

# Inspection Report

**Name of Service:** Hamilton Care Home

**Provider:** Hamilton Nursing Home Ltd

**Date of Inspection:** 4 November 2025

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

## 1.0 Service information

<b>Registered Provider:</b>	Hamilton Nursing Home Ltd
<b>Responsible Individual:</b>	Ms Lucinda Dawn Hamilton
<b>Registered Manager:</b>	Ms Lucinda Dawn Hamilton
<b>Service Profile –</b> 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 ground floor. Laundry, staff and office areas are on the lower level of the building. Patients have access to communal lounges, dining room and an internal courtyard.	

## 2.0 Inspection summary

An unannounced inspection took place on 4 November 2025 from 9.20 am to 4.00 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.

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.

The previous care inspection resulted in no areas for improvement being identified. As a result of this inspection four new areas for improvement were 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 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 were helpful and friendly. Patients' comments included: "It is a great home. The staff are very good and pleasant. They respect my privacy", "I am content here. The staff are lovely. They never refuse to do anything. The food is great" and "The staff are first class and the home is clean and tidy."

Patients told us that staff offered choices to them 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.

Relatives commented positively about the overall provision of care within the home. Comments included: "I like that the patients have relatives who work here. I can't speak highly enough of the care."

Staff spoken with said that Hamilton Care Home was a good place to work and said the teamwork was very good. Staff commented positively about the manager and described them as supportive and approachable. Comments from staff included, "I am very happy here. Everyone is so accommodating."

We did not receive any responses from the staff online survey within the timescale specified. We received three questionnaire responses from relatives. Comments received included, "Staff are first class. Plenty of activities on and everyone enjoys the fun", "The staff are wonderful. This is a five star home" and "Everyone is so willing to care and attend everyone with a smile."

### 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 systems in place to manage staffing.

While there was evidence of systems in place to manage some aspects of staffing; discussion with the manager established that pre-employment checks had not been completed, as part of the recruitment process, prior to each staff member commencing in post. Review of agency staff induction records confirmed that not all staff had a documented induction and an induction to the home for an identified staff member had been completed within one day. Two areas for improvement were identified.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they were satisfied with the staffing levels. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

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

#### 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 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 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.

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about their patients, especially changes to care, that they needed to assist them in their caring roles.

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. A restrictive practice register was monitored and reviewed monthly. It was established that safe systems were not consistently in place to safeguard patients and to manage this aspect of care. Hourly bedrail checks had not been completed for an identified patient in keeping with their assessed needs. An area for improvement was identified.

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 and records maintained.

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 ensure those patients who cannot use the system are appropriately supervised.

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.

Nutritional risk assessments were completed monthly to monitor for weight loss or weight gain. Nutritional care plans were in line with the recommendations of the speech and language therapists and/or the dieticians. Patients were safely positioned for their meals and the mealtimes were well supervised. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. 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.

The importance of engaging with patients was well understood by management and staff and patients were encouraged to participate in their own activities such as watching TV, reading, resting or chatting to staff. Arrangements were also in place to meet patients' social, religious and spiritual needs. An activity planner displayed highlighted events such as beauty sessions, bingo, chair dancing, ladies morning, Remembrance day events, one to one crafts and talks and church services. Patients said they enjoyed recent Halloween events.

It was pleasing to note that one of the Registered Nurse's had won the Staff Nurse of the Year award the in the Peninsula Care Awards and the manager had been highly commended at the same event.

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.

Care records, for the most part, were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. However, care plans were not in place for patients who required one to one care. Records reflecting the patient's likes and preferences were not available to the care staff providing one to one care. An area for improvement was identified.

Nursing staff recorded regular evaluations about the delivery of care: some of these had been completed prior to midday and no further entries had been made to reflect the care delivered after midday. This was discussed with the manager who agreed to meet with registered nursing staff and monitor compliance through their audit processes.

### **3.3.4 Quality and Management of Patients' Environment**

The home was clean and tidy. Bedrooms and communal areas were very well decorated, furnished to a high standard, warm and comfortable. Patients' bedrooms were personalised with items important to them.

A small number of shortfalls in individual staff practice with infection prevention and control (IPC) practices were discussed with the manager who agreed to monitor this through their audit processes and arrange additional training and supervisions if required.

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 no change in the management of the home since the last inspection. Ms Lucinda Dawn Hamilton has been the manager since 5 June 2008.

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 or delegated staff members completed regular audits to quality assure care delivery and service provision within the home.

However, based on the inspection findings and a review of a sample of audits it was evident that improvements were required regarding the audit process to ensure it was effective in identifying shortfalls and driving the required improvements; particularly in relation to oversight of incidents, IPC practices and care records.

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.

There was a system in place to manage any complaints received.

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.

Patients and their 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
<b>Total number of Areas for Improvement</b>	2	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Lucinda Dawn Hamilton, Registered Manager and Responsible Individual, as part of the inspection process. The timescales for completion commence from the date of inspection.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 21 (1) (b) Schedule 2  <b>Stated:</b> First time  <b>To be completed by:</b> 4 November 2025	<p>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.</p> <p>Ref: 3.3.1</p> <hr/> <p><b>Response by registered person detailing the actions taken:</b> This has been fully addressed.</p>
<b>Area for improvement 2</b>  <b>Ref:</b> Regulation 16 (1)  <b>Stated:</b> First time  <b>To be completed by:</b> 4 November 2025	<p>The registered person shall ensure detailed and person centred care plans are in place for those patients who require one to one care.</p> <p>Ref: 3.3.3</p> <hr/> <p><b>Response by registered person detailing the actions taken:</b> This has been fully addressed.</p>
<b>Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 39.1  <b>Stated:</b> First time  <b>To be completed by:</b> 4 November 2025	<p>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. Records should evidence managerial oversight of all staff inductions.</p> <p>Ref: 3.3.1</p> <hr/> <p><b>Response by registered person detailing the actions taken:</b> This has been fully addressed. All agency staff complete an induction form which is kept with their profile and ID checked by the staff nurse in charge of shift. Same checked and signed off by management.</p>

<p><b>Area for improvement 2</b></p> <p><b>Ref:</b> Standard 4.9</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 4 November 2025</p>	<p>The registered person shall ensure that bedrail checks are completed contemporaneously in keeping with the patients' assessed need and accurate records are maintained.</p> <p>Ref: 3.3.2</p>
	<p><b>Response by registered person detailing the actions taken:</b> All residents using bedrails now have 4 hourly bedrail checks while in bed and these checks are recorded on Person Centred Software. All care plans reviewed and updated.</p>



## The Regulation and Quality Improvement Authority

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