The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Nightingale Care Home

Provider: Healthcare Ireland No 2 Ltd

Date of Inspection: 13 August 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 2 Ltd
Responsible Person:	Ms Amanda Mitchell
Registered Manager:	Mr Andrei Popescu- not registered
Service Profile – This is a nursing home which is registered to provide general nursing care for up to 35 patients. Nightingale Care Home also provides care for patients living with a physical disability other than sensory impairment and those with mental health needs. The home is a single storey building and all bedrooms are single occupancy. Patients have access to communal lounges, a dining room and a garden. This home shares the same building as Nightingale Residential Care Home and the same manager is responsible for both services.	

2.0 Inspection summary

An unannounced inspection took place on 13 August 2026, from 9:30 am to 4:00 pm 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 areas for improvement identified, by RQIA, during the last care inspection on 3 December 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

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.

While we found care to be delivered in a safe and compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery.

As a result of this inspection one area for improvement from the previous inspection was carried forward for review at the next inspection. Full details, including new areas for improvement

identified, 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 patient's, 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 they were happy with the care and services provided. Comments made included "staff treat me well and the food is lovely" and "I have no complaints".

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV.

Patients told us that staff offered choices to patients 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.

Staff spoke in positive terms about the provision of care, their roles and duties, training and managerial support.

Families spoken with told us that they were very happy with the care provided and that there was good communication from staff.

Following the inspection, we received two completed patient questionnaires indicating they were satisfied that the care provided was safe, effective, compassionate and well led. No staff or relative 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.

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 satisfied with the staffing levels.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

There were systems in place to ensure staff were trained and supported to do their job. However there was evidence that a significant number of staff did not have two recorded supervisions within the past 12 months. An area for improvement was identified.

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.

Staff 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. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

It was observed that 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. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

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.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly. However a number of repositioning charts did not have the date recorded or the patient's full name. An area for improvement was identified.

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, 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.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home. The activity schedule was on display. Activities planned for the week included hairdressing, baking, bingo and puzzles.

Staff were observed sitting with patients and engaging in discussion. Patients who preferred to remain private were supported to do so and had opportunities to listen to music or watch television or engage in their own preferred activities.

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.

However, a review of a number of care records evidenced names and pronouns that were not relevant to the named patient. Additionally, a number of alterations had been made that were not in line with best practice guidance. An area for improvement was identified.

Review of the care records for an identified patient who presented with distressed reactions provided evidence that care plans were in plans, however, these care plans lacked specific details of the care and support required. An area for improvement was identified.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. For example, patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

The enclosed courtyard was overgrown and unkempt. Assurances were given by the regional manager that work was planned for this area and any immediate trip hazards would be removed immediately. This will be reviewed at the next inspection.

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 a change in the management of the home since the last inspection. Mr Andrei Popescu has been the manager in this home since 9 December 2025.
There was evidence that a number of audits were being completed on a regular basis to review the quality of care and other services within the home.

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.

It was established that the manager had a system in place to monitor accidents and incidents that happened in the home.

Patients and their relatives said that they knew who to approach if they had a complaint.

Compliments received about the home were kept and shared with the staff team.

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 one regulation which is carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Karen Agnew, Regional 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 13 (4) **Stated:** First time **To be completed by:** From the date of inspection (4 July 2024)	The registered person shall ensure that medication administration records are clearly maintained. 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.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 40 **Stated:** First time **To be completed by:** 31 October 2026	The registered person shall ensure that staff receive a minimum of two recorded supervisions per year. Ref: 3.3.1
	Response by registered person detailing the actions taken: The supervision matrix has been reviewed and staff team members who do not have the required supervisions have been identified. A plan has been developed and implemented to ensure all staff receive supervision within the required timeframe. The supervsion matrix will be reviewed during each regualtion 29 monitoring visit and outcomes will be recorded on the report.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 31 August 2026	The registered person shall ensure that repositioning records are accurately completed to reflect the date that the information is recorded and the patient's full name. Ref: 3.3.2
	Response by registered person detailing the actions taken: A system has been introduced to ensure all repositioning charts have the resident's name and date of birth typed at the top of every record sheet. Management monitoring and daily spot-checks have been established to ensure staff accurately log the specific date and time for every repositioning entry.

Area for improvement 3 **Ref:** Standard 37 **Stated:** First time **To be completed by:** 31 August 2026	The registered person shall ensure that care records are accurate and maintained in line with best practice guidance. Ref: 3.3.3
	Response by registered person detailing the actions taken: A meeting has been completed with the trained staff team and expectations in relation to the completion of care plans have been discussed. Each nurse has been allocated a number of care plans and has been directed to review each plan. Where an incorrect name or pronoun is discovered, the care plan is rewritten. Clinical supervision has been completed in terms of accepted standards for records and record-keeping—specifically in relation to amendments to care records, which must be dated and signed by the registrant making the correction, leaving the original entry plainly visible.This will be monitored by the home manager through care plan audits and ad hoc samples will be checked during senior managemnt monitor visits
Area for improvement 4 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 31 August 2026	The registered person shall ensure detailed and patient centred care plans are in place for those patients who present with distressed reactions. Ref: 3.3.3
	Response by registered person detailing the actions taken: The care plan referred to has been reviewed and updated to ensure it is robustly person-centred, detailing specific triggers and tailored support strategies. This care plan update has been validated by the Home Manager and continues to be reviewed during routine monitoring visits by the Senior Management Team to ensure ongoing compliance and quality.

Please ensure this document is completed in full and returned via the Web Portal

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