The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Strangford Court**

Provider: **Ann's Care Homes**

Date of Inspection: **11 September 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:	Ann's Care Homes
Responsible Individual:	Mrs Charmaine Hamilton
Registered Manager:	Ms Claire Quail
Service Profile – This home is a registered nursing home which provides nursing care for up to 38 patients. The home is divided into two units; The Oakland Suite provides care to people who have a learning disability and The Millar Suite provides care to people who have a dementia. There are communal dining and lounge areas within both units.	

2.0 Inspection summary

An unannounced inspection took place on 11 September 2026 from 9.15am to 4.15pm 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 inspection on 16 April 2026; 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 areas for improvement from the previous care inspection were assessed as having been addressed by the provider and no new areas for improvement were identified.

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. Patients chatted freely and did not raise any concerns about staff or living in the home.

Relatives were complimentary on the care their loved one was receiving. During the inspection a relative told us, “The staff are all lovely and welcoming. (name) is always well presented. Hair and nails done every week. Any concern raised was dealt with immediately. The manager keeps a good eye on the tidiness of rooms and makes sure linen is ironed properly”. Another commented, “We have no concerns at all”.

Staff told us that they felt well trained to perform their duties and that teamwork in the home was good. Staff thought that the manager and management team were approachable and they would not have any concerns about raising concerns if they felt that they needed to.

There were no responses from patients’ or relatives’ questionnaires and we received no responses from the staff 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.

Recruitment safety checks had all 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 staff were compliant with pre-determined mandatory training requirements.

Staff told us they were satisfied that the number and skill mix of staff on duty met the needs of the patients. One staff member raised concerns which were shared with the manager for their review and action as appropriate. Several patients were on enhanced one to one care. A review of the duty rota confirmed that at all times one to one care had been provided in addition to the planned staffing levels.

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.

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. 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. Handover sheets were available to be used as an aide memoire.

Pressure management risk assessments were completed and reviewed monthly to ensure that skin integrity was maintained. Patients who required special attention with skin care were assisted by staff to change their position and care records accurately reflected the patients' assessed needs. Care plans identified each patient's mobility requirements and how to safely move and handle each patient, where appropriate.

Continence needs were assessed on admission and care plans identified any continence aids required to assist patients. Care plans identified how to manage constipation and bowel management records were detailed using the Bristol Stool Score.

A system was in place to ensure that inhaler spacer devices were cleaned and replaced in line with manufacturer's guidelines. Each spacer device in use had been labelled for individual patient use.

Patients' weights were monitored monthly, or more frequently if required, for weight loss or weight gain. Nutritional assessments were completed and the nutritional care plans were in line with the recommendations from dieticians and/or speech and language therapists. Food and fluid intakes had been monitored well.

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. A nominated mealtime coordinator conducted a safety pause with staff before food was served to ensure that patients received the correct food and drinks in accordance with their nutritional needs. Food was only served when the patients were ready to eat. The meals served appeared appetising

and nutritious. Staff sat with patients when helping with their meal and assistance was given in an unhurried manner. Patients enjoyed their meal and spoke positively on the quality of their meal.

Activities for patients were provided incorporating both group and one to one engagement. On admission the activities therapist would liaise with the patient and/or next of kin to establish the patient's interests and hobbies. A programme of activities was displayed allowing patients to see what was planned for each day. Activities included bingo, sensory games, reading, massage, dancing, chatting, movies and arts and crafts. Patients engagements with the activities were recorded. Residents' meetings were hosted six monthly.

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 and also reviewed when patients returned to the home from a period of time in, for example, hospital.

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.

Care records were stored securely.

3.3.4 Quality and Management of Patients' Environment

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. Access to rooms containing hazards had been restricted. There were no lingering 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 drills had been completed to aid in preparation for evacuations. Staff had attended additional fire safety training and fire safety checks were regularly conducted. The fire risk assessment was current and actions required had been managed in a timely manner.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. Staff were observed to be bare below the elbow and performed hand hygiene at the appropriate times. Personal protective equipment and hand hygiene facilities were readily available throughout the home.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Ms Claire Quail has been registered as manager of the home since 10 March 2011. Staff commented positively about the manager and described her as supportive and approachable and always available to provide any advice or guidance.

In the absence of the manager there was a nominated nurse-in-charge (NIC) to provide guidance and leadership. The NIC first completed a competency and capability assessment on taking charge prior to commencing the role and 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.

The number of accidents in the home was low. Accidents were monitored monthly for pattern and trends in an effort to potentially prevent any future falls from occurring.

There were no recent or ongoing complaints relating to the home. There was a system in place to manage any complaints received. Complaints were managed in accordance with the Model Complaints Handling Procedures. 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. Patients and relatives were satisfied that if they raised any concerns, these would be dealt with by the manager or person in charge and in a timely manner.

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 Claire Quail, Manager and Barbara Armstrong, Regional 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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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