

Inspection Report

Name of Service:	Kintullagh Care Home
Provider:	Healthcare Ireland (Belfast) Limited
Date of Inspection:	30 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:	Healthcare Ireland (Belfast) Limited
Responsible Individual:	Ms Andrea Louise Campbell
Registered Manager:	Mrs Shereen Mattu
Service Profile – This home is a registered nursing home that provides general nursing care for up to 61 patients. The home is divided into three units over two floors; the Willow and Beech units are on the ground floor with the Oak unit located on the first floor. Patients have access to communal lounges, dining rooms and garden space.	

2.0 Inspection summary

An unannounced inspection took place on 30 June 2026 from 9.20am to 5.20pm by two care inspectors.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the area for improvement identified, by RQIA, during the last care inspection on 25 September 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 three areas for improvement from the previous care inspection were assessed as having been sufficiently addressed by the provider; one carried forward for review at the next inspection and one stated for the second time. Three new areas for improvement were 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, "I am happy here; the care is good" and "I like it here, have no grumbles. I'm happy and the staff are very good". 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.

Relatives consulted responded positively in relation to the care provision in the home. One told us, "It's great here. Staff are very good and always welcoming. We are told the codes to get in and out. Relatives' meetings do happen". Another said, "Staff are very patient and always polite. They would knock the door before coming in. There is a great variety of food here".

A visiting professional complimented staff in the home and told us that they adhered well to any recommendations left.

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 were 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. Although, staff raised concerns with the time allocated to the induction process; especially for those with no care experience and those new to the nursing role. This was discussed with the manager and identified as an area for improvement.

A robust system was in place to ensure that staff were compliant with pre-determined mandatory training requirements. The overall completion compliance rate was 95%. Training topics included dementia management, delirium, catheter care, oral health, dysphagia and moving and handling theory and practical.

Staff raised concerns regarding the staffing levels. Concerns were also shared from patients and relatives. This was discussed with the manager who confirmed that concerns about the staffing arrangements had already been raised with the senior management team. During the inspection, we received confirmation that approval had been given to increase the staffing levels. RQIA will continue to monitor staffing arrangements in the home at subsequent inspections.

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

Patients told us that they were happy living in the home. 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.

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 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. Where a patient had a wound, wound care records directed staff on how to treat the wound and wound evaluation records monitored the progress of the treatment. However, where patients required an airflow mattress to maintain skin integrity, the care plan did not always refer to the type of mattress and three mattresses in use were not correctly set in accordance with the patients' weights. This was discussed with the manager and identified as an area for improvement.

Staff did not have the appropriate photographic equipment in which to photograph wounds. This was discussed with the manager and during the inspection we confirmation was received that three cameras had been approved for purchase.

Patients were well presented in their appearance. Each patient had a personal hygiene care plan in place identifying, where appropriate, the level of assistance they required with hygiene needs. In addition, patients had specific oral hygiene care plans in place. Assistance given with personal and oral care was recorded well. Patients could select the gender preference of the person providing the care and staff confirmed that the patients' preferences would always be complied with. A patient told us, "I like it here. Staff tend to me well".

Accidents in the home were reviewed monthly for any patterns and trends in an effort to prevent any future falls from occurring. A falls action plan was completed each month following the review.

Patients had good access to food and fluids throughout the day and night. Patients were safely positioned for their meals and the mealtimes were appropriately supervised. Staff communicated well to ensure that every patient received their meals in accordance with their assessed needs and assisted patients in an unhurried and compassionate manner. Food was only served when the patients were ready to eat their meal. The meals served appeared appetising and nutritious. Patients had mixed views on the food provision. While some enjoyed their meals; others felt that this could be improved. Patients views were shared with the manager for their review and action as appropriate. Patients had fluid targets recorded in order to maintain hydration. Care plans identified the actions to take when targets were not met.

A new activities therapist had recently taken up post and had redeveloped the programme of activities. Activities included reading groups, music appreciation, breakfast club, bingo, games, Sunday services and arts and crafts. A greater emphasis had been placed on one to one activity for those who had to or chose to remain in their rooms. Birthdays and annual holidays were celebrated. A new reading room had been created. Patients engaged in intergenerational work with a local school and centre. Monthly joint patient/relative meetings were hosted to discuss what's going well, what they would like to see and how everyone feels. Daily records were kept of all patients' engagements with activities. An area for improvement in relation to activity provision has been carried forward to the next inspection to allow for planning to be embedded.

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. The 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.

Three bedroom floors, which had been recently washed, did not have warning signage in place to alert any person entering the room of a slip hazard. This was discussed with the manager and identified as an area for improvement.

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.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. Although, during the inspection we observed several staff not bare below the elbow with gel nails worn. Being bare below the elbow is important to ensure effective hand hygiene. This was discussed with the manager and identified as an area for improvement. Personal protective equipment and hand hygiene facilities were readily available throughout the home. The equipment in use in the home was clean.

Externally the home was well maintained. There was a garden area to the back and sides of the home.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Mrs Shereen Mattu has been managing the home since 13 February 2026. Staff commented positively about the manager and described her as friendly, 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. We discussed ways of enhancing the action plan process when deficits were identified.

The number of complaints to the home was low. There was a system in place to manage any complaints received. A compliments log was maintained which included cards and verbal compliments received. 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

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	2	3*

*The total number of areas for improvement includes one that has been stated for a second time and one which has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Leanna Bonnar, Regional Manager and Sheeren Mattu, 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 14 (2) (a) and (c) Stated: First time To be completed by: With immediate effect (30 June 2026)	The registered person shall ensure that the appropriate signage is displayed when floors are wet to warn patients, visitors and staff of slip hazards. Ref: 3.3.4 Response by registered person detailing the actions taken: A meeting was conducted with housekeeping staff in the month of July 2026 to reiterate the importance of always using a wet floor sign to reduce the risks of slips and falls. Home manager has ensured that there is an adequate supply of wet floor signs available for all units in the home.

Area for improvement 2 Ref: Regulation 13 (7) Stated: First time To be completed by: 25 July 2026	The registered person shall ensure that the infection control issues identified on inspection are managed appropriately. Ref: 3.3.4 Response by registered person detailing the actions taken: Post Inspection, a meeting was conducted with all staff to discuss correct infection prevention and control measures. The correct use of PPE was also discussed and the correct disposal of laundry. This area for improvement will be observed by the home manager during her daily walkabout.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 11 Stated: Second time To be completed by: 1 December 2025	The registered person shall review the arrangements for activity provision in the home including in the absence of the activity co-ordinator. A contemporaneous record of activities delivered must be retained. Activities must be an integral part of the care process with daily notes reflecting these activities. Ref: 2.0 and 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.
Area for improvement 2 Ref: Standard 23 Stated: Second time To be completed by: With immediate effect (30 June 2026)	The registered person shall ensure care plans for the repositioning of patients includes the settings for the pressure-relieving mattress and that the care plans and mattress settings are regularly reviewed to ensure the setting is appropriate. Ref: 2.0 and 3.3.2 Response by registered person detailing the actions taken: The care plans of all residents were reviewed post inspection and it was also discussed at a nurses meeting the requirement to ensure mattress type and settings are included in all care plans and the frequency of mattress setting also. All staff, including domestic staff, have been informed of the need to ensure the mattress is at the correct setting prior to leaving each room.

Area for improvement 3 Ref: Standard 39 Criteria (1) Stated: First time	The registered person shall review the induction process to ensure that, depending on role, sufficient supernumerary time is allocated in line with the inductees' abilities. Ref: 3.3.1
To be completed by: 30 July 2026	Response by registered person detailing the actions taken: The induction process for new employees, especially those who have no prior experience in a caring role, will be progressed depending on the understanding and capabilities of the employee.

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