



The Regulation and  
Quality Improvement  
Authority

# Inspection Report

**Name of Service:** Kingscourt  
**Provider:** Manor Healthcare Ltd  
**Date of Inspection:** 6 October 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>	Manor Healthcare Ltd
<b>Responsible Individual:</b>	Mr Eoghain King
<b>Registered Manager:</b>	Miss Helen Ward, not registered
<b>Service Profile:</b> Kingscourt is a nursing home registered to provide nursing care for up to 19 patients. The home provides care for patients living with a learning disability under the age of 65 years. Patients have their own bedrooms and access to a number of communal areas throughout the home.	

## 2.0 Inspection summary

An unannounced inspection took place on 6 October 2025, from 10.20am to 2.50pm. 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 areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. 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 insulin management and antibiotic administration.

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.

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, including areas 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).

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**

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.

Staff advised that they were familiar with how each patient liked to take their medicines and medicines were administered in accordance with individual patient preference. Staff also said that they prioritised patients who required pain relief and time-critical medicines during each medicine round.

No completed questionnaires or 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 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 clozapine, pain and epilepsy 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.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Directions for use were clearly recorded on the personal medication record and patient-centred care plans were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. Most records of administration included the reason for and outcome of each administration. However, there were a small number of gaps when the outcome was not recorded, this was discussed in detail with the manager for on-going monitoring.

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. Records of prescribing which included the recommended consistency level were maintained. However, records of administration recorded the number of scoops rather than the prescribed consistency level. This was discussed with staff and the manager for immediate action and on-going monitoring to ensure that the consistency level is recorded on administration records.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside of the recommended range. Three in use insulin pens had not been labelled with the patients' names and date of opening to denote ownership and facilitate 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 the large majority of medicines were available for administration when patients required them. However, it was observed that three patients did not have stock of some prescribed medications. Review of records of administration indicated that the patients had their medicines administered on the morning of the inspection. This was discussed with staff and the manager and assurances were provided that the medicines had been ordered and supply was expected to be delivered on the day of inspection. Staff were aware that medicines should be ordered in a timely manner to ensure that doses are not omitted. Any potential stock supply issues must be escalated to the manager for appropriate corrective action.

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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately.

Satisfactory arrangements were in place for medicines requiring cold storage, the storage of controlled drugs and safe disposal of medicines.

### **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. Most of the records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review. One missed signature for a weekly medication was brought to the attention of the manager for review and on-going monitoring. A review of administration records indicated that there were a number of missed doses for one antibiotic resulting in a four day delay in finishing the course. An area for improvement was identified.

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 places for the receipt, administration and disposal of controlled drugs. Controlled drugs were reconciled at each shift handover, however a review of records indicated that the reconciliation book had been pre-signed by one staff member for the evening handover. Records should be signed after the reconciliation checks have taken place. This was discussed with staff and the manager for on-going monitoring.

Management and staff audited the administration of medicines on a regular basis within the home. While regular medicines audits were conducted, review of recently completed audits found that some aspects of medicines management were not included in the audit process. The RQIA inspection tool audit was shared with the manager following the inspection to assist implementation of a more robust audit system which covers all aspects of the management of medicines.

### **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.

There had been no recent admissions/readmissions to the home. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the patient's medicines and this was shared with the GP and community pharmacist.

### **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.

There have been no medicine related incidents reported to RQIA since the last medicines management inspection. Management and staff were familiar with the type of incidents that should be reported. The inspector signposted staff to the RQIA provider guidance in relation to the statutory notification of medication related incidents available on the RQIA website.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with the nurse on duty and the manager for on-going monitoring (see Section 3.3.3).

### 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 they 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.

Records of staff training in relation to medicines management and epilepsy awareness were available.

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 Regulations.

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	3*	4*

\* the total number of areas for improvement includes five which were carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Helen Ward, 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>	
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 13 (4)  <b>Stated:</b> First time  <b>To be completed by:</b> 6 October 2025	<p>The registered person shall ensure that insulin pens are individually labelled and dated when opened to facilitate audit and disposal at expiry.</p> <p>Ref: 3.3.1</p> <p><b>Response by registered person detailing the actions taken:</b>            Reminders sent with monthly pharmacy order to request labels for insulin pen, rectified following inspection. Staff to contact pharmacy if pens are dispensed without labels.</p>
<b>Area for improvement 2</b>  <b>Ref:</b> Regulation 13 (4)  <b>Stated:</b> First time  <b>To be completed by:</b> 6 October 2025	<p>The registered person shall ensure that antibiotics are administered as prescribed.</p> <p>Ref: 3.3.3</p> <p><b>Response by registered person detailing the actions taken:</b>            Medication administration must be prescribed as per medical instruction, detailed on kardex. If a resident is on leave from the home with a relative during required administration time this must be documented with the appropriate coding to advise for missed doses. In the event a resident declines this must be coded within the kardex. Consultation must be sought with the GP to ensure the course of antibiotic is completed as per prescription.</p>
<b>Area for improvement 2</b>  <b>Ref:</b> Regulation 14 (2) (a)  <b>Stated:</b> Second time  <b>To be completed by:</b> 14 April 2025	<p>The registered person shall ensure cleaning and laundry chemicals are secured or supervised at all times.</p> <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>	
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 44	<p>The registered person shall ensure the premises are well maintained and remain suitable for their stated purpose.</p>

<p><b>Stated:</b> Second time</p> <p><b>To be completed by:</b> 30 April 2025</p>	<p><b>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</b></p> <p>Ref: 2.0</p>
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<p><b>Area for improvement 2</b></p> <p><b>Ref:</b> Standard 35</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 30 April 2025</p>	<p>The registered person shall ensure that there is evidence of managerial oversight of the governance systems are in place to ensure staff are registered with their professional body.</p> <hr/> <p><b>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</b></p> <p>Ref: 2.0</p>
<p><b>Area for improvement 3</b></p> <p><b>Ref:</b> Standard 4</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 30 April 2025</p>	<p>The registered person shall ensure that the monthly care plan evaluations are person centred and informative, for example, moving and handling and personal care.</p> <hr/> <p><b>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</b></p> <p>Ref: 2.0</p>
<p><b>Area for improvement 4</b></p> <p><b>Ref:</b> Standard 48</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 17 April 2025</p>	<p>The registered person shall ensure that PEEPs for all patients are recorded and maintained up to date.</p> <hr/> <p><b>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</b></p> <p>Ref: 2.0</p>

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



## The Regulation and Quality Improvement Authority

James House  
2-4 Cromac Avenue  
Gasworks  
Belfast  
BT7 2JA

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**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