

Inspection Report

Name of Service: Hamilton Court

Provider: EBBAY Limited

Date of Inspection: 9 July 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:	EBBAY Limited
Responsible Individual:	Mr Patrick Anthony McAvoy
Registered Manager:	Mr Daniel Dougan
Service Profile – This home is a registered nursing home which provides nursing care for up to 40 patients living with dementia. The home is a single storey building with individual bedrooms, lounges, bath/shower rooms and toilets located throughout. There is an enclosed courtyard providing patients with access to outside space.	

2.0 Inspection summary

An unannounced inspection took place on 9 July 2026 from 9.10am to 5.00pm 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 29 May 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 patients and the service was well led.

Patients spoke positively when describing their experiences of living in the home. Refer to Section 3.2 for more details.

As a result of this inspection the area for improvement from the previous care inspection was assessed as having been addressed and one new area for improvement was identified. Details can be found in the main body of the 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 were well presented in their appearance and were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. One told us, "This is a great place; I can do and go where I want. Staff are very nice". Another commented, "It's OK here. The food is nice and the staff are nice". We received no questionnaire responses from patients or relatives.

Staff told us that they were happy working in the home and enjoyed engaging with the patients. They felt that they worked well together and were supported by management to do so. There were no responses from the staff online survey.

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. All appropriate recruitment safety checks had been verified prior to staff commencing in post. Newly employed staff completed a structured induction at the commencement of their employment which included mandatory training.

A robust system was in place to ensure that all staff were compliant with pre-determined mandatory training requirements. Training records showed an overall compliance rate of 93.5 percent. Staff confirmed that they were further supported through staff supervisions and staff appraisals. A system was in place to ensure that staff received two supervisions per year and an annual appraisal.

Staff told us they were satisfied that the number and skill mix of staff on duty met the needs of the patients. Patients raised no concerns in relation to the staffing arrangements. Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty and that staff responded to requests for assistance promptly in a caring and compassionate manner.

Minutes of staff meetings held were available to all staff to aid in the communication within the home.

Checks were made to ensure nurses maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

3.3.2 Quality of Life and Care Delivery

Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences. Interactions between staff and patients were noted to be caring and compassionate. Patients spoke fondly about the staff.

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. Patients told us that they had choice in where and how they spent their day, what they wore and what they had to eat.

Staff confirmed that they received a detailed handover at the commencement of their shift and the information shared included important aspects of patients' needs, especially changes to care.

Patients who required special attention with skin care were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs. Where a patient had a wound, wound care records directed staff on how to treat the wound and wound evaluation records monitored the progress of the treatment. Wound care records reflected the views of the podiatrist and the tissue viability nurse.

Patients had good access to food and fluids throughout the day and night. Patients were safely positioned for their meals and the mealtimes were appropriately supervised. Staff communicated well to ensure that every patient received their meals in accordance with their assessed needs. Food was only served when the patients were ready to eat their meal. The meals served appeared appetising and nutritious. Staff sat with patients when providing assistance and assistance was given in a caring and an unhurried manner. Patients told us that they enjoyed their meal.

Nutritional care records consistently referenced the current assessed needs of the patients throughout. Where patients required supplements for weight management, the supplements

taken were recorded as part of the food/fluid intake records. Personal care records evidenced daily oral care delivery.

Gaps were identified in bowel management. Appropriate actions had not been taken when a significant gap between bowel movements had been identified. This was discussed with the manager and identified as an area for improvement.

Hourly checks were in place for those who had to, or, wished to remain in their bedrooms and for those who liked to walk around the unit.

Two new activities therapists had been recruited and were awaiting verification checks prior to starting. In the interim, care assistants were nominated to provide activities incorporating both group and one to one activity. A programme of activities was displayed and included exercise, bowling, music, newspaper reading, gardening, quiz and arts and crafts. Several pieces of completed arts and crafts had been displayed throughout the home. Patients had attended a barbeque on the grounds the day before inspection and were awaiting a planned entertainer to come to the home on the day of inspection. Birthdays and annual holidays were celebrated. Records were kept of all activity engagements with patients.

Relatives were invited to attend a planned relatives' meeting. Quality questionnaires had recently been sent to patients and relatives to allow them the opportunity to feedback their opinions of the care and service delivery in the home. The manager confirmed that feedback would be compiled into a report accessible to all parties involved.

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 the patients' needs. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate. Risk assessments and care plans were reviewed regularly to ensure that they remained reflective of patient need. Care records were stored securely in an archive storeroom.

Supplementary care records were maintained to evidence the care delivered to patients. The records included personal care delivery, food and fluid intake, repositioning, checks made on patients and continence care.

Nurses completed daily progress notes to monitor and evaluate the care delivered to the patients in their care. We discussed ways of enhancing the recording of the daily evaluations.

3.3.4 Quality and Management of Patients' Environment

There was evidence of recent environmental improvements in the home. Twenty bedrooms and the sunroom had recently been repainted as part of an ongoing painting programme. Vanity unit doors and worktops had been replaced in bedrooms. Externally the courtyard had been neatened and window sills around the building repaired.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. Storage and communal rooms were maintained clean and tidy. There were no malodours in the home.

Corridors and fire exits were clear of clutter and obstruction should the need to evacuate occur and fire extinguishers were easily accessible. Fire safety checks were regularly conducted. Fire drills had been conducted and a system in place to ensure all staff were involved in, at least, one fire drill per year.

In addition to fire safety checks, other checks were conducted to ensure safety with, for example, wheelchairs in use, nurse call system, temperature in the building, window restrictors in place and with the break glass panels.

Items which could be considered hazardous to patients had all been securely stored and none were accessible to patients. Staff consulted were aware of what constituted a hazard. An area for improvement in this regard has been met.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. Personal protective equipment and hand hygiene facilities were readily available throughout the home. Good infection control practices were identified during the inspection.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mr Daniel Duggan has been registered as manager of the home since 8 June 2018. Staff commented positively about the manager and described him as supportive and approachable. The manager was supported by a deputy manager.

In the absence of the manager there was a nominated nurse-in-charge (NIC) to provide guidance and leadership. The NIC was clearly identified on the duty rota.

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 had a suite of audits to complete.

Accidents in the home were monitored monthly for patterns and trends in an effort to prevent further falls from occurring. Action plans were developed from the review and shared with staff. The provider company developed their own Post Falls Guidelines Monitoring Template for staff to utilise when a patient fell and the manager confirmed that a 24-hour post fall review was completed after a fall to ensure that the correct actions had been taken and the correct persons notified.

There were no ongoing or recent complaints relating to the home. There was a system in place to manage any complaints received in accordance with the Model Complaints Handling Procedure. All compliments received were shared with staff.

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.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	1

The area for improvement and details of the Quality Improvement Plan were discussed with Daniel Duggan, Registered Manager and Sharon Loane, Operational Director, 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 21 Criteria (11) Stated: First time To be completed by: 9 August 2026	The registered person shall review patients' bowel management to make sure that care plans identify the actions to take when outside of normal bowel patterns and that these actions are taken. Ref: 3.3.2 Response by registered person detailing the actions taken: All care plans have been reviewed and updated to clearly record normal bowel patterns and the actions required when deviations occur. Staff have been reminded to document bowel movements consistently and to follow escalation steps when patterns fall outside normal expectations. Regular reviews and ongoing monitoring are now in place to ensure these actions are completed and sustained.

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