The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Greenvale House Nursing Home

Provider: Greenvale House

Date of Inspection: 2 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:	Greenvale House
Responsible Persons:	Mr Norman Foster Mrs Margaret Foster Mrs Barbara Foster
Registered Manager:	Mrs Winnie Eriyo
Service Profile: Greenvale House is a registered nursing home which provides care for up to 36 patients living with dementia and general nursing care needs. There are a range of communal areas throughout the home and patients have access to an enclosed garden.	

2.0 Inspection summary

An unannounced inspection took place on 2 September 2025 from 9:30am to 4:55pm by a care inspector and from 10:00am to 2:15pm by a pharmacist 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 care inspection on 14 November 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The management of medicines was inspected 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.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Review of medicines management found mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely and 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. However, improvements were necessary in relation to the management of liquid medicines. Whilst an area for improvement was identified, there was evidence that with the exception of a small number of medicines, patients were being administered their medicines as prescribed.

As a result of this inspection, two areas for improvement were assessed as having been addressed by the provider. Two areas for improvement have been stated for a second time. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

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 patient's, 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 told us they were happy with the care and services provided. Comments made included "I'm very settled here, the staff treat me well" and "there is always something going on, and the food is lovely

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV.

Patients told us that staff offered them choices throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Staff spoke in positive terms about the provision of care, their roles and duties, training and managerial support with comments such as " I really enjoy my job, I wouldn't change a thing" and "everybody pulls together, there is really good teamwork".

Families spoken with told us that they were very happy with the care provided and that there was good communication from staff with comments such as “I am very happy with the care, I would give the home 10 out of 10” and “I am very happy, my …’s room is always nice and clean and there is always plenty of staff around”.

Following the inspection, no response was received regarding patient/relative questionnaires and no staff questionnaires were received 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.

Checks were made to ensure that staff maintained their registrations with the Northern Ireland Social Care Council (NISCC); however, review of monthly checks carried out evidenced a small number of gaps in recording this. This was discussed with the manager and will be reviewed at the next inspection.

There were systems in place to ensure staff were trained and supported to do their job. An overview of staff compliance with mandatory training was maintained. Staff had been trained on the moving and handling of patients, however, observation of one manual handling manoeuvre evidenced this training had not been embedded into practice. An area for improvement was identified.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role and that they were generally satisfied with the staffing levels.

The staff duty rota accurately reflected the staff working in the home on a daily basis. However, the duty rota did not identify the hours allocated to the activity provision within the home. This was discussed with the manager and assurances were given that this would be addressed.

It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way; and to provide patients with a choice on how they wished to spend their day. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of individual patients’ needs, their daily routine wishes and preferences.

Staff 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.

Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

It was observed that 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. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. However records reviewed, evidenced that there was no system in place to review the use of restrictive practice within the home. An area for improvement was identified.

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.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

The dining experience was an opportunity for patients to socialise and the atmosphere was calm and relaxed. It was observed that patients were enjoying their meal and their dining experience. It was clear that staff had made an effort to ensure patients were comfortable.

Whilst care staff recorded the quantity of each meal consumed by individual patients, there were gaps in the recording of which dish they were served to confirm that patients were offered a choice and that they received a varied diet. This area for improvement was stated for a second time.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home. The importance of engaging with patients was well understood by the manager and staff understood that meaningful activity was not isolated to the planned social events or games. Patients' needs were met through a range of individual and group activities such as bingo, arts and crafts, hairdressing or hand massage.

Patients were well informed of the activities planned for the month and of their opportunity to be involved and looked forward to attending the planned events. Patients told us that they were looking forward to the upcoming "Family Fun Day" with guest singers.

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.

Daily records were kept of how each patient spent their day and the care and support provided by staff. Access to confidential patient information was evident within the home. This was identified as an area for improvement.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly. Records were maintained of when patients were assisted to reposition however, the records did not consistently evidence that patients were repositioned in accordance with their care plan. This area for improvement was stated for a second time.

3.3.4 Quality and Management of Patients' Environment Control

The home was clean, tidy and well maintained. Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. Art and craft work undertaken by patients as part of the activity programme were on display throughout the home.

Review of records and observations confirmed that systems and processes were in place to manage infection prevention and control which included regular monitoring of the environment. Staff were observed to carry out hand hygiene at appropriate times, however some staff were observed to have gel polish on, this can impede effective hand hygiene. An area for improvement was identified.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Winnie Eryio has been the manager in this home since 27 November 2023.

Relatives and staff commented positively about the manager and described her as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place. 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 their relatives spoken with said that they knew how to report any concerns and said they were confident that the manager would address their concerns.

Compliments received about the home were kept and shared with the staff team.

3.3.6 Medicines Management

Monitoring and review of 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 nurse 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 were highlighted for immediate corrective action and on-going vigilance. 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, thickening agents and insulin was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans were in place and reviewed regularly. Two care plans needed updating with the most recent prescription, this was discussed with the manager and updated at the time of inspection.

Medicine supply, storage and disposal

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. 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 the safe disposal of medicines.

Medicines administration

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 painkillers. 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. Whilst the medicines administration records described when medicines should be crushed a care plan was not in place, this was highlighted to the manager who provided assurances that patient specific care plans would be put into place following the inspection.

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.

Transfer of medicines

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.

Management of medicine 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 the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a number of liquid medicines. The audits were discussed in detail with the manager for on-going monitoring and an area for improvement was identified.

Medicines management training

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 Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	1	6*

* the total number of areas for improvement includes two standards that have been stated for a second time

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

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 2 September 2025	The registered person shall ensure that liquid medicines are administered as prescribed. Ref: 3.3.6
	Response by registered person detailing the actions taken: We are introducing monitoring forms for all regular liquid medications.We will also increase the frequency of liquid medications auditing to fortnightly.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 12 **Stated:** Second time **To be completed by:** 30 September 2025	The registered person shall ensure that records are maintained of the exact nature of each meal consumed by patients to evidence that a varied diet is provided and that patients are availing of choice. Ref: 2.0 & 3.3.2
	Response by registered person detailing the actions taken: Residents are offered meal choices and receive a varied meals. The challenge we face its that the majority of our resident have cognitive issues and are not always able to verbalise their choices. In such cases we seek information about their preferences from their next of kin and record these in their care plans. There is always an option availble if the resident changes their mind or refuses to eat what they have been served. The electronic system we use allows for the recording of the actual meals taken which is reflected in some of the the records.However there were some entries which only indicated that the residents had taken a main course or a dessert. On further investigation we identied that the system had a technical issue whereby if the cursor was clicked in the spaces between the meal description, it would have recorded the meal as main course or desert.The developer has since rectified this and since the inspection, all records now reflect what was actually served.

Area for improvement 2 **Ref:** Standard 4.9 **Stated:** Second time **To be completed by:** 30 September 2025	The registered person shall ensure that repositioning charts evidence that patients are repositioned in accordance with their care plan. Ref: 2.0 & 3.3.3
	Response by registered person detailing the actions taken: Repositioning charts are now being reviewed at each handover by the Nurses in charge. Discrepancies are forwarded to the Nurse manager for follow up. Auditing of the repositioning records carried out monthly and randomly for residents whose risk assessments and care plans indicate that they need to be repositioned. The care plan that the inspector discussed on the day of inspection was discussed with the named nurse and the discrepancy which was as a result of a resolved issue with the resident that had not been ended has been rectified. We had no pressure sores in the home on the day of inspection and we still not have any to date which is a reflection of the excellent care provided in the home particularly repositioning of residents.
Area for improvement 3 **Ref:** Standard 39 **Stated:** First time **To be completed by:** 31 October 2025	The registered person shall ensure that training in moving and handling of patients is embedded into practice. Ref: 3.3.1
	Response by registered person detailing the actions taken: Staff member who assisted the relative in the move referenced in the report was spoken to about the incident and a one to one clinical supervision was carried out.It was reinforced to her to get a colleague to help her with transfers rather than follow the instruction of the relatives which in this case was not the correct way to transfer the named resident. Learning was shared with all staff at a staff meeting. We also discussed the incident with the family member involved and advised them to let staff carry out the transfers their loved one. Regular spot checks being carried out by the persons in charge and the Nurse Manager.
Area for improvement 4 **Ref:** Standard 18 **Stated:** First time **To be completed by:** **31 October 2025**	The registered person shall ensure that there is a system in place to monitor the use of restrictive practice and it is kept under review. Ref: 3.3.2
	Response by registered person detailing the actions taken: Monthly restrictive practice audit now in place.

Area for improvement 5 **Ref:** Standard 37 **Stated:** First time **To be completed by:** 2 September 2025	The registered person shall ensure that any record in the home which details patient information is securely stored in accordance with the General Data Protection Regulation (GDPR) and best practice guidance and that records are not accessible to visitors to the home. Ref: 3.3.3
	Response by registered person detailing the actions taken: The programme developer of the electronic record system we use has upgraded our system so that staff can safely log out the system. We have also put a timer for automatic log out should an employee leave the computer abruptly or forgets to log out.
Area for improvement 6 **Ref:** Standard 46.11 **Stated:** First time **To be completed by:** 30 September 2025	The registered person shall ensure that staff are aware of their responsibilities regarding maintaining effective IPC measures. This is in relation to the wearing of gel nails. Ref: 3.3.4
	Response by registered person detailing the actions taken: Staff who had gel nails on have been spoken to and they have removed them. This was shared at the staff meeting and it is being reviewed during hand washing audits.

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

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