The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Holywood Care Home

Provider: Beaumont Care Homes Limited

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

Registered Provider:	Beaumont Care Homes Limited
Responsible Individual:	Mrs Ruth Burrows
Registered Manager:	Mrs Claire Campbell – not registered
Service Profile – This home is a registered nursing home which provides nursing care for up 71 patients. The home is divided into three units over two floors. The unit on the first floor provides general nursing care. On the ground floor there are two separate units; one unit provides nursing care for people living with dementia and the other unit provides nursing care for patients living with a mental illness. Patients have access to communal lounges, dining rooms and garden space.	

2.0 Inspection summary

An unannounced inspection took place on 13 August 2026 from 9.15 am to 5.30 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 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.

It was evident from discussions with patients and relatives that staff promoted patients' dignity and well-being and that staff were knowledgeable and well trained to deliver safe and effective care.

As a result of this inspection one area for improvement was assessed as having been addressed by the provider. 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 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 spoke positively about their experience of life in the home; they said they felt well looked after by the staff who they described as helpful and friendly. Patients' comments included: "The staff are all very nice to me. They couldn't be any better. The food is good and they keep the place clean and tidy"; "The staff couldn't be better. They are nice, kind and helpful" and "The staff are very good to me."

Relatives and visitors commented positively about the overall provision of care within the home. Comments from relatives included, "The staff are nice, kind and considerate. The attention they give is first class"; "I have no concerns regarding the care" and "The care is fantastic. I couldn't ask for better. The place always looks well when I come in."

Staff spoken with said that Holywood Care Home management were dealing with some staffing challenges which was impacting on teamwork, communication and the daily routine. Staff commented positively about the manager and described them as supportive and approachable. Comments received included, "I love it here. The residents are great. The new manager is lovely and approachable", "There are so many issues with teamwork and communication" and "We don't have enough permanent staff. We have mostly agency staff who don't know each other well or the routine." Management confirmed they were aware of the ongoing challenges and had a plan in place to address these, which included recruitment of new staff.

We did not receive any questionnaire responses from patients or their visitors or any 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.

While there was evidence of systems in place to manage some aspects of staffing; discussion with the manager and review of records established that all pre-employment checks had not been completed, as part of the recruitment process, prior to each staff member commencing in post. Review of staff induction records confirmed that not all staff, including agency staff, had a documented induction. Discussion with staff confirmed they did not have access to staff profiles when inducting agency staff to confirm their identity. Areas for improvement were identified.

Staff consulted with confirmed that they received regular training in a range of topics such as moving and handling, adult safeguarding and fire safety. A review of training records and discussion with staff evidenced that crisis prevention intervention (CPI) training had not been delivered to all staff given responsibility to work in the mental health unit. An area for improvement was identified.

A number of staff said that they were not satisfied that the number and skill mix of staff on duty met the needs of the patients due to the high reliance on agency staff. Patients raised no concerns in relation to the staffing arrangements. Observation of the delivery of care and discussions with staff confirmed that the number and skills of the staff on duty did not consistently meet patients' needs, although, staff did respond to requests for assistance promptly in a caring and compassionate manner.

Details were discussed with the manager who acknowledged the concerns raised by the staff and was very open and honest regarding the ongoing challenges. The manager spoke of their plans to address the concerns raised which included a culture review with the existing staff and ongoing recruitment.

RQIA were satisfied that management understood their role and responsibilities in terms of oversight of aforementioned areas and needed a period of time to address this area of work. Given these assurances additional areas for improvement were not identified on this occasion. This will be reviewed at a future care inspection.

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 interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences.
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. It was observed that patients did not have control over who enters their bedroom as a number of doors to bedrooms had the locking system removed. This was also observed on some communal toilet and shower room doors. An area for improvement was identified.

Some staff were skilled in communicating with patients and were respectful, understanding and sensitive to patients' needs; although this was not consistently observed. A formal structured observation of the afternoon meal in the first floor dining room was carried out. Some staff were observed not engaging with patients in a manner that was sensitive to their needs. An area for improvement was identified.

A number of residents looked unkempt and unwashed hair was observed. It was unclear from the records reviewed on the day of inspection how often residents were having their hair washed. Gaps of up to two weeks were identified in record keeping. Details were discussed with senior management during inspection feedback and assurances were provided that all residents' personal care needs had been attended to and assurances were provided regarding actions taken to address the cause of the shortfalls in care delivery and to ensure a similar situation would not arise. An area for improvement was identified.

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included important information about patients, especially changes to care, that they needed to assist them in their caring roles. Some staff highlighted that the handover sheet that they received had not been updated to accurately reflect the assessed needs of patients. This was discussed with the manager who confirmed that they had addressed this with relevant staff and will continue to monitor the handover sheet for accuracy.

A number of patients nursed in their bedroom were unable to use the nurse call system due to their cognitive impairment. This was discussed with the manager who agreed to review the systems in place to ensure those patients who cannot use the system are appropriately supervised.

Patients may require special attention to their skin care. For example, some patients may need assistance to change their position in bed or get pressure relief when sitting for long periods of time. These patients were assisted by staff to change their position regularly.

Where a patient was at risk of falling, measures to reduce this risk were put in place. In addition, falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented.

Patients may need support with meals ranging from simple encouragement to full assistance from staff. It was observed that some patients were not appropriately supervised in keeping with their assessed needs. An area for improvement was identified.

Observation of the lunchtime meal, review of records and discussion with patients, staff and the manager indicated that there were systems in place to manage patients' nutrition. The food served looked appetising and nutritious. Patients told us they enjoyed the meal and the food was good.
Patients were encouraged to participate in their own activities such as watching TV, listening to music, reading or chatting to staff and visitors. Arrangements were also in place to meet

patients' social, religious and spiritual needs although no activity planner was available for the week of the inspection. Activity records reviewed confirmed gaps in record keeping of up to two weeks. Other records reviewed were repetitive, not person centred and lacking in sufficient detail. There was no evidence that registered nursing staff had oversight of these records. There is a need for improvement in regard to the system in place for evidencing delivery of meaningful and patient centred activities. An area for improvement was identified.

Patients spoken with told us they enjoyed living in the home and that staff were friendly.

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.

Review of a selection of care records evidenced that care plans were in place to meet patients' assessed needs in a timely manner. Nursing staff recorded regular daily evaluations about the delivery of care.

Some supplementary care records such as hourly checks, food and fluid intake, bedrails checks and repositioning charts were not completed contemporaneously. An area for improvement was identified.

Information relating to patient care and treatment was observed to be accessible in the nurses' offices on the first floor as the door was unlocked and the room was unsupervised. Further information was accessible and unsupervised in a lounge on the ground floor. This was discussed with staff who took necessary action to secure access to the information. An area for improvement was identified.

3.3.4 Quality and Management of Patients' Environment

The home was clean and tidy. Bedrooms and communal areas were warm and comfortable. For example, patients' bedrooms were personalised with items important to the patient. Surface damage was evident on identified walls and some woodwork required painting. Some floor coverings required cleaning or replacing. This was discussed with the manager who provided assurances that these works formed part of an updated refurbishment plan which would be shared with RQIA once available.

Bed linen and curtains were not matching in several rooms. Multiple beds were found to be dressed with bed linen that was stained. This was discussed with senior management who confirmed that there was sufficient clean bed linen in the home and arranged for the identified bed linen to be changed immediately. An area for improvement was identified.

Four 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.

Fire safety measures were in place to protect patients, visitors and staff in the home.

Robust systems and processes were not in place to manage infection prevention and control (IPC) practices. For example, staff were using vinyl gloves which is unsafe for staff as the use of vinyl gloves is not indicated for use in healthcare. In addition, personal protective equipment (PPE) was not consistently available in the PPE dispensers.

Observation of staff and their practices evidenced that basic IPC practices were not consistently adhered to. For example, all staff did not use PPE correctly or take opportunities for hand hygiene particularly after contact with patients and the patients' environment. Some staff were not bare below the elbow. An area for improvement was identified.

Discussion with the manager confirmed there was no identified nurse to lead on IPC procedures and compliance within the home. Assurances were given that a registered nurse would be identified to lead on this role.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Mrs Claire Campbell has been the manager in this home since 29 June 2026.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. The manager completed audits to quality assure care delivery and service provision within the home.

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.

Relatives 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	5	8

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Claire Campbell, 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 21 (1) (b) Schedule 2 **Stated:** First time	The registered person shall ensure that all pre-employment checks are completed before any staff commence working in the home and evidence retained of managerial oversight of all such records. Ref: 3.3.1
To be completed by: 13 August 2026	**Response by registered person detailing the actions taken:** The Home Manager will ensure that no staff member commences work within the Home until all required pre-employment checks have been fully completed, verified, and documented. The Manager is responsible for conducting a thorough review of each applicant's staff file and confirming that all elements of safe recruitment have been satisfied. This includes verification of references and documented follow-up where clarification is required; a full review of the applicant's employment history, with all employment gaps explored, explained, and recorded; completion and assessment of the Access NI disclosure; confirmation of registration with relevant professional bodies where applicable; verification of right-to-work status; and authentication of all qualifications presented. The Manager must record evidence of these checks within the staff file checklist. This will provide evidence of managerial oversight, demonstrating that each check has been reviewed, signed off, and deemed satisfactory. This checklist must show that the Manager has actively assessed the suitability, safety, and legal compliance of the applicant. Only when all checks have been completed in full, and the Manager has formally confirmed this, may the staff member begin any duties within the Home. This will be further reviewed as part of the monthly monitoring visit.

Area for improvement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** 13 August 2026	The registered person shall ensure residents' personal care and grooming needs are met and that any records maintained are accurate and up to date. Ref: 3.3.2
	Response by registered person detailing the actions taken: Daily monitoring of personal care will be further embedded into the Home Manager's routine governance systems to ensure consistency, accountability, and timely intervention in relation to personal care. Daily flash meetings include a review of each resident's showering and bathing frequency, with the Manager confirming that personal care has been delivered in accordance with assessed need and individual preference. Any gaps or omissions identified in personal care records will be discussed, actions agreed, and these actions will be checked for completion the following day to ensure timely follow-through and sustained improvement. Registered nurses will evidence their own oversight of personal care by reviewing care records, confirming completion of tasks, and actively participating in the delivery of personal care themselves. This involvement reinforces professional accountability and demonstrates to care staff that personal care is not solely the responsibility of care assistants, but a shared duty within the multidisciplinary team to uphold dignity, hygiene, and wellbeing. Where any resident is identified as struggling with personal care, individualised interventions will be developed and incorporated into the resident's care plan. The multidisciplinary team will be consulted to ensure that all contributing factors are fully considered and that appropriate support strategies are implemented. During the Manager's focused walkarounds, hair washing and oral care will be specifically checked. The Manager or delegated person will ensure that toothbrushes, toothpaste, and other oral hygiene items are present, used, and replaced as required. These checks will be documented as part of ongoing quality assurance and will contribute to the overall improvement of personal care standards within the Home. This will be further reviewed as part of the monthly monitoring visit.

Area for improvement 3 **Ref:** Regulation 13 (1) (b) **Stated:** First time	The registered person shall ensure that patients are appropriately supervised in accordance with their assessed needs at mealtimes. Ref: 3.3.2
To be completed by: 13 August 2026	**Response by registered person detailing the actions taken:** The Home Manager will ensure that all residents are appropriately supervised at mealtimes in accordance with their assessed needs, including the ISSDI-recommended levels of supervision recorded within each resident's *Recommendations for Eating and Drinking Safely (REDS)* folder. These supervision levels will be clearly communicated to all staff supporting residents during mealtimes, and staff will adhere to these requirements at all times. The Mealtime Champion will be proficient in completing the Safety Pause and will consult the unit's REDS folder to confirm the correct supervision level, safe-swallowing recommendations, positioning requirements, and any texture-modified diet or fluid recommendations. The Mealtime Champion will ensure that these safety measures are consistently applied and that any concerns identified during the safety pause are escalated immediately. Observations of mealtimes have commenced by the Learning and Development team at Beaumont. Staff are being provided with practical support to be able to implement the Safety Pause effectively. All staff supporting residents with meals will be aware of each resident's supervision status, and where 1:1 supervision is required, this will be provided without exception. Staff will remain attentive, ensuring that residents are positioned appropriately, and will monitor for signs of fatigue, reduced intake, or swallowing difficulty. Any deviation from the assessed supervision level will be treated as a safety concern and addressed promptly. Agency staff will not assist residents at high risk when eating and drinking unless in exceptional circumstances where the staff member is fully aware of the needs of the resident. Where a resident is identified as being at increased risk of choking, or where supervision requirements appear to be changing, the resident's needs will be reviewed and individualised interventions will be care-planned. Staff nurses will be confident in temporarily enhancing observation levels to maintain resident safety until they can be assessed by the Speech and Language Team. Ultimately, the Home Manager will ensure that mealtime support is safe, consistent, and aligned with assessed need, and that all records—including REDS guidance, supervision levels, and

	mealtime documentation—are accurate, current, and reflective of the care delivered. This will be further reviewed as part of the monthly monitoring visit
Area for improvement 4 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** 13 August 2026	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the following: ● donning and doffing of personal protective equipment ● appropriate use of personal protective equipment ● staff knowledge and practice regarding hand hygiene Ref: 3.3.4
	Response by registered person detailing the actions taken: The Registered Person will ensure that all infection prevention and control (IPC) issues identified on inspection are fully addressed and that robust systems are in place to minimise the risk and spread of infection throughout the Home. Staff practice, environmental controls, and managerial oversight aim to demonstrate safe, consistent adherence to IPC standards within Holywood. Routine hand hygiene audits and PPE audits will be completed by nurses, domestic staff and care assistants. This will encourage ownership and accountability within the staff team. These audits are intended to monitor staff compliance with correct donning and doffing procedures, appropriate use of personal protective equipment, and adherence to the WHO 5 Moments for Hand Hygiene. Staff will not commence personal care without performing hand hygiene, nor will they leave residents' bedrooms until they have performed effective hand hygiene, and this expectation will be reinforced through supervision, spot checks, and audit feedback. Inappropriate use of PPE will be addressed where it is observed within the Home. Staff will ensure that DANI centres are kept fully stocked with gloves, aprons and hand sanitiser and that items are replenished promptly when used. These centres will be checked during managerial walkarounds to confirm accessibility, cleanliness, and compliance with IPC standards. Stocking of Dani centres has been added as an action within the unit's respective Decontamination Folders. Residents will be offered hand hygiene before all meals, either through the use of Clinell wipes or by being supported to access

	appropriate hand-washing facilities. This practice will be monitored during mealtime oversight and managerial walkarounds to ensure consistency and dignity in care. All clinical waste will be disposed of safely and in accordance with infection control guidance. Staff will not carry clinical waste around the Home unless it is properly bagged, sealed, and transported directly to the designated clinical waste disposal point. Any breaches in waste-handling practice will be addressed immediately and recorded as part of IPC oversight. Managerial oversight will include regular focused walkarounds, during which hand hygiene practice, PPE use, and waste disposal procedures will be observed and gaps addressed. Findings from these walkarounds continue to inform actions, training, and improvements. This will be further reviewed as part of the monthly monitoring visit.
Area for improvement 5 **Ref:** Regulation 14 (2) (a) and (c) **Stated:** First time **To be completed by:** 13 August 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: The Home Manager will ensure that appropriate wet-floor signage is displayed whenever floors have been mopped, providing clear warning to patients, visitors, and staff of slip hazards. To support this, domestic staff will undertake supervisions specifically focused on the correct use, placement, and removal of wet-floor signs. These supervisions will reinforce staff understanding of when signage must be used, how it should be positioned to maximise visibility, and the importance of maintaining a safe environment during cleaning tasks. Domestic staff will be reminded that wet-floor signs must be placed before any mopping or cleaning begins, remain in situ until the floor is fully dry, and be removed promptly once the area is safe. This will be further reviewed as part of the monthly monitoring visit.

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 39.1 **Stated:** First time **To be completed by:** 13 August 2026	The registered person shall ensure that all staff newly appointed, including agency staff, complete a structured orientation and induction programme in a timely manner and that accurate records are retained for inspection. The current system of induction should be reviewed to ensure that those staff involved in inducting agency staff have access to their profiles to confirm their identity. Records should evidence managerial oversight of all staff inductions. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Home Manager is responsible for ensuring that all staff within the Home have received a structured orientation and induction programme in a timely manner so that they are able to deliver safe and effective care. The induction system will be strengthened to ensure that staff involved in inducting agency personnel have full access to their agency profiles to confirm identity and verify that appropriate pre-employment checks have been completed. Agency profiles will be printed, checked, and stored alongside the completed induction form for each agency worker. This ensures that the individual presenting for duty is the same person cleared by the agency and that they have undergone the required vetting, training, and identity verification. These documents will be available for inspection at all times. The Manager will sign all completed induction forms for core staff and will ensure that inductions are fully completed before staff commence working on the floor. This process will be strengthened through focused managerial walkarounds, during which the Manager will check that agency profiles and induction forms have been completed and filed correctly. Additional oversight will occur during the 3pm flash meeting, where any gaps in induction documentation will be identified and addressed immediately. Where agency staff have previously worked in the Home, a remedial induction will be undertaken to ensure that all required information has been covered, updated, and held on record. This ensures that returning staff remain familiar with current procedures, environmental layout, safeguarding expectations, and IPC requirements.

	Each unit, kitchen, and domestic department will maintain its own folder containing induction forms and agency profiles for inspection. To strengthen induction for new core staff nurses, part of their induction will be completed within other Beaumont Homes when this is deemed to be necessary by Senior Management. This provides the Manager with assurance that nurses have been inducted effectively, especially in relation to administration of medication, that they understand organisational standards, and are safe to practice before taking responsibility within the Home. This will be further reviewed as part of the monthly monitoring visit.
Area for improvement 2 **Ref:** Standard 39.4 **Stated:** First time **To be completed by:** 13 August 2026	The registered person shall ensure that crisis prevention intervention (CPI) training needs for individual staff, specific to their roles and responsibilities, are identified and arrangements are in place to meet them. Ref: 3.3.1
	Response by registered person detailing the actions taken: A planned CPI training programme will be delivered for staff working in both the Dunville Unit and the Dementia Unit, reflecting the enhanced behavioural support requirements within these areas. This programme will consist of a full two-day CPI training course, or a CPI update/refresher where applicable, depending on the staff member's previous training history and assessed competency.
Area for improvement 3 **Ref:** Standard 6.6 **Stated:** First time **To be completed by:** 13 August 2026	The registered person shall ensure that patients have control over who goes into their bedroom, toilet and shower room. These areas should have a locking system that the patient can lock, but may be opened by staff in emergencies. Ref: 3.3.2
	Response by registered person detailing the actions taken: It is acknowledged that all locks were removed erroneously a number of years ago, and the service recognises that this was not the correct practice and did not support patient autonomy or privacy. To address this, suitable locks will now be reinstated on all bedroom, toilet, and shower room doors. These locks will allow patients to secure their personal spaces while ensuring staff can

	override them safely in emergency situations. The installation of these locks will restore resident dignity, privacy, and choice. This will be further reviewed as part of the monthly monitoring visit.
Area for improvement 4 **Ref:** Standard 19 **Stated:** First time **To be completed by:** 13 August 2026	The registered person shall ensure that all staff understand patients' communication needs and communicate in ways that are sensitive to these needs. Ref: 3.3.2
	Response by registered person detailing the actions taken: The Home Manager will ensure that all staff understand patients' communication needs and communicate in ways that are sensitive, person-centred, and responsive to those needs. Many residents within the Home have complex needs and require staff to communicate with them in a calm, respectful, and sensitive manner, adapting their approach to each individual's abilities, preferences, and emotional state. It is recognised that effective communication is strengthened by having a stable staff team who know the residents well. Staff will be encouraged to develop meaningful familiarity with each resident, including their life histories, likes, dislikes, routines, and preferred ways of interacting. This knowledge will support more effective communication, reduce distress, and promote trust. Conversation will be encouraged as part of daily care, and staff will be supported to take time to speak with residents, observe non-verbal cues, and respond appropriately. Communication care plans will be strengthened to reflect each resident's specific communication needs. These plans will include tailored strategies for residents who cannot communicate verbally, who rely on gestures or facial expressions, or who require additional reassurance. Where a resident is unable to use a call bell, specific monitoring arrangements will be put in place to ensure their safety. This may include regular checks or environmental adjustments to ensure the resident can attract attention when needed. These measures will be clearly documented within the communication care plan and monitored through managerial oversight. This will be further reviewed as part of the monthly monitoring visit.

Area for improvement 5 **Ref:** Standard 11 **Stated:** First time **To be completed by:** 13 August 2026	The registered person shall review the provision of activities to ensure that meaningful engagement is an integral part of everyday life in the home; that there is flexibility for patients' choice and that a comprehensive and person centred record of the activities delivered is retained. Records should evidence oversight by registered nursing staff. Ref: 3.3.2
	Response by registered person detailing the actions taken: We aim to strengthen the provision of activities to ensure that meaningful engagement is an integral part of everyday life in Holywood. Activities will reflect patient choice, and comprehensive, person-centred records will be retained within each resident's individual file, with clear oversight from registered nursing staff. A revised activities structure has been implemented. The existing 15-hour-per-week activities coordinator will work solely within the Dunville Unit, where the focus will be on mental-health-specific interventions tailored to residents with complex emotional, behavioural, and psychological needs. This will include therapeutic engagement, structured routines, and personalised interventions designed to reduce distress and promote stability. To further strengthen the therapeutic environment in Dunville, an RMN has been recruited to work within the unit. Their presence will support the delivery of non-pharmacological interventions, collaborative therapeutic activities, and enhanced emotional support delivered alongside the dedicated activities coordinator. The utility room and garden area within Dunville will be used for their intended purpose, providing dedicated spaces for life-skills activities. A new full-time activities coordinator will commence on 20th October 2026. We aim that she will work across the Nursing and Dementia Units. She will deliver a programme of activities that maximises time spent outdoors, encourages engagement with the local community, and supports cognitive stimulation, reminiscence, and social connection. For residents who are unable to leave their bed or chair, Namaste-style activities will be implemented to ensure they continue to experience meaningful sensory engagement, comfort, and connection. A dedicated relaxation area upstairs will support these activities in a calm, therapeutic environment. This will be further reviewed as part of the monthly monitoring visit.

Area for improvement 6 **Ref:** Standard 4.9 **Stated:** First time **To be completed by:** 13 August 2026	The registered person shall review the current system in place to ensure that supplementary care records are accurately maintained and completed contemporaneously. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Home Manager has reviewed the current system to ensure that supplementary care records are accurately maintained and that staff are able to complete these contemporaneously. To strengthen this, nurses will work to deliver personal care wherever possible, giving them direct opportunity to oversee the completion of supplementary charts such as fluid intake, bowel monitoring, and repositioning records. This approach ensures that nursing oversight is embedded within daily care delivery and that charts are completed at the time care is provided. Supervisions have been carried out specifically in relation to the completion of supplementary charts. Staff meetings have reinforced staff understanding of the meaning of "contemporaneous" and the importance of recording care at the point it is delivered. These sessions have clarified expectations and emphasised accountability across the team. Oversight of supplementary charts continues to form part of the daily flash meeting and the Manager's focused walkaround. During these checks, the Home Manager or senior person is able to review completion, identify any gaps, and ensure that corrective actions are taken immediately. This provides ongoing assurance that records are accurate, timely, and reflective of the care delivered. This will be further reviewed as part of the monthly monitoring visit
Area for improvement 7 **Ref:** Standard 37 **Stated:** First time **To be completed by:** 13 August 2026	The registered person shall ensure that information about a patient's health and treatment is securely stored to ensure patient information is only accessible to those with permission. Ref: 3.3.3
	Response by registered person detailing the actions taken: All nursing stations will be kept locked at all times, with access restricted to authorised staff. This will prevent unauthorised entry and ensure that confidential records, medication information, and care documentation remain protected in line with data protection and professional standards.

	Nursing staff will be reminded through supervision and daily oversight that maintaining secure storage of records is a core part of safe practice. This forms part of wider governance arrangements relating to record security, confidentiality, and safe documentation. This will be further reviewed as part of the monthly monitoring visit
Area for improvement 8 **Ref:** Standard 44.1 **Stated:** First time **To be completed by:** 13 August 2026	The registered person shall ensure bed linen and clothing is of good quality and changed when required. Ref: 3.3.4
	Response by registered person detailing the actions taken: The Home Manager will ensure that bed linen and clothing are of good quality and changed when required. A new decontamination schedule has been implemented to strengthen standards of cleanliness and ensure that linen is managed safely and appropriately across all units. As part of the Manager's focused walkaround, checks are carried out specifically in relation to bed linen to confirm that it is clean, suitable, and replaced when necessary. These checks form part of wider governance arrangements relating to linen hygiene, infection control, and environmental cleanliness. Domestic staff and care staff are being encouraged to dispose of stained or unsuitable linen immediately and to open and use the packages of new linen that had previously been purchased for dissemination around the Home. This ensures that high-quality linen is in active use and that older or unsuitable items are removed from circulation. Suitable cotton bed linen will become the standard throughout the Home, and any linen that does not meet required quality or comfort standards will be disposed of. This will be further reviewed as part of the monthly monitoring visit.

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

The Regulation and Quality Improvement Authority

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