

# Inspection Report

10 May 2024



## Daisyhill Private Nursing Home

Type of Service: Nursing Home  
Address: 50a Ahoghill Road, Randalstown, BT41 3DG  
Tel no: 028 9447 9955

[www.rqia.org.uk](http://www.rqia.org.uk)

---

Assurance, Challenge and Improvement in Health and Social Care

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

## 1.0 Service information

<b>Organisation:</b> Town & Country Care Homes Limited	<b>Registered Manager:</b> Ms Foteini Kourakou
<b>Responsible Individual:</b> Dr Marina Lupari	<b>Date registered:</b> 29 April 2024
<b>Person in charge at the time of inspection:</b> Ms Foteini Kourakou	<b>Number of registered places:</b> 25
<b>Categories of care:</b> Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years.	<b>Number of patients accommodated in the nursing home on the day of this inspection:</b> 25
<b>Brief description of the accommodation/how the service operates:</b> This home is a registered nursing home which provides nursing care for up to 25 people who have a learning disability. Patients' bedrooms are located over two floors. Patients have access to communal dining and lounge areas within the home and a garden area to the back of the home.	

## 2.0 Inspection summary

An unannounced inspection took place on 10 May 2024 from 10.00am to 4.30pm by two care inspectors.

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

Patients were well presented in their appearance and appeared comfortable and settled in their environment. Patients told us that they were happy living in the home and engaging with staff. Comments received from patients and staff are included in the main body of this report.

We found that there was safe, effective and compassionate care delivered in the home and the home was well led by the manger/management team. There were no areas for improvement identified as a result of this inspection.

### **3.0 How we inspect**

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service 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 RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with the registered manager and management team at the conclusion of the inspection.

### **4.0 What people told us about the service**

During the inspection we consulted with patients and staff. Patients told us that they felt safe in the home and were offered choice in how they spent their day. Staff told us that they worked well together and enjoyed engaging with the patients. Staff also confirmed that there were good working relationships between staff and the home's management team.

There were six questionnaire responses received from patients and one from a relative. Comments received were all positive in nature. One patient commented, "If there is something which is bothering me I tell the staff and they sort it out". Another commented, "I feel safe when the staff are giving me care; they are always around when I need them or need reassurance". We received no feedback from the online staff survey.

## 5.0 The inspection

### 5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to the nursing home was undertaken on 27 July 2023 by two care inspectors; no areas for improvement were identified.

## 5.2 Inspection findings

### 5.2.1 Staffing Arrangements

A comprehensive pre-determined list of pre-employment checks had been completed and verified prior to any new employee commencing work in the home. All staff completed an induction to become more familiar with the homes policies and procedures. A booklet was completed to record the topics of induction covered. A list of training was identified for the new staff member to complete as part of the induction process. The manager maintained a list of when staff commenced/completed their induction and a list of when probationary meetings were due.

Staff had a suite of mandatory training topics to complete annually to maintain their knowledge and skills in order to provide safe and effective care. The majority of training was completed face to face and some electronically. Training topics included falls awareness, challenging behaviours, adult safeguarding, deprivation of liberty and first aid. A system was in place to ensure staff completed their training.

Staff confirmed that they received an annual appraisal to review their performance and, where appropriate, identify any training needs. Staff also confirmed that they received recorded supervisions on a range of topics.

Checks were made to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council (NMC) and care staff with the Northern Ireland Social Care Council (NISCC).

Patients raised no concerns in regard to the staffing arrangements in the home. One commented, "The care from the staff makes me feel safe because they are always there when I need them". The relative confirmed that their loved one's needs were 'very complex and challenging' and was happy to know that their needs were being met in the home.

Staff were content that the staffing levels and skill mix met the patient's needs. The staff duty rota captured all of the staff working in the home and under which designation they worked. A staff member commented, "We have a good routine here; all tasks are delegated". Staff were complimentary of the teamwork in the home. One told us, "It's brilliant, we all get on together very well". Another commented, "It is very easy to communicate with each other". Staff were observed to work well and communicate well with one another during the inspection. Care was delivered in a caring and compassionate manner.

### 5.2.2 Care Delivery and Record Keeping

Patients' needs were assessed 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. Risk assessments and care plans were reviewed regularly to ensure that they remained relevant and reflective of actual care needs. Patients' care records were held confidentially. All staff received a handover at the commencement of their shift to keep them informed of any changes to the care needs of patients. There was evidence that the handover reports were discussed at a recent staff meeting.

Care records were well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Patients' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each patients' care needs and what or who was important to them.

Supplementary care records were completed to evidence the care given to patients. These records confirmed patients' food and fluid intake, when they were checked and the personal care that was given to them.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

Incident forms were completed electronically by staff to record any accidents or incidents which occurred in the home. A falls' safety cross was utilised to monitor the number of falls each month. The number of falls were low. Falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented. In addition, falls in the home were audited to ensure that the correct actions were taken following a fall; the correct documentation completed and/or updated and the correct people notified.

At mealtimes the menu was displayed in written and pictorial format. Patients had a choice of meals at mealtimes. The lunch meal was well supervised with several patients requiring one to one care at this time. Safe systems were in place to ensure that each patient received the correct modification of meals. Food served appeared appetising and nutritious. Portion sizes were appropriate for the patients to whom the food was served. Patients had access to food and fluids throughout the day.

### 5.2.3 Management of the Environment and Infection Prevention and Control

During the inspection we reviewed the home's environment including a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. Patients' bedrooms were personalised with items important to them. Bedrooms were suitably furnished and decorated. Appropriate doors leading to rooms which contained hazards to patients had been locked. The home was warm, clean and comfortable.

Staff had received training in fire safety and fire drills were conducted regularly with reports of the drills completed. Fire safety checks, including fire door checks and fire alarm checks, were conducted regularly. Actions had been taken in response to the most recent Fire Risk Assessment. Corridors in the home were free from clutter and obstruction as were the fire exits should patients have to be evacuated. Fire extinguishers were easily accessible.

Infection prevention and control audits were conducted monthly. In addition, hand hygiene and use of personal protective equipment (PPE) audits were completed. There was evidence where management had met with staff during a recent staff huddle to feedback findings on the use of PPE. Good compliance on infection control practices were observed during the inspection.

#### **5.2.4 Quality of Life for Patients**

It was observed that staff provided care in a caring and compassionate manner. It was clear through patient and staff interactions that they knew one another well and were comfortable in each other's company.

A socialisation lead was employed to promote socialisation and the provision of activities. Care staff also engaged in activities with patients. A monthly activities programme was available for review. Activities included spa days, international world days, board games, music, karaoke, arts and crafts, relaxing, reminiscence and exercises. Activities were conducted on a group basis or on a one to one basis where this was preferred. Patients were taken outside for games or walks, weather permitting, and/or out in the bus for a drive. Individual records of activity involvement were maintained. Patients told us that they enjoyed engaging in activities.

Patients had the opportunity to attend monthly patients' meetings to share their views on the service provision in the home. Minutes of these meetings were drafted to evidence the discussions which had taken place. Patients could share what they were happy with; anything that they didn't enjoy and anything additional that they would like to do.

In addition to the complaints' records, patients had a dissatisfaction log to record the detail of dissatisfaction and how this was resolved.

Visiting had returned to pre-covid arrangements in line with Department of Health guidelines. Patients were free to leave the home with family members if they wished. Patients, who could, were also free to leave the home alone to go to the shop, for example.

#### **5.2.5 Management and Governance Arrangements**

Since the last inspection Foteini Kourakou had registered with RQIA as manager of the home. Discussion with the manager and staff confirmed that there were good working relationships between staff and the manager. Staff told us that they found the manager and management team to be 'approachable'.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff had a good understanding of the home's organisational structure should they need to escalate their concern and were aware of the departmental authorities that they could contact should they need to escalate further.

The manager confirmed their own internal governance practices in order to monitor the quality of care and other services provided to patients. A monthly list identified which audits were to be completed and who was responsible for completing them. Following the completion of the audits, a summary of audit findings was collated and shared with the responsible individual and staff. Audits were conducted on, for example, patients' care records, restrictive practice, medicines management, staff registrations, staff training and the environment.

In addition to the audits, the manager completed a recorded weekly walk around the home to spot check the environment and care records and consult with staff and patients. A 'Monthly Improvement Log' was collated to record improvements made in relation to estates, nursing care, caring roles and socialisation.

The manager identified that the home managers of Town and Country Homes achieved second place in the Royal College of Nursing Independent Sector Leadership Challenge 2024. The award was proudly placed at the reception area to the home.

The home was visited each month by a representative of the registered provider 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 and completed reports were available for review by patients, their representatives, the Trust and RQIA. Where improvement actions were required, a separate action plan was included with the report. The action plan would be reviewed at the subsequent monthly monitoring visit to ensure completion. In addition, a separate Regulation 29 monthly visit conclusion was drafted to highlight the monitoring findings.

A complaint's file was maintained and complaints records were reviewed monthly for any learning. The number of complaints made to the home was low. A compliment's log was completed containing verbal compliments, thank you cards, emails of thanks and any gifts received. A compliments book was available at reception for anyone to complete. The manager confirmed that all compliments received were shared with the staff.

## **6.0 Quality Improvement Plan/Areas for Improvement**

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Foteini Kourakou, Registered Manager and the management team, as part of the inspection process and can be found in the main body of the report.



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](mailto:info@rqia.org.uk)  
**Web** [www.rqia.org.uk](http://www.rqia.org.uk)  
**Twitter** @RQIANews

Assurance, Challenge and Improvement in Health and Social Care