The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **County Care Home**

Provider: **EBBAY Limited**

Date of Inspection: **29 April 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:	EBBAY Limited
Responsible Individual:	Mr. Patrick Anthony McAvoy
Registered Manager:	Mrs. Caroline McCrea

Service Profile – This home is a registered nursing home which provides nursing care for up to 52 patients.

Accommodation is provided over two floors. The ground floor unit provides accommodation for 31 patients within the general nursing care category of care and the lower ground floor level provides accommodation for 21 patients within the dementia category of care.

Each unit has its own shared communal lounge and dining areas and access to well appointed grounds.

2.0 Inspection summary

This unannounced inspection took place on 29 April 2026, from 9.15am to 3.40pm. The inspection was conducted by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to regulation and standards; and to assess progress with the seven areas of improvement identified by RQIA, during the last care inspection on 15 October 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The previous areas of improvement were 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. Patients said that living in the home was a good experience. Patients who were unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and interactions with staff.

This inspection resulted in three areas of improvement being identified. These were in respect of the preadmission assessment process for potential patients, smoking risk assessments and details of spiritual care to be recorded in care records.

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 were happy with the care in the home; that there was a nice atmosphere, staff were kind and attentive and they enjoyed the meals. Comments from patients included the following statements; "It is fabulous here. The staff are very friendly and kind. The food is delicious too.", "I am cared for very well here. All the staff are very good to me and I have all my comforts.", "I'm the best here. They (the staff) are all good." and "I am cared for the best here."

Frailer patients were seen to be comfortable and at ease in their surroundings and interactions with staff.

Six visiting relatives said that staff were kind, caring and attentive and management were readily available. One visitor said that they always found the home "spotlessly clean." Two visitors were seen to have a lovely rapport with staff on duty and remarked on such. One visitor said that they felt the care to be "a 100%" and any issues they may have with the home they were more than happy to raise these with management. One visitor said; "It is an excellent home. The staff are very good."

Staff spoke positively about their roles and duties, the provision of care, training and managerial support. Staff also said there was good team working and morale was good in the home.

There were no feedback from patient / representative or staff questionnaires received 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, 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 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 of staff on duty. Call assistance alarms were found to be answered promptly.

There was an effective system in place to manage the registration of nurses 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 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, 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.

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 patient choices in how and where they spent their day or how they wanted to engage socially with others.

It was established that safe systems were in place to safeguard patients with use of equipment that could be considered as restrictive, such as bedrails and alarm mats.

Examination of care records and discussion with the manager confirmed that the risk of falls were well managed and referrals were made to other healthcare professionals as needed. For example, patients were referred to the Trust's Specialist Falls Service, their GP, or for physiotherapy.

Observation of the dinner time meal, review of records and discussion with patients and staff indicated that there were systems in place to manage patients' nutrition and mealtime experience.

Prior to the mealtime, staff held a safety pause to consider those patients who required a modified diet. The dinnertime meal was appetising, wholesome and nicely presented.

It was observed that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. Patients spoke positively on the meals including the provision of choice.

A varied programme of activities and events was in place for patients to avail, both group and individual based. In the morning, a number of patients enjoyed a planned exercise session. In the afternoon entertainment was provided by a visiting clergyman or patients were enjoying the pleasant weather outside in the grounds of the home. Other patients were engaged in their own activity of choice, such as reading, watching television or resting.

An area of improvement was made to clearly document patients' spiritual care needs and contact details within assessments and care plans.

3.3.3 Management of Care Records

Patients' care records were maintained safely and securely.

The manager confirmed that a preadmission assessment is undertaken before a patient is admitted to the home. This is to ensure that the home can meet the assessed needs. An area of improvement was made for the preadmission assessment to clearly assess the associated risk of the open access to a stairwell in consultation with the patient's aligned named worker and representative.

Following admission care plans are developed to direct staff how to meet patients' needs. These included any advice or recommendations made by other health care professionals.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet patients' needs.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. Patients' bedrooms were comfortable and nicely personalised. Communal areas were suitably furnished and homely. Bathrooms and toilets were clean and hygienic.

The grounds of the home were very well maintained with good accessibility for patients to avail of.

Cleaning chemicals were stored safely and securely.

The home's most recent fire safety risk assessment was dated 28 January 2026. This assessment had corresponding evidence in place of actions taken in response to the six recommendations made.

Fire safety training, fire safety drills and fire safety checks were maintained on a regular and up-to-date basis.

An area of improvement was made for patients' risk assessments in relation to smoking to be person centred and in accordance with current safety guidance.

Review of records and observations confirmed that appropriate systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

Mrs. Caroline McCrea is the Registered Manager of the home.

Staff, relatives and patients commented positively about the management team and described them as supportive, approachable and able to provide guidance.

The manager had processes in place to monitor the quality of care and other services provided to patients. A comprehensive list of quality assurance audits was maintained on an up-to-date basis. Perusal of these audits found these to action plans in place for any issues identified.

Patients and relatives spoken with said that they knew how to report any concerns/complaints and said they were confident that the manager and responsible individual would address their concerns. Complaints were well documented and included confirmation whether the complainant was satisfied with the outcome.

Records of visits undertaken on behalf of the responsible individual were in detail with subsequent evidence of governance arrangements in the home.

4.0 Quality Improvement Plan/Areas for Improvement

Three 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	1	2

The three areas for improvement and details of the Quality Improvement Plan were discussed with Mrs. Caroline McCrea, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

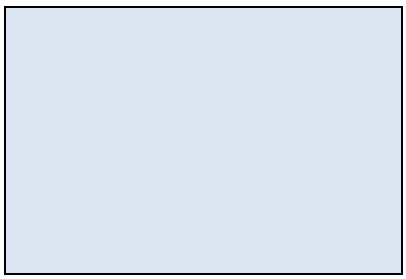
Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 15(1)(a) and (c) **Stated:** First time	The registered person shall ensure the preadmission assessment clearly assesses the associated risk of the open access to an identified stairwell in consultation with the patient's aligned named worker and representative. Ref: 3.3.3
To be completed by: 29 May 2026	**Response by registered person detailing the actions taken:** The preadmisson assessment document has been reveiwed to include the above environmental risk.

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)

Area for improvement 1 **Ref:** Standard 7(9) **Stated:** First time **To be completed by:** 29 May 2026	The registered person shall ensure clearly document patients' spiritual care needs and contact details in assessments and care plans. Ref: 3.3.2
	Response by registered person detailing the actions taken: All care plans have been reveiwed and updated to reflect spirtual care needs.
Area for improvement 2 **Ref:** Standard 4(8) **Stated:** First time	The registered person shall ensure that patients' risk assessments in relation to smoking are more person centred and in accordance with current safety guidance. Ref: 3.3.4
To be completed by: 29 May 2026	**Response by registered person detailing the actions taken:** A revised smoking risk assessment has been developed and implemented to reflect the above area of improvement.



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