterns. Registered nurses, when reviewing these aspects of care, should detail in their daily evaluation of care any actions taken.

Activities for patients were provided incorporating one to one activities in the morning and group activities in the afternoon. Birthdays and annual holidays were celebrated. Planned activities included exercise, games, chatting, reminiscence, art, decoration, window painting and book club. Activities included outings to local places of interest or for shopping and external performers came to the home to entertain the patients. Daily records of activity engagements were maintained.

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 the care delivered to patients. These records included personal care delivery, food and fluid intake, repositioning, checks made on patients and continence care.

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

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 ensure patients and those working and visiting the home were kept safe. 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. A Fire Risk Assessment had recently been completed.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. Housekeeping audits monitored the cleanliness in the home. Personal protective equipment and hand hygiene facilities were readily available throughout the home.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Ms Georgeana Tarabuta has been Registered Manager of the home since 22 August 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 system for reviewing the quality of care, other services and staff practices was in place. The manager had a suite of audits to complete.

The number of complaints to the home was low. There was a system in place to manage any complaints received. A compliments file was available with cards and emails of thanks. Verbal compliments were captured in a compliment's log. 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

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 Ms Georgeana Tarabuta, Registered Manager and Ms Jo Browne, Responsible Individual, 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:** 31 May 2026	The registered person shall review the oversight of patient's bowel and hydration management records to ensure that patients received any required intervention. Actions taken should be documented as part of the daily evaluation of care. Ref: 3.3.2
	Response by registered person detailing the actions taken: The registered person shall ensure that oversight of patients' bowel and hydration management records is strengthened through regular review, spot checks, and weekly audits by senior staff to ensure patients receive appropriate and timely interventions. Staff have been reminded of the requirement to clearly document all interventions, actions taken, and outcomes within the daily evaluation of care records. Additional guidance and support have been provided to staff on recognising, responding to, and escalating concerns relating to bowel care and hydration management, including documenting interventions such as encouragement of fluids, dietary adjustments, administration of prescribed medication, repositioning, GP contact, and referrals to relevant healthcare professionals. Any omissions or concerns identified through audit and monitoring processes will be addressed promptly through staff feedback, supervision, competency support, and ongoing governance oversight to ensure sustained improvement in practice and accurate recording of care delivered.

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