

Inspection Report

Name of Service: The Glebe Care Centre

Provider: Ann's Care Homes

Date of Inspection: 18 September 2025

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:	Ann's Care Homes Ltd
Responsible Individual:	Mrs Charmaine Hamilton
Registered Manager:	Mr Christopher Walsh – not registered
<p>Service Profile – This home is a registered nursing home which provides nursing care for up to 31 patients. The home is divided over two floors. Patient's bedrooms are located over both floors and patients have access to communal space.</p>	

2.0 Inspection summary

An unannounced inspection took place on 18 September 2025, between 10.00 am to 5.00 pm by a care inspector.

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.

The inspection established that safe, effective and compassionate care was delivered to patients and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

As a result of this inspection, one new area for improvement was identified. Full 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 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 who were able to share their opinions on life in the home said or indicated that they were well looked after. Patients who were less able to share their views were observed to be at ease in the company of staff and to be content in their surroundings.

Relatives spoken with reported that they were satisfied with the care and services provided in the home. Comments made were shared with the manager for review and action as appropriate.

Staff spoke positively in terms of the provision of care in the home and their roles and duties.

Following the inspection, there were no responses received from the staff questionnaires or patient/relative questionnaires.

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.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

Staff told us that the patients' needs and wishes were important to them. Staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through observation of the interactions between the patients and staff that the staff knew the patients well.

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 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. 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 and to manage this aspect of care.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs.

The risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed.

Observation of the lunchtime meal, review of records and discussion with patients, staff and the manager evidenced that there were robust systems in place to manage patients' nutrition and mealtime experience.

Arrangements were in place to meet the patients' social, religious and spiritual needs within the home. Activities for patients involved both group and one to one activities.

3.3.3 Management of Care Records

Patients' needs were assessed by a suitably qualified member of staff 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.

Care records were person centred and regularly reviewed to ensure they continued to meet the patients' needs.

Patients care records were held confidentially.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and welcoming. For example, patients' bedrooms had varying degrees of personalisation with items important to the patient.

It was observed that a dining room was being used for a training session on the day of inspection. This resulted in patients not having access to the dining room for their meals; this was discussed with the manager who immediately addressed the issue to ensure patients had access to the dining room; an area for improvement was identified.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records kept.

3.3.4 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Mr Christopher Walsh has been the Manager in this home since 6 January 2025. Mr Walsh is in the process of applying to register with RQIA.

Staff commented positively about the manager and described them as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place.

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	0	1

Areas for improvement and details of the Quality Improvement Plan were discussed with the 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)	
<p>Area for improvement 1</p> <p>Ref: Standard 44.3</p> <p>Stated: First time</p> <p>To be completed by: 18 September 2025</p>	<p>The Registered Person shall ensure the nursing home including all spaces is only used for the purpose for which it is registered. This is in relation to a patient dining room used for staff training.</p> <p>Ref: 3.3.4</p> <hr/> <p>Response by registered person detailing the actions taken: This was addressed, as referenced in the report, on the day of the inspection. Moving forward, rooms will only be used in line with their registered use.</p>

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



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