

Inspection Report

Name of Service:	Bohill House Nursing Home
Provider:	Healthcare Ireland (No.4) Limited
Date of Inspection:	10 June 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:	Healthcare Ireland (No.4) Limited
Responsible Individual/Responsible Person:	Ms Andrea Louise Campbell
Registered Manager:	Ms Monika Kania – not registered
Service Profile – Bohill House Nursing Home is a registered nursing home which provides nursing care for up to 62 patients. The home is divided into two units over two floors. The unit downstairs provides care for patients living with dementia and the first floor provides general nursing care. Patients have access to communal lounges, dining rooms and a garden space. There is a separate registered residential care home which occupies the same building and the registered manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 10 June 2026, from 10.30 am to 6.20 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 3 June 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

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. Refer to Section 3.2 for more details.

As a result of this inspection five areas for improvement were assessed as having been addressed by the provider. One area for improvement relating to medicines management and one relating to the environment have been carried forward for review at a future inspection. There were no new areas for improvement identified during this inspection.

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 or indicated that they were well looked after. Patients who were less able to share their views were observed to be at ease in the company of staff and to be content in their surroundings.

Patients told us that staff offered choices to them 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.

Following the inspection, there were no responses received from the staff questionnaires or patient/relative questionnaires.

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. A system was in place to ensure appropriate recruitment checks had been verified prior to staff commencing in post.

Newly employed staff completed an 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 mandatory training requirements.

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.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role and that they were mostly satisfied with the staffing levels, where comments were made these were shared with the management for review and action as appropriate. The manager confirmed that staffing levels are kept under review to ensure that the assessed needs of the patients are met.

Staff responded to requests for assistance promptly in a caring and compassionate manner.

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.

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.

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.

The risk of falling was well managed and referrals were made to other healthcare professionals as needed.

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.

The dining experience was an opportunity for patients to socialise, music was playing, and the atmosphere was calm, relaxed and unhurried. It was observed that patients were enjoying their meal and their dining experience. It was clear that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

There was a choice of meals offered, the food was attractively presented and smelled appetising. Staff knew which patients preferred a smaller portion and demonstrated their knowledge of individual patient's likes and dislikes.

The programme of social events was displayed on the noticeboard in the main entrance advising of future events. Activities for patients were provided which involved both group and one to one activities. For example, arts and crafts and nail and hand care. A number of patients were observed attending the hairdresser. Arrangements were in place to meet the patients social, religious and spiritual needs within the home.

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, regularly reviewed and updated to ensure they continued to meet the patients' needs; where minor shortfalls were identified these were discussed with the manager for immediate review and action as appropriate.

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 neat and tidy and patients' bedrooms were personalised with items important to the patient. The previous inspection had identified an area for improvement pertaining to flooring. Discussion with the management team confirmed that a refurbishment plan is in place to include the flooring; and the home has submitted an application to vary the registered premises, which will include further refurbishment works. Progress will be reviewed at a future inspection.

Observation identified a number of items stored inappropriately on a small number of wardrobes. This was discussed with the manager who provided assurance that this would be immediately reviewed and actioned as appropriate; this will be reviewed at a future inspection.

Fire safety measures were in place and well managed 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.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records kept.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Miss Monika Kania has been the Manager in this home since 29 September 2025.

Staff commented positively about the manager and described them as supportive, approachable and able to provide guidance.

Review of the records relating to accidents and incidents which had occurred in the home evidenced that these were notified, if required, to patients' next of kin, their care manager and to RQIA.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the management team 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	2*

* The total number of areas for improvement includes two standards that have been carried forward for review.

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 Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 43 Stated: Second time To be completed by: 3 August 2025	The registered person shall ensure that the flooring in the identified area is repaired or replaced. Ref: 3.3.4
	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 4 Stated: First time To be completed by: 12 December 2024	The registered person shall ensure care plans for the management of distressed reactions, epilepsy and insulin are updated to include the name of the prescribed medicine(s) and the parameters for the administration are clearly detailed.
	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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