The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Hamilton Care Home**

Provider: **Hamilton Nursing Home Ltd**

Date of Inspection: **11 March 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:	Hamilton Nursing Home Ltd
Responsible Individual:	Ms Lucinda Dawn Hamilton
Registered Manager:	Ms Lucinda Dawn Hamilton
Service Profile – This is a registered nursing home which provides nursing care for up to 36 patients over the age of 65. The home is a two storey building. All patient bedrooms are on the same floor. Laundry, staff and office areas are on the lower level of the building. Patients have access to communal lounges, dining room and a courtyard.	

2.0 Inspection summary

An unannounced inspection took place on 11 March 2025, between 9.30 am and 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; to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 14 March 2024; 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.

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.

As a result of this inspection all of the previous areas for improvement were assessed as having been addressed by the provider and no new areas for improvement were identified. Details can be found in the main body of this report.

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.

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 staff were "as good as you could hope for", "they come quite promptly", and "everyone's really nice here", and "I think it's really good here the staff are always looking after you".

Patients who like to spend much of their time in their room told us that staff 'check in' with them throughout the day. Patients spoke fondly of some of the planned activities and entertainment such as singing and dancing.

Relatives said that they felt their loved ones were very well cared for; staff were very attentive regarding personal care and they always found their loved ones to be well presented. Others said they felt confident that the quality of care provided was very good, they appreciated the effort made to have a homely atmosphere and that they were always made to feel very welcome.

A healthcare professional who was visiting the home at the time of this inspection told us that they found the home to be very willing to learn, responding well to special instructions given to meet patients' needs.

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.

It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way; and to provide patients with a choice on how they wished to spend their day. For example, after lunch patients were supported by staff to choose where in the home they wished to relax.

Staff said they had good induction, worked well together and spoke of appreciating the support from their colleagues. Staff knew who to raise concerns with and felt confident that any concern raised would be managed effectively.

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 prompt in recognising patients' needs. Where patients had difficulty in making their wishes known, staff demonstrated skill in communication; seeking to offer choice and assist the person to express their preference. Staff were respectful, understanding and sensitive to patients' needs; staff assisted patients in a way which facilitated independence when completing a task.

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 offered patients choice in how and where they spent their day or how they wanted to engage socially with others. For example, some patients said that they liked to stay up late and therefore have a long lie some mornings and staff were supportive in facilitating this. Patients were encouraged to engage in hobbies while enjoying the company of others for example, crosswords. When patients expressed they no longer wished to have company, staff supported them to have a rest in bed in the afternoon, or if they wished to have a snack in a lounge elsewhere in the home.

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.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, patients were encouraged to wear appropriate footwear and staff supported patients to utilise walking aids by keeping them close by. Patients were also encouraged to utilise the alert system to ask for support.

Examination of care records evidenced that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. For example, staff made contact with the GP when required and appropriately monitored patients after they had fallen.

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. It was positive to note that staff took appropriate opportunities for hand hygiene throughout the day and prior to serving lunch. The manager agreed to discuss with staff of the importance of continuing hand hygiene throughout mealtimes also.

Observation of the lunch time meal confirmed that there were robust systems in place to manage patients' nutrition and mealtime experience. The dining experience was an opportunity for patients to socialise and the atmosphere was calm, relaxed and unhurried. Patients enjoyed the company of one another and their dining experience, laughing and joking with one another as they met in the dining room. Staff made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. Patients who changed their mind on what they wanted to eat, were accommodated as staff provided an alternative. Staff upheld the dignity of patients in how they assisted with meals, ensuring that patients had the opportunity to protect their clothes and clean their face.

The importance of engaging with patients was well understood by the manager and staff. Patients' needs were met through a range of individual and group activities such as chair dancing, beauty, crafts, music and Irish dancing shows. A plan for the week was on display in each bedroom. Patients were encouraged to attend these but staff also facilitated time with patients one-to-one. Patients spoke fondly of the entertainment. Arrangements were in place to meet patients' social, religious and spiritual needs within the home and staff knew the patients well in order to facilitate this.

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.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care. 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.

Nursing and care staff were able to describe what patient's preference were and care plans provided detailed information to guide staff in individual preferences. For example, care plans directed staff what level of support people required and which tasks patients prefer additional support to maintain independence where possible.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained for example corridors and communal areas were free from clutter. Patients' bedrooms were personalised with items important to the patient such as photographs and artwork made for them by relatives. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

There was access to a communal sitting area which had refreshments and newspapers available for patients and visitors. There were other 'homely' touches throughout the home such as ornaments, flowers and artwork on the walls.

Patients told us that the staff are respectful when cleaning their room. The equipment for both personal and communal use were regularly cleaned. One commode had rust around the wheels which the manager has agreed to replace.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection.

Patients and staff commented positively about the manager and described her as supportive, approachable and able to provide guidance. Staff commented positively that they had been supported by the manager to engage in training to enhance their knowledge and practice.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. 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/or the quality of services provided by the home.

Review of one of the audits identified that information had been overlooked; where there had been a change in care the written record was not wholly accurate. This had been overlooked in the care plan audit and reviewing processes. The manager agreed to review this system to improve the effectiveness of this audit.

Review of records evidenced that where an issue was raised, the manager communicated with the complainant until a resolution was achieved. Patients and staff told us that they felt confident the manager would respond effectively if they raised concerns.

Many compliments have been received by the home from relatives expressing gratitude in how their loved one was cared for; these were shared with staff for their encouragement.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Lucinda Dawn Hamilton, manager, as part of the inspection process and can be found in the main body of the report.

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