

Inspection Report

Name of Service: Scrabo House

Provider: Scrabo House

Date of Inspection: 29 June 2026

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

1.0 Service information

Registered Provider:	Scrabo House
Responsible Person:	Mr Alexander Buchanan
Registered Manager:	Mr Grant Alexander Buchanan
Service Profile: This home is a registered Residential Care Home which provides health and social care for up to 17 residents living with dementia and general residential care to those over 65 years of age. Resident's bedrooms are located over two floors and residents have access to communal lounge areas, dining areas and outside garden areas.	

2.0 Inspection summary

An unannounced care inspection took place on 29 June 2026, from 9.25 am to 3.30 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 assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 30 June 2025; 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 residents 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 residents and that staff were knowledgeable and well trained to deliver safe and effective care.

Residents said that living in the home was a good experience. Residents were observed to be relaxed, comfortable and content in their home environment, and staff interactions were warm, positive and respectful.

While care was found to be delivered in a safe and compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery.

As a result of this inspection six areas for improvement from the previous care inspection were assessed as having been addressed by the provider. Full details, including new areas for improvement identified, 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 resident'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. 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

Residents told us they were happy living in the home, they felt well looked after and listened to by staff and management. Resident's comments included "staff are brilliant", "I feel safe staying here" and "the staff are helpful and patient".

Two relatives spoken with spoke highly of the care and services provided in the home. One relative told us that it "is a home from home".

Staff spoke positively in terms of the provision of care in the home and their roles and duties. Staff told us that the manager was supportive and available for advice and guidance.

There were no questionnaire responses returned following the inspection.

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 residents. There was evidence of robust systems in place to manage staffing.

Residents 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 residents in a timely way; and to provide residents 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.

A review of the person left in charge of the home in absence of the manager competency and capability assessments highlighted that the system used to monitor staff competency and capability assessments, required improvements to ensure accurate recording, timely reassessment and effective managerial oversight. An area for improvement has been identified.

The staff training matrix evidenced good over all compliance with mandatory training requirements. However advice was provided to the manager to ensure that Dysphagia and Deprivation of Liberty Safeguards (DoLS) training are also included in the system used to monitor staff training compliance. This will be reviewed at a future inspection.

A review of the system used to monitor staff supervision evidenced that staff had not received supervision in line with the required standard of twice per year. An area for improvement has been identified.

3.3.2 Quality of Life and Care Delivery

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

Staff interactions with residents were observed to be polite, friendly, warm and supportive and the atmosphere throughout the home was relaxed. Staff were knowledgeable of individual resident's needs, their daily routine, wishes and preferences.

Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs. Staff were also observed offering residents choice in how and where they spent their day or how they wanted to engage socially with others.

At times, some residents 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. Discussion with staff about restrictive practice, such as the keypad on the front door and their understanding of Deprivation of Liberty

Safeguards (DoLS) highlighted that staff were unclear as to whether or not they would, or should provide residents with egress from the home if they requested this. The need to ensure that residents with capacity have the right to freedom of movement which is not inappropriately restricted was discussed with the management team and an area for improvement identified.

Residents may require special attention to their skin care. Care records accurately reflected the residents' assessed needs and input from other professionals such as the District Nursing team.

Examination of care records and discussion with the manager confirmed that falls were well managed and referrals were made to other healthcare professionals as needed. For example, residents were referred to their GP if required. However, concerns about the review and update of falls risk assessments is discussed further in section 3.3.3.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents 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 lunchtime meal served in the main dining room confirmed that enough staff were present to support residents with their meal and that the food served appeared appetising and nutritious.

Activities for residents were provided which included both group and one to one activities. Activity records were mostly well maintained and included a range of activities including, music, arts & crafts, hairdressing, nail care and world cup football activity.

3.3.3 Management of Care Records

Residents' 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 residents' needs and included any advice or recommendations made by other healthcare professionals. However, advice was provided to the manager to ensure that staff who complete pre-admission assessments sign and date the document once completed.

Review of residents' care records identified concerns in relation to the development, review and update of care plans to ensure they reflected the residents' care needs. For example; documentation included a catheter care plan that was not relevant to the resident's current care needs, indicating that care plans had not been appropriately reviewed to ensure it remained accurate and up to date. Another resident who had an airflow mattress in place had no care plan in place to manage this aspect of care. An area for improvement has been identified.

For those residents living with dementia, care-planning relating to dementia care required improvement as these care plans were absent or lacking sufficient details resulting in limited guidance for staff to support the delivery of person centred dementia care. An area for improvement has been identified.

A sample of care files reviewed, evidenced that for residents assessed as needing a Deprivation of Liberty Safeguard (DoLS) there was no care plan in place to manage this aspect of care and support. An area for improvement has been identified.

It was also identified that residents risk assessments were not always reviewed or updated in a timely manner. For example, records showed that the falls risk assessment for one resident had not been reviewed since January 2025. The lack of timely review of this assessment increased the potential for outdated information to inform care delivery and risk management. Records also identified that a choking risk assessment had not been completed for a resident who required one, based on their assessed needs. An area for improvement has been identified.

A number of care records remained within residents' records despite no longer being current or applicable and should have been archived to ensure documentation accurately reflected residents' current care needs. An area for improvement has been identified.

3.3.4 Quality and Management of Residents' Environment

The home was clean and comfortable for residents. Bedrooms were tidy and personalised with photographs and other personal belongings for residents. Communal areas were well decorated, suitably furnished and homely.

Observations identified some concern with environmental risk management. For example; two containers of steradent denture cleaning tablets were located in a residents ensuite, which were easily accessible to anyone and presented a potential risk to residents and others. An area for improvement has been identified.

Review of records and observations confirmed that 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.

Fire safety measures were in place and well managed to ensure residents, staff and visitors to the home were safe.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mr Grant Buchanan has been the registered manager in this home since 6 December 2022.

Residents and staff commented positively about the manager and described him as supportive, approachable and able to provide guidance.

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 in the home. However, advice was provided to the manager to review care record audits to ensure they are effective in identifying shortfalls and driving the required improvements, based on the concerns identified during the inspection. An area for improvement has been identified.

Although staff meetings were held regularly, the quality of staff meeting agendas required improvement as they lacked sufficient structure and detail to support effective communication and governance. Meeting agendas were not detailed to demonstrate that key areas relating to residents care, safety and quality improvement were routinely addressed. An area for improvement has been identified.

Staff told us that they would have no issue in raising any concerns regarding residents' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further.

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
Total number of Areas for Improvement	2	9

Areas for improvement and details of the Quality Improvement Plan were discussed with Grant Buchanan, 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 14 (5) Stated: First time To be completed by: 29 June 2026	The registered person shall ensure that all staff fully understand what constitutes a restrictive practice and Deprivation of Liberty Safeguards (DoLS) in order to appropriately promote residents' freedom of movement. Ref: 3.3.2 Response by registered person detailing the actions taken: All staff were current and up to date with Deprivation of Liberty Safeguards (DoLS) training at the time of inspection. Following the inspection, all staff have received refresher training in relation to DoLS and restrictive practices to reinforce their knowledge and understanding. Staff have been reminded of the importance of promoting residents' freedom of movement and ensuring that any restrictive practice is appropriately identified, considered and managed in accordance with residents' individual needs and relevant guidance. Staff understanding will continue to be monitored through supervision, staff meetings and ongoing training.

Area for improvement 2 Ref: Regulation 14 (2) (a) & (c) Stated: First time To be completed by: 29 June 2026	The registered person shall ensure that all areas of the home to which residents have access are free from hazards to their safety. This area for improvement is made with specific reference to the storage of steradent denture cleaning tablets. Ref: 3.3.4 Response by registered person detailing the actions taken: Following the inspection, the storage arrangements for steradent denture cleaning products and other potentially hazardous items were reviewed. Lockable storage boxes have now been provided within residents' rooms to allow such products to be stored safely and securely. Residents will continue to be supported to access and use their personal products as appropriate, with staff supervision provided where required. Staff have been reminded of the importance of ensuring that potentially hazardous products are stored safely, while continuing to promote residents' independence, choice and autonomy. Storage arrangements will be monitored as part of ongoing environmental checks.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (Version 1.2) (Dec 2022)	
Area for improvement 1 Ref: Standard 25.3 Stated: First time To be completed by: 1 August 2026	The registered person shall ensure there is a robust system in place to monitor and oversee the competency and capability assessments for the person left in charge of the home in absence of the manager. Ref: 3.3.1 Response by registered person detailing the actions taken: The home has an established system whereby staff considered competent and capable of being left in charge in the absence of the manager are assessed and issued with a competency certificate. Following the inspection, this process has been further strengthened through the introduction of a detailed competency assessment, to be completed in addition to the existing competency certificate. All staff who may be left in charge have now completed and signed the competency assessment. Going forward, competency assessments and certificates will be reviewed and updated as required to ensure that staff left in charge continue to demonstrate the appropriate knowledge, skills and capability to undertake this responsibility.

Area for improvement 2 Ref: Standard 24.2 Stated: First time To be completed by: 1 August 2026	The registered person shall ensure that staff have recorded individual, formal supervision no less than every six months. Ref: 3.3.1 Response by registered person detailing the actions taken: At the time of inspection, all staff had completed their required formal supervision and appraisal and no member of staff was overdue for supervision. The next cycle of staff supervision was due to commence the following month. Dates for these supervision sessions have been scheduled and communicated to staff. To further strengthen the existing system, a forward schedule will be maintained to clearly identify when each member of staff's next formal supervision is due and to ensure that recorded formal supervision continues to take place at least every six months.
Area for improvement 3 Ref: Standard 6.6 Stated: First time To be completed by: 29 June 2026	The registered person shall ensure that care plans are reflective of the current and up to date assessed needs of the resident. Ref: 3.3.3 Response by registered person detailing the actions taken: Following the inspection, residents' care plan documentation has been reviewed. Previous and superseded care plans which had been retained within residents' current care files to provide a historical record have now been removed from the active care plan section and appropriately archived. Current care files will contain the resident's most up-to-date needs assessment and care plans, ensuring that staff can clearly identify the resident's current assessed needs and the care and support required. Historical documentation will continue to be retained within the resident's archived records as appropriate. Care plans will continue to be reviewed regularly and updated whenever there is a change in assessed need. A comprehensive review of each resident's needs assessment and care plan will also be undertaken annually to ensure that the documentation remains current, clear and reflective of the resident's needs.

Area for improvement 4 Ref: Standard 6 Stated: First time To be completed by: 29 June 2026	The registered person shall ensure that for those residents living with dementia, a written care plan is in place with sufficient detail to meet the resident's needs and direct care for staff. Ref: 3.3.3 Response by registered person detailing the actions taken: At the time of inspection, residents living with dementia had care planning in place; however, it was identified that further detail could be included to provide clearer direction to staff. Following the inspection, the care plans of all residents living with dementia have been reviewed and expanded to provide more comprehensive, person-centred information and clear guidance for staff regarding each resident's individual needs, preferences, communication, behaviours and support required. These care plans will continue to be reviewed regularly and updated in response to any changes in the resident's assessed needs.
Area for improvement 5 Ref: Standard 6.6 Stated: First time To be completed by: 29 June 2026	The registered person shall ensure that any resident who is subject to Deprivation of Liberty Safeguards (DoLS) has an up to date care plan in place, which details the rationale for the DoLS and this is kept under regular review. Ref: 3.3.3 Response by registered person detailing the actions taken: Following the inspection, the care plans of all residents subject to Deprivation of Liberty Safeguards (DoLS) have been reviewed and amended to clearly document the rationale for the DoLS arrangements in place. Care plans will be kept under regular review to ensure that the rationale remains current and reflective of each resident's assessed needs and circumstances. Any changes to a resident's DoLS arrangements will be reflected within their care plan accordingly.
Area for improvement 6 Ref: Standard 6.6 Stated: First time To be completed by: 29 June 2026	The registered person shall ensure that where a risk has been identified regarding a resident, a risk assessment is completed and kept under regular review. Ref: 3.3.3 Response by registered person detailing the actions taken: The risk assessment auditing process has been strengthened to ensure that risk assessment review dates are monitored and that assessments are reviewed within the required timescale, or sooner where there is a change in the resident's needs or circumstances.

Area for improvement 7 Ref: Standard 22.6 Stated: First time To be completed by: 1 September 2026	The registered person shall ensure there is a system in the home for archiving of care records to ensure outdated documentation is removed in a timely manner. Ref: 3.3.3 Response by registered person detailing the actions taken: This Area for Improvement substantially overlaps with Area for Improvement 3, which also relates to the presence of historical and superseded documentation within residents' active care records. As detailed in the response to Area for Improvement 3, the documentation identified during the inspection had been retained to provide a chronological and historical record of residents' care. Following the inspection, superseded documentation has been removed from active care files and appropriately archived, ensuring that current files clearly reflect residents' present assessed needs. The actions taken in response to Area for Improvement 3 therefore also address this Area for Improvement. To further formalise the existing process, care records will be reviewed on an ongoing basis and superseded documentation will be transferred to the resident's archived records. A comprehensive annual review will also be undertaken to ensure active care files contain current and relevant documentation while maintaining an appropriate historical record.
Area for improvement 8 Ref: Standard 20.10 Stated: First time To be completed by: 29 June 2026	The registered person shall ensure that care record audits are robust in driving the improvements required, if actions are identified these are completed and signed off by the relevant person responsible. Ref: 3.3.5 Response by registered person detailing the actions taken: A programme of care record auditing was already in place at the time of inspection, and completed care record audits were available and provided as evidence to the inspector. Following the inspection, the care record audit process has been reviewed and strengthened. The areas identified for improvement during this inspection will be incorporated into the audit programme to ensure that these matters are routinely monitored going forward. Where an audit identifies an action required, this will be clearly recorded, allocated to the appropriate person and monitored through to completion and sign-off. This will provide a clear audit trail demonstrating that identified actions have been addressed and that improvements are sustained.

Area for improvement 9 Ref: Standard 25.8 Stated: First time To be completed by: 29 June 2026	The registered person shall ensure that staff meetings include a robust agenda which is resident focused, supports communication, governance and service improvement. Ref: 3.3.5 Response by registered person detailing the actions taken: Formal staff and resident meetings were already being undertaken and recorded at the time of inspection. Staff meeting agendas included matters relevant to the operation of the home, including staffing, training, communication, equipment and other service issues. Resident-specific needs, changes and concerns were routinely communicated to staff through established systems including staff handovers, care documentation and ongoing communication throughout each shift. Following the inspection, the formal staff meeting agenda has been reviewed and expanded to provide a greater focus on resident care and outcomes, alongside the existing operational matters. Future meetings will include discussion of relevant resident-focused matters, communication, governance, quality assurance and opportunities for service improvement, with any actions identified clearly recorded and followed through.
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The Regulation and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority

James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA



Tel: 028 9536 1111



Email: info@rqia.org.uk



Web: www.rqia.org.uk



Twitter: @RQIANews