The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Sanville**

Provider: **Abbey Private Nursing Home Ltd**

Date of Inspection: **11 & 12 September 2025**

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

1.0 Service information

Organisation/Registered Provider:	Abbey Private Nursing Home Ltd
Responsible Individual:	Mrs Alice McAleer
Registered Manager:	Mrs Eilis Bell
This home is a registered nursing home which provides nursing care for up to 40 patients, including patients living with a physical disability, dementia, those with mental health needs and patients with a learning disability. The home is also approved to provide care on a day basis for one patient. Patients' bedrooms are located over two floors and patients have access to communal lounges, dining rooms and a garden space.	

2.0 Inspection summary

An unannounced inspection took place on 11 September 2025, from 10.15am to 2.15pm by a pharmacist inspector and on 12 September 2025 from 09.40am to 5.30pm by a care inspector.

The inspection on 11 September 2025 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.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care plans were generally 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 records for thickening agents.

Evidence of good practice was found in relation to staffing levels, staff training, care delivery and the dining experience. There were examples of good practice found in relation to the culture and ethos of the home in maintaining the dignity and privacy of patients and maintaining good working relationships.

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.

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

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 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 commented positively about staff. They confirmed that staff offered them choices throughout the day which included preferences for what clothes they wanted to wear and where and how they wished to spend their time. They told us that they could have a lie in or stay up late to watch TV if they wished and they were given the choice of where to sit and where to take their meals; some patients preferred to spend most of the time in their room and staff were observed supporting patients to make these choices. Patients said, "The staff are good, kind and approachable and I have no issues at all. I go to the dining room for meals and enjoyed a good breakfast this morning of porridge, tea and toast. I'm invited to join in the activities and I enjoy the ones I want to attend," and, "The staff are marvellous. There's enough staff about if I need them and they usually come to me quickly when I use my call bell. I have no concerns but if I had I could discuss them with staff and I would be confident that they would sorted them out".

Patients' relatives spoken with said, "This is a good spot and we're very happy with the care. She has settled in well and is happy here." and, "The whole family is more than happy with the

care. Staff are attentive and they offer Mum a choice of meals. Mum says she likes the food. We had a small issue lately and this was promptly addressed by the manager. It's a good home".

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients to 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.

Staff advised that they were familiar with how each patient liked to take their medicines. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

Following the inspection, we received no patient, patient representative or staff questionnaires within the timescale specified.

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

Staff spoken with said there was good teamwork and that they felt well supported in their role. Staff also said that, whilst they were kept busy, staffing levels were satisfactory apart from when there was an unavoidable absence. Patient call systems were noted to be answered promptly by staff.

Patients told us that they felt well cared for; that there was enough staff on duty if they needed them; they enjoyed the food and that staff were kind. They said that the manager and staff are approachable and they felt if they had any issues that they could discuss them and were confident any concerns would be addressed accordingly.

Staff told us they were aware of individual patient's wishes, likes and dislikes. It was observed that staff responded to requests for assistance promptly in an unhurried, caring and compassionate manner. Patients were given choice, privacy, dignity and respect.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss patients' care, to ensure good communication across the team about any changes in patients needs. Staff were knowledgeable about individual patient's needs, their daily routine, wishes and preferences; and were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known.

It was observed that staff respected patients' privacy and dignity by offering personal care to patients discreetly and discussing patients' care in a confidential manner. Staff were also

observed offering patients choice on how and where they spent their day or how they wanted to engage socially with others.

The dining experience was an opportunity for patients to socialise. The menu was displayed on the notice board, outlining what was available at each meal time for patients and the atmosphere was calm, relaxed and unhurried. It was observed that patients were enjoying their meal and their dining experience. It was noted that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

Staff demonstrated their knowledge of patients' individual needs, likes and dislikes regarding food and drinks. They were able to describe the various International Dysphagia Standardisation Initiative (IDDSI) levels of modified foods and demonstrated how to modify the consistency of drinks for patients with swallowing difficulties. Adequate numbers of staff were observed assisting patients with their meal appropriately.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home. The weekly programme of activities was displayed on the notice board advising patients of forthcoming events.

Patients' needs were met through a range of individual and group activities such as armchair exercises, story telling and arts and crafts. Patients spoken with said they enjoyed the activities they attended and that they were looking forward to a forthcoming barbecue party. On the afternoon of inspection on 12 September 2025 patients were observed enjoying a game of bingo with staff.

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 patients' needs and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care. 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.

Examination of care records and discussion with staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. However, whilst staff were adhering to the recently revised falls pathway and had access to an information booklet, the Falls Policy for the home had not been updated accordingly. This was discussed with the management team. A copy of the updated Falls Policy was requested and received by RQIA after the inspection.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. Patients' bedrooms were personalised with items important them. Bedrooms and communal areas were suitably furnished, warm and

comfortable. A variety of methods was used to promote orientation. There were clocks and photographs throughout the home to remind patients of the date, time and place Treatment rooms, sluice rooms and cleaning stores were observed to be appropriately locked.

Review of records and discussion with the manager confirmed environmental and safety checks were carried out, as required on a regular basis, to ensure the home was safe to live in, work in and visit.

Personal protective equipment (PPE), for example, face masks, gloves and aprons were available throughout the home. Dispensers containing hand sanitiser were seen to be full and in good working order. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance.

3.3.5 Quality of Management Systems

Since the last inspection there has been no change in the management arrangements. Mrs Eilis Bell has been the manager in this home since 14 July 2023.

Review of competency and capability assessments evidenced they were completed for trained staff left in charge of the home when the manager was not on duty.

Patients, relatives and staff commented positively about the manager and described her as supportive, approachable and able to provide guidance. Staff confirmed that there were good working relationships.

Review of a sample of records evidenced that the manager had processes in place to monitor the quality of care and other services provided to patients. 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 the quality of services provided by the home.

Patients and patients' relatives said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

Patient, patient representative and staff meetings were held on a regular basis. Minutes were available.

Cards and letters of compliment and thanks were received by the home. Comments were shared with staff. This is good practice.

3.3.6 Medicines management

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 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.

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, insulin and warfarin 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. Staff were reminded that in use insulin pen devices must be individually labelled with the date of opening recorded to facilitate audit and disposal at expiry.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

The management of thickening agents was reviewed. Speech and language assessment reports and care plans were in place and patients were being administered the correct consistency level. However, three records of prescribing and one administration record reviewed had the incorrect consistency level recorded. An area for improvement was identified.

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. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

Satisfactory arrangements were in place for the safe disposal of medicines.

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. 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.

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. The date of opening was recorded on most medicines to facilitate audit and disposal at expiry.

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. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

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 the majority of medicines were being administered as prescribed.

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 the staff are competent in managing medicines and that they are supported.

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

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

One new area for improvement has been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	1

The findings of the inspection, the new area for improvement and details of the Quality Improvement Plan were discussed with Mrs Eilis Bell, Registered Manager, and the Management Team, as part of the inspection process. The timescale for completion commences 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 29 **Stated:** First time **To be completed by:** Immediate and ongoing (11 September 2025)	The registered person shall review the management of thickening agents to ensure that records of prescribing and administration include the correct consistency level. Ref: 3.3.6
	Response by registered person detailing the actions taken: Monthly audits in relation to thickening agents will be completed and nurses have been advised to ensure that prescriptions are updated promptly in all the relevant areas such as care plans, Kardex, MARS, kitchen and handovers.

Please ensure this document is completed in full and returned via the Web Portal

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