

# Inspection Report

**Name of Service:** Ladyhill Private Nursing Home

**Provider:** Town and Country Care Homes Ltd

**Date of Inspection:** 3 July 2025

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

## 1.0 Service information

<b>Organisation/Registered Provider:</b>	Town & Country Care Homes Limited
<b>Responsible Individual:</b>	Mr Christopher Philip Arnold
<b>Registered Manager:</b>	Miss Faye McDonnell – not registered
<b>Service Profile:</b> Ladyhill Private Nursing Home is a nursing home registered to provide nursing care for up to 28 patients. Patients' bedrooms are located over one floor. Patients have access to communal dining and lounge spaces in the home. Patients also have access to a garden area around the home.	

## 2.0 Inspection summary

An unannounced inspection took place on 3 July 2025, from 10.15am to 1.30pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The area for improvement identified at the last care inspection was carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. However, improvements were necessary in relation to the management of insulin and medicines storage.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, patients were being administered their medicines as prescribed.

Details of the inspection findings, including the area for improvement carried forward for review at the next inspection, and new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients well.

RQIA would like to thank the staff for their assistance throughout the inspection.

### **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 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, information held by RQIA about this home was reviewed. This included areas for improvement identified at previous inspections, 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.

#### **3.2 What people told us about the service and their quality of life**

Questionnaires completed by/on behalf of patients indicated that staff provide patients with enough time to take their medicines, are available to answer questions about their medicines and provide pain relief when needed. Comments included: "I like how the staff have good banter with me and cheer me up".

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

No responses to the staff survey were received following the inspection.

### **3.3 Inspection findings**

#### **3.3.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?**

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it.

At times patients' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments.

The personal medication records reviewed were mostly accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. A small number of minor discrepancies, for example, omitted medicine formulations were highlighted to the manager for immediate corrective action and on-going vigilance.

Some obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly. Records with attached pictures of patients to aid in identification had recently been archived in error. Both issues were addressed during the inspection.

Copies of patients' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets etc.

The management of distressed reactions, pain and thickening agents was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed.

The management of insulin was reviewed. A patient specific care plan was in place which detailed the insulin regime and provided direction on what action to take if a patient's blood sugar is outside of the recommended range. However, one in-use insulin pen had not been labelled with the patient's name and the date of opening had not been recorded to allow audit and disposal at expiry. An area for improvement was identified.

### **3.3.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?**

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

Records reviewed showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. Satisfactory arrangements were in place for medicines requiring cold storage, the storage of controlled drugs and the safe disposal of medicines.

The temperature of the medicine storage area was monitored daily. Review of these records indicated that the temperature had regularly exceeded 25°C over the past month; medicines were therefore not stored in line with the manufacturers recommendations. This had not been escalated by staff and no corrective action had been taken. An area for improvement was identified.

### **3.3.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?**

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. The records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plan. Written consent and care plans were in place when this practice occurred.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits had been discussed with staff and addressed. With the exception of one insulin pen, the date of opening was recorded on medicines to facilitate audit and disposal at expiry.

### **3.3.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?**

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

A review of records indicated that satisfactory arrangements were in place to manage medicines at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. There was evidence that any discrepancies had been followed up in a timely manner to ensure that the correct medicines were available for administration. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

### **3.3.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?**

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

### **3.3.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?**

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that their staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Medicines management policies and procedures were in place.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

## **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
<b>Total number of Areas for Improvement</b>	1*	2*

\* the total number of areas for improvement includes one that has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Faye McDonnell, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005</b>	
<p><b>Area for improvement 1</b></p> <p><b>Ref:</b> Regulation 13 (1) (a)</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> With immediate effect (23 January 2025)</p>	<p>The registered person shall ensure that all nursing and care staff coming on duty receive a detailed handover on the patient/s that they will be caring for.</p> <hr/> <p><b>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.</b></p> <p>Ref: 2.0</p>
<b>Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022</b>	
<p><b>Area for improvement 1</b></p> <p><b>Ref:</b> Standard 30</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 3 July 2025</p>	<p>The registered person shall ensure that in use insulin devices are individually labelled to denote ownership and the date of opening is recorded to facilitate audit and disposal at expiry.</p> <p>Ref: 3.3.1</p> <hr/> <p><b>Response by registered person detailing the actions taken:</b> New SOP developed v1 3rd July 2025 with all RNs to advise of appropriate storage of Insulin and ensure compliance with same. SOP states: Once opened, insulin pens must be stored at room temperature (below 25°C) in accordance with manufacturer guidelines, unless otherwise specified. Each insulin pen or vial in use must be clearly labelled with the following:</p> <ul style="list-style-type: none"> <li>o Resident’s full name</li> <li>o Date of birth (DOB)</li> <li>o Date of opening</li> <li>o Signature of the RN who opened it</li> </ul> <p>Opened insulin must be discarded after 28 days (or as per manufacturer’s instructions). The expiry date should be calculated and noted on the pen label.</p>

	<ul style="list-style-type: none"> <li>- Weekly checks of insulin storage and labelling will be carried out by the Acting Nurse Manager or Deputy Nurse Manager.</li> <li>- Monthly audits of insulin administration and storage practices will be conducted to ensure compliance with this SOP when a resident prescribed Insulin is within Ladyhill PNH.</li> </ul>
<p><b>Area for improvement 2</b></p> <p><b>Ref:</b> Standard 30</p> <p><b>Stated:</b> First time</p>	<p>The registered person shall ensure that the treatment room temperature is maintained at or below 25°C to ensure medicines are stored in accordance with manufacturers’ instructions.</p> <p>Ref: 3.3.2</p>
<p><b>To be completed by:</b> 3 July 2025</p>	<p><b>Response by registered person detailing the actions taken:</b></p> <p>An ongoing issue with maintaining the clinical room temperature within the required range of 18–25°C was discussed with the maintenance team. Due to the environmental structure of the room—specifically, the presence of only a fixed skylight window and two small vents which were not providing adequate airflow and temperature regulation were not achievable.</p> <p>Following consultation, it was agreed that a ceiling ventilation unit would be installed to improve air circulation and support consistent temperature control. This installation was completed on 16th July, and since then, the temperature has been maintained within the 18–25°C range.</p> <p>To ensure ongoing compliance with manufacturer guidelines, the Acting Nurse Manager has and will continue to carry out weekly temperature checks, along with random spot checks, to monitor the effectiveness of the ventilation. Any deviations from the recommended temperature range will be actioned immediately.</p>



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