

Inspection Report

Name of Service: Oak Tree Manor Nursing Home

Provider: Healthcare Ireland (Belfast) Limited

Date of Inspection: 15 June 2026

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

1.0 Service information

Registered Provider:	Healthcare Ireland (Belfast) Limited
Responsible Individual:	Ms Amanda Mitchell
Registered Manager:	Miss Veronica Sousa
Service Profile: Oak Tree Manor Nursing Home is a nursing home registered to provide nursing care for up to 25 patients living with dementia. The home is situated on the first floor of the building. This home shares the same building as Oak Tree Manor Residential Home. The registered manager is responsible for both services.	

2.0 Inspection summary

An unannounced inspection took place on 15 June 2026 from 09.30 am to 6.00 pm by a care inspector.

This 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 medicines management inspection.

Evidence of good practice was found throughout the inspection in relation to care delivery, the provision of activities and the patient dining experience. There were examples of good practice found in relation to the culture and ethos of the home in maintaining the dignity and privacy of patients and maintaining good working relationships.

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, six areas for improvement were assessed as having been addressed by the provider; two new areas for improvement were identified and three areas for improvement in relation to medicines management have been carried forward for review at the next inspection. 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 commented positively about staff. They confirmed that staff offered them choices throughout the day which included preferences for what clothes they wanted to wear and where and how they wished to spend their time. They told us that they could have a lie in or stay up late to watch TV if they wished and they were given the choice of where to sit and where to take their meals; some patients preferred to spend most of the time in their room and staff were observed supporting patients to make these choices.

Patients said, "I enjoy having my hair and nails done. We're going to play cards now and I'm looking forward to attending Current Affairs later, as I'm always interested on what's going on" and "I'm settled and happy here and the staff are nice".

Patients' relatives spoken with said, "Staff are approachable and very nice. My husband is always well presented and well cared for." and "I'm very happy with the care. Staff are friendly, helpful and kind. I have no concerns".

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients to meet their needs. Staff told us that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Following the inspection no patient, patient representative or staff questionnaires were received 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.

Review of agency staff documentation evidenced that inductions had been carried out and individual staff profiles were available to view. Staff spoken with confirmed that they had a good induction to the home.

Staff said there was good teamwork and that they felt well supported in their role. Staff also commented that, whilst they were kept busy, staffing levels were satisfactory apart from when there was an unavoidable absence.

Staff told us they were aware of individual patient's wishes, likes and dislikes. It was noted that staff responded to requests for assistance promptly in an unhurried, caring and compassionate manner. Patients were given choice, privacy, dignity and respect.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss patients' care, to ensure good communication across the team about any changes in patients' needs. Staff were knowledgeable about individual patient's needs, their daily routine, wishes and preferences; and 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.

It was observed that staff respected patients' privacy and dignity by offering personal care to patients discreetly and discussing patients' care in a confidential manner. Staff were also observed offering patients choice on how and where they spent their day or how they wanted to engage socially with others.

Patients were observed to be offered a selection of drinks, yoghurt and biscuits from the mid-morning tea trolley.

The dining experience was an opportunity for patients to socialise. We observed the serving of the lunchtime meal in the dining room. The registered nurse was overseeing the mealtime. A written menu along with a pictorial menu was displayed outlining what was available at each meal time for patients and the atmosphere was calm, relaxed and unhurried. Staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

Staff demonstrated their knowledge of patients' individual needs, likes and dislikes regarding food and drinks. They were able to describe the various International Dysphagia Diet Standardisation Initiative (IDDSI) levels of modified foods and demonstrated how to modify the consistency of drinks for patients with swallowing difficulties.

Patients spoken with said they enjoyed lunch and that they got enough to eat.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home. The weekly programme of activities was displayed on the notice board advising patients of forthcoming events.

Patients' needs were met through a range of individual and group activities such as knitting club, balloon tennis, sing-alongs and also arts and crafts.

Birthdays and annual holidays were celebrated and on occasions patients' families and staff were invited to larger events, such as a forthcoming Father's Day party.

A daily record is kept of all activities that patients take part in. Patients spoken with said they enjoyed the activities that were provided.

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. 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.

3.3.4 Quality and Management of Patients' Environment

The home was welcoming, clean, tidy and nicely decorated. Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were suitably furnished, warm and comfortable. A variety of methods was used to promote orientation. There were clocks and photographs throughout the home to remind patients of the date, time and place.

The Treatment Room and kitchen were observed to be appropriately locked and equipment used by patients such as hoists and shower chairs were noted to be effectively cleaned.

Review of the environment evidenced that not all fire doors were closing fully in order to contain fire in the event of an emergency. This was discussed with the manager for attention. An area for improvement was identified.

Corridors and fire exits were clear from clutter and obstruction.

Personal protective equipment (PPE), for example, face masks, gloves and aprons were available throughout the home. Dispensers containing hand sanitiser were seen to be full and in good working order. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance.

3.3.5 Quality of Management Systems

Since the last inspection there has been no change in the management arrangements. Miss Veronica Sousa has managed the home since 3 January 2023.

Review of competency and capability assessments evidenced they were completed with the registered nurses left in charge of the home when the manager was not on duty. Staff were able to identify the person in charge of the home in the absence of the manager. However, although competency and capability assessments had been carried out and were available to view, a robust and meaningful recording system was not in place, to evidence that identified training has been achieved. An area for improvement was identified.

Discussion with the manager and review of records confirmed that staff supervision and appraisal had commenced and that arrangements were in place to ensure that all staff members have regular supervision and an appraisal completed this year.

Relatives and staff commented positively about the manager and described her as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced that the manager had processes in place to monitor the quality of care and other services provided to patients. 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.

Patients' relatives said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

Staff and relative meetings were held on a regular basis. Minutes were available.

Cards and letters of compliment and thanks were received by the home. Comments were shared with staff. This is good practice.

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	4*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Veronica Sousa, Registered Manager and Mrs Mary Stevenson, Regional Area Manager, 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 27 (4) (d) (i) Stated: First time To be completed by: 15 June 2026	The Registered Person shall make arrangements to ensure that all fire doors close fully, in order to contain fire in the event of an emergency. Ref: 3.3.4
	Response by registered person detailing the actions taken: The mentioned doors were addressed at time of inspection. HCI Maintenance Checks on doors have been introduced in this Home now. The Home has had a visit from NIFRS on 15.07.2026 as discussed and recommendations actioned. The Home has had a Fire Risk Assessment completed 09.07.2026. Home has now received the report and HM is reviewing action plan within Home and with Estates Manager. There is ongoing monitoring during HM walkround that doors are closing fully and during Senior Management visits
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 29 Stated: First time To be completed by: 21 April 2026	The registered person shall ensure that obsolete personal medication records are cancelled and archived promptly. Ref: 2.0
	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 28 Stated: First time To be completed by: 21 April 2026	The registered person shall review the management of warfarin as detailed in the report. Ref: 2.0
	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 3 Ref: Standard 28 Stated: First time To be completed by: 21 April 2026	The registered person shall ensure review arrangements in place to audit the management of medicines. This is in reference to the audit of medicines used on a 'when required' basis, in line with the home's own policy. Ref: 2.0
Area for improvement 4 Ref: Standard 39 Stated: First time To be completed by: 29 June 2026	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.
	Response by registered person detailing the actions taken: HCI have now introduced their systems and tools for competency assessments in this Home and all nurses have completed competency assessments for Person in Charge, Medication Management, Syringe Driver Management, Catheter Management and Wound Management. These competency assessments will be re- completed at least annually for all nurses.

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The Regulation and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority

James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA



Tel: 028 9536 1111



Email: info@rqia.org.uk



Web: www.rqia.org.uk



Twitter: @RQIANews