The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Dungannon**

Provider: **Ann's Care Homes Limited**

Date of Inspection: **30 January 2026**

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 Limited
Responsible Individual/Responsible Person:	Mrs Charmaine Hamilton
Registered Manager:	Mrs Leena Mary Francis Correa
Service Profile – This home is a registered nursing home which provides nursing care for up to 36 patients who have a learning disability. The home is divided in two units; the Lambfields Unit and the Killybracken Unit. Patients' bedrooms are located on the ground floor. Patients have access to communal lounge and dining areas within each unit and a centralised garden area with access to seating.	

2.0 Inspection summary

An unannounced inspection took place on 30 January 2026, from 9.30am to 2.40pm. The inspection was conducted by a care inspector.

The inspection was undertaken to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

There was safe, effective and compassionate care delivered in the home and the home was well led by the manager.

It was evident that staff promoted the dignity and well-being of patients.

Patients said that living in the home was a good experience. Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

No areas of improvement were identified during this inspection.

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 appeared comfortable and at ease in their interactions with staff and their environment. Two patients said; "it is very good. The staff are very nice." and "I am very happy. I can get what I want to eat."

Staff spoke positively in terms of the provision of care and advised that there was good care provided in this home. Staff said there was good staffing levels, teamwork, training and managerial support.

Five returned patient questionnaires received following this inspection were all positive.

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.

Staff training records and schedule of supervision and appraisals were maintained well with good managerial oversight.

Staff registrations with the Nursing & Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC) were audited on a monthly basis. A review of these audits found these to be appropriately maintained.

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; if they wished to have a lie in or if they preferred to eat their breakfast later than usual.

3.3.2 Quality of Life and Care Delivery

Staff had knowledge and understanding of each individual patient's usual conduct, behaviours and means of communication. Responses and interventions of staff promote positive outcomes for patients.

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.

Staff said there was good support with seeking advice and training with patients' individual behaviours. This included the relevant professional(s) and where appropriate, the patient's representative.

Behavioural support plans were detailed in the patient's care plan. Consent was obtained from the patient's representative and they were informed of the approach or response to be used. Specific behaviour management programmes were approved by an appropriately trained professional and formed part of the patient's care plan.

Staff were provided with the necessary training, guidance and support in respect of these plans. Care was followed up by timely multi-disciplinary reviews of the patient's care plan.

At times some patients may require the use of equipment that could be considered restrictive or 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.

Examination of care records and discussion with the manager confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. For example, patients were referred to their GP if required.

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.

Observation of the serving of the lunchtime meal confirmed that enough staff were present to support patients with their meal. The atmosphere was calm and organised. It was observed that patients were enjoying their meal and their dining experience.

The importance of engaging with patients was well understood by the manager and staff. A designated activities co-ordinator was on duty, with a programme of small group and individual activities in place. Additional to this there was a display, of photographic and video activity participation and social outings, in the reception area.

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

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. 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, with good accessibility for patients to avail of.

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.

Review of the home's fire safety risk assessment dated 10 February 2025 evidenced that there was corresponding actions recorded of the six recommendations made from this assessment.

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 (IPC) measures and the use of personal protective equipment (PPE) had been provided. Staff were also seen to adhere to correct IPC protocols.

3.3.5 Quality of Management Systems

Mrs Leena Mary Francis Correa is the registered manager of this home since 21 May 2018. Staff spoke positively about the managerial arrangements in the home, saying that they would readily feel comfortable about raising any issue of concern.

It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk. 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.

There was a system of audits and quality assurance in place. These audits included; care records, infection prevention and control and dining room experience.

The home was visited each month by a representative on the 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

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Leena Mary Francis Correa, Registered Manager, as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority

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