The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Crana Care Centre

Provider: East Eden Ltd

Date of Inspection: 9 and 10 December 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:	East Eden Ltd
Responsible Individual:	Dr Una McDonald
Registered Manager:	Ms Joy Hynds
Service Profile – This home is a registered nursing home which provides nursing care for up to 79 patients. The home is divided into seven units with designated communal areas, lounges and dining facilities.	

2.0 Inspection summary

This unannounced inspection took place on 9 December 2025, from 9.20am to 3pm and on 10 December 2025, from 9.20am to 2.15pm. The inspection was conducted by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; to assess the progress with the one area of improvement identified by RQIA, during the last care inspection on 19 March 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led. The previous area of improvement was assessed as met.

The inspection found that safe, effective and compassionate care was delivered to patients and 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 the staff were knowledgeable and trained to deliver safe and effective care.

Patients were complimentary about the care and the services provided and said that staff were kind and attentive. Patients were seen to be comfortable, content and at ease in their environment and interactions with staff.

Visiting relatives said they were very happy with the care provided in the home and had good confidence with the service.

One area of improvement was made as a result of this inspection. Full details of this area for improvement, 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 said that they felt well cared for and that staff were kind and attentive, that they enjoyed the meals and the general atmosphere in the home. Two patients made the following comments; "All's very well here. I am very happy" and "It's working out great here. I couldn't be happier and better cared for. The food is lovely."

Patients who were unable to articulate their views, appeared comfortable, content and at ease in their interactions with staff and their environment.

Staff said they were very happy with their roles and duties, that there was good team working and morale and they received good training and managerial support. Staff said that they felt the standard of care provided in the home was very good.

Eight visitors said they were very happy with the care provided and had good confidence with the service.

No questionnaires were returned in time for inclusion to this report.

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, regular supervision and appraisal 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.

Staff said there was good teamwork, morale and that they felt well supported in their role and that they were satisfied with the staffing levels.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

There was an effective system in place to manage the registration of nursing staff with the Nursing & Midwifery Council (NMC) and care staff with the Northern Ireland Social Care Council (NISCC).

3.3.2 Quality of Life and Care Delivery

Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences. Staff have received training on a range of patients' assessed care needs and conditions.

Staff interactions with patients were polite, friendly and supportive.

It was observed that 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 patients choice in how and where they spent their day or how they wanted to engage socially with others.

Patients were seen to be comfortable and at ease in their interactions with staff.

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.

Examination of care records and discussion with the staff confirmed that the risk of falling and falls were managed and referrals were made to healthcare professionals as needed. For example, residents were referred to the Trust's Specialist Falls Service, their GP, or for physiotherapy. Nursing and care staff had received up-to-date training in falls management.

At times some patients may require the use of equipment, such as fall alarm mats and / or bedrails, or live in a unit that is secure, that could be considered restrictive. Use of such practices were reviewed and maintained on an up-to-date basis.

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

Good nutrition and a positive dining experience are important to the health and social well-being of patients. Patients may need a range of support with their meal, including simple encouragement through to full assistance and their diets modified as assessed. Staff assistance and support was organised and unhurried. The dinnertime meal was appetising, wholesome and nicely presented. Supervision and assistance with the dinnertime was organised and unhurried.

A varied programme of individual and group activities and events was in place for patients to avail of and enjoy. The genre of TV channels and music played was in keeping with patients' age groups and tastes.

3.3.3 Management of Care Records

The home's management team undertakes a preadmission assessment to all potential patients to the home to ensure the home can meet the assessed needs of the patient. Patients' needs are then 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' assessed 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.

Progress records were in large appropriately maintained, with issues of assessed need having a recorded statement of care given and effect of same. However, evaluations pertaining patients' mental health and well-being, lacked the required detail. An area of improvement was made for these evaluations to be reviewed.

Patients' care records were held safely and securely.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and fresh smelling throughout, with a good standard of décor and furnishings being maintained. Patients' bedrooms were personalised with items important to the patient. Communal areas were suitably furnished and comfortable. Bathrooms and toilets were clean and hygienic.

The catering and laundry departments were tidy and well organised.

Cleaning chemicals were stored safely and securely.

The grounds of the home were suitably maintained.

All staff were in receipt of up-to-date training in fire safety. Fire safety records were appropriately maintained with up-to-date fire safety checks of the environment and fire safety drills.

The home's fire safety risk assessment dated 30 April 2025 had no recommendations.
Fire safety exits were free from obstruction.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control measures and the use of PPE had been provided. Staff were also seen to adhere to correct IPC protocols.

3.3.5 Quality of Management Systems

Staff spoke positively about the managerial arrangements in the home, saying there was good support and availability.

It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults. The safeguarding policy was up-to-date and in accordance with legislation. Discussions with staff confirmed knowledge and understanding of the safeguarding policy and procedure. Staff also said that they felt confident about raising any issues of concern to management and felt these would be addressed appropriately.

It was established that the manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to the patient's next of kin and their aligned named worker, and as appropriate to RQIA.

Expressions of dissatisfaction were well recorded and had evidence that such expressions were taken serious and managed appropriately.

There was a system of audits and quality assurance in place. These audits included; care records, infection prevention and control, weights and nutrition, and wound care audits.

The home was visited each month by a representative on behalf of the responsible individual to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail. These reports are available for review by patients, their representatives, the Trust and RQIA.

4.0 Quality Improvement Plan/Areas for Improvement

One area of improvement has been identified where action is required to ensure compliance with regulations and standards.

	Regulations	Standards
Total number of Areas for Improvement	0	1

The one area of improvement and details of the Quality Improvement Plan was discussed with Ms Joy Hynds, Registered 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 4 **Stated:** First time **To be completed by:** 20 January 2026	The registered person shall ensure evaluations pertaining patients' mental health and well-being are recorded in sufficient detail. Ref: 3.3.3
	Response by registered person detailing the actions taken: A documented group supervision has been completed with all Nurses at planned Nurses meeting on 14/1/26 focusing on evidence based approaches to ensuring sufficient detail regarding patient's mental health and well-being are recorded in daily evaluations. From a Governance perspective, audit of such daily evaluations have been added to care plan audit documentation.

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

The Regulation and Quality Improvement Authority

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