The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Daisyhill Private Nursing Home

Provider: Town & Country Care Homes Limited

Date of Inspection: 4 December 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:	Town & Country Care Homes Limited
Responsible Individual:	Mr Christopher Philip Arnold
Registered Manager:	Miss Foteini Kourakou
Service Profile – This home is a registered nursing home which provides nursing care for up to 25 patients who have a learning disability. Patients' bedrooms are located over two floors and 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 4 December 2025 from 10.30am to 4.00pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to patients and the service was well led.

Patients were positive when describing their experiences of living in the home and those unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

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 told us that they were happy living in the home and spoke positively on their engagements with staff. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients told us that they were looking forward to Christmas and had enjoyed decorating the home.

A relative consulted confirmed that they were very happy with the care delivery in the home.

Staff told us that they were happy working in the home and enjoyed engaging with the patients. They felt that they worked well together and were supported by management to do so.

We received no questionnaire responses from patients or their visitors/relatives and no responses from the staff online survey.

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. Staff were safely recruited and a system was in place to ensure that staff completed identified mandatory training. Staff confirmed that they were further coached and supported through staff supervisions and appraisals.

An allocation sheet directed staff to planned duties during their shift to ensure that all patients were appropriately supervised and staff were aware of who was responsible for which duties during the day/night.

Checks were made to ensure nurses maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty and that staff responded to requests for assistance promptly in a caring and compassionate manner.

3.3.2 Quality of Life and Care Delivery

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences. Patients spoke fondly on their interactions with staff.

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.

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

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about patients' needs, especially changes to care.

Patients had good access to food and fluids throughout the day and night. Patients were safely positioned for their meals and the mealtimes were appropriately supervised. Staff communicated well to ensure that every patient received their meals in accordance with their nutritional needs. Food was only served when the patients were ready to eat their meal. The meals served appeared appetising and nutritious. The menu offered a good range and variety

of food. Several patients received meals of their choice not on the menu. Staff were aware of the actions to take should patients repeatedly refuse their meals.

Care plans were personalised and identified triggers for behaviours that challenge and the actions to take should this happen. Care plans identified what constituted as a safe environment for individual patients. Staff were aware of the actions to take should a patient self-harm.

Care plans identified how to safely move and handle each patient. Personal care plans were detailed and skin integrity care plans identified the equipment required and the frequency of repositioning where this was needed.

Each patient had an activities care plan. Staff were aware of each patient's interests and were observed engaging with patients socially. Daily records of activity engagements were recorded well.

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 the patients' needs. 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. Risk assessments and care plans were reviewed regularly to ensure that they remained reflective of patient need. Care records were stored securely.

Supplementary care records were maintained to evidence care delivery in areas, such as, personal care delivery, food/fluid intake, continence management, behavioural monitoring, sleep patterns and records were kept of any checks staff made on patients.

Registered nurses record a daily evaluation of the planned care delivery to monitor the effectiveness of the care. Any changes to planned care were recorded.

3.3.4 Quality and Management of Patients' Environment

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were suitably furnished, warm and comfortable. There were no malodours in the home.

Monthly infection prevention and control (IPC) and environmental audits were completed to monitor the environment and staffs' practices. Personal protective equipment was readily available throughout the home.

Fire safety measures were in place to protect patients, visitors and staff in the home. Corridors and fire exits were clear of clutter and obstruction should the need to evacuate occur and fire extinguishers were easily accessible. Staff had attended fire training and fire safety checks were regularly conducted.

3.3.5 Quality of Management Systems

There has been no change to the management arrangements since the last inspection. Ms Foteini Kourakou continues as registered manager of the home. Staff confirmed that they found the manager to be friendly, approachable and would listen to any concerns that they have.

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 a system in place to manage any complaints received.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further. Patients spoken with said that if they had any concerns they could talk to the staff about them.

4.0 Quality Improvement Plan/Areas for Improvement

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

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