The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Kings Castle

Provider: Messana Investments Ltd

Date of Inspection: 8 September 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:	Messana Investments Ltd
Responsible Individual:	Mr Gerald Ward
Registered Manager:	Ms Mary Peake
Service Profile – Kings Castle is a nursing home registered to provide general nursing care for up to 42 patients under and over the age of 65 years. Patients' bedrooms are located over three floors and patients have access to communal dining and lounge areas and an enclosed garden.	

2.0 Inspection summary

An unannounced inspection took place on 8 September 2026 from 9.25am to 5.25pm 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 26 February 2026; 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 all areas for improvement from the previous care inspection were assessed as having been addressed and two 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 were well presented in their appearance and were observed to be relaxed and content in their surroundings and in their interactions with staff. Patients communicated comfortably with one another and with staff. One told us, "I love it here; very happy. We are well looked after". Another commented, "It's grand here. We are well fed and the staff come when I ring my buzzer". We received no responses from patients' questionnaires.

Relatives were complimentary on the care their loved ones were receiving. During the inspection a relative told us, "The staff are excellent; they really go out of their way. They are kind and thoughtful and always keep us updated. We can't praise them highly enough". Another told us, "We can't fault the care home at all. They (the staff) are all brilliant. No concerns at all". We received no questionnaire returns from relatives.

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 online staff 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.

Recruitment safety checks had been verified prior to staff commencing in post, however, not all gaps in employment history had been explored or recorded prior to employment being offered. This was discussed with the manager and identified as an area for improvement.

Newly employed staff completed a structured 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 pre-determined mandatory training requirements.

Staff told us they were satisfied that the number and skill mix of staff on duty met the needs of the patients. Patients raised no concerns in relation to the staffing arrangements. Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty and that staff responded to requests for assistance promptly in a caring and compassionate manner.

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 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. 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.

Pressure management risk assessments were completed and reviewed monthly to ensure that skin integrity was maintained. 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. The manager confirmed that there were no wounds in the home requiring dressing.

The manager confirmed that a new updated fall's pathway was being introduced to guide staff on actions to take when a fall occurred. A fall's cross was in place identifying the number of actual falls and near misses occurring each month. A review of recent accidents in the home evidenced that RQIA had been informed of notifiable falls. Accidents were reviewed monthly for any patterns or trends in an effort to prevent any future falls from occurring.

Patients' weights were monitored monthly, or more frequently if required, for weight loss or weight gain. Nutritional assessments were completed and the nutritional care plans were in line with the recommendations from dieticians and/or speech and language therapists. Food and fluid intakes had been monitored well.

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. Food was only served when the patients were ready to eat. The meals served appeared appetising and nutritious. Staff sat with patients when helping with their meal and assistance was given in an unhurried manner. Patients enjoyed their meal and spoke positively on the quality of their meal. Staff were aware of the actions to take should a patient regularly refuse food. Nutritional audits were conducted monthly.

Patients' preferred rising and retiring times were recorded within their care records. Staff confirmed that patients were only washed and dressed for the day at a time of the patients' preference. Patients could have a lie in or get up earlier if they wished.

Records showed that hearing aids were checked and cleaned regularly. Although, they did not indicate when the hearing aid batteries were changed. This was discussed with the manager who confirmed that they will implement a new check sheet to evidence the changes. This will be reviewed at a subsequent inspection.

Activities for patients were provided incorporating both group and one to one engagement. We observed a group activity quiz involving 12 patients. Each patient was included in the activity and patients enjoyed engaging with the activity coordinator.

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.

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. However, several of the evaluation entries were completed up to half way through the shift and not accounting for the remainder of the shift. This was discussed with the manager and identified as an area for improvement.

Care records were stored securely.

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. Storage and communal rooms were maintained clean and tidy. Access to rooms containing hazards had been restricted. There were no lingering malodours in the home.

Corridors and fire exits were clear of clutter and obstruction should the need to evacuate occur and fire extinguishers were easily accessible. Multiple fire drills had been completed to aid in preparation for evacuations. Ways of enhancing the recording of fire drill reports was discussed with the manager. Staff had attended additional fire safety training and fire safety checks were regularly conducted.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. Staff were observed to be bare below the elbow and performed hand hygiene at the appropriate times. Personal protective equipment and hand hygiene facilities were readily available throughout the home. The manager had developed a 'Managing Outbreak File' to guide staff on actions to take should an infectious outbreak occur in the home.

Externally the home was well maintained. There were garden areas with views of the coastline and sea where patients could sit.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Ms Mary Peake has been managing the home since 8 January 2021 and has now registered as manager with RQIA. Staff commented positively about the manager and described her as supportive and approachable. In the absence of the manager there was a nominated nurse-in-charge to provide guidance and leadership.

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.

There were no recent or ongoing complaints relating to the home. There was a system in place to manage any complaints 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.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with standards.

	Regulations	Standards
Total number of Areas for Improvement	0	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Mary Peake, 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 Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 38 Criteria (3) **Stated:** First time **To be completed by:** With immediate effect (9 September 2026)	The registered person shall ensure that any gaps in employment history are explored and recorded. Ref: 3.3.1
	Response by registered person detailing the actions taken: Following on from our inspection we updated out GAP Report to now include all gaps in employment history dating back to secondary school. This has now been updated on our application form.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** With immediate effect (9 September 2026)	The registered person shall ensure that nursing staff evaluate care in a meaningful manner that is person centred. Ref: 3.3.3
	Response by registered person detailing the actions taken: Staff nurses notes continue to be patient centred, staff nurses are aware to update their notes continuously during their shift, staff nurses also aware to complete a final summary at the end of their shift.

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

The **Regulation** and **Quality Improvement** Authority

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