

Inspection Report

Name of Service:	Kingscourt
Provider:	Manor Healthcare Ltd
Date of Inspection:	28 May 2026

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:	Manor Healthcare Ltd
Responsible Individual:	Mr Eoghain King
Registered Manager:	Miss Helen Ward
Service Profile – This home is a registered nursing home, which provides nursing care for up to 19 patients living with a learning disability. Patients have access to a communal dining room, lounges and an outside area with suitable seating.	

2.0 Inspection summary

An unannounced inspection took place on 28 May 2026, from 09.30 am to 4.30 pm by a care 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 pharmacy inspection on 6 October 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

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.

While we found care to be delivered in a safe and compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery.

As a result of this inspection four areas for improvement were assessed as having been addressed by the provider. Other areas for improvement have either been stated again or will be reviewed at the next inspection. 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 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 spoken with told us that they were happy living in Kingscourt, they were being looked after and the food was very good.

Staff described the manager as supportive, said there were enough staff to care for the patients and advised they were receiving regular training for their roles in the home.

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 they were encouraged to participate in regular residents' meetings which provided an opportunity for them to comment on aspects of the running of the home. For example, planning activities and menu choices. It was observed that patients were taking part in a meeting on the day of the inspection.

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 robust systems in place to manage staffing, including induction and completion of mandatory training.

Staff said there was good teamwork and that they felt well supported in their role, however, examination of the staff duty rota and discussions with staff confirmed that deficits in staffing were not always addressed. This was discussed with the manager and an area for improvement was identified.

The staff duty rota was examined and identified that it required the full name of staff working over a 24-hour period, identification of the nurse in charge and a key code for ease of understanding the rota. An area for improvement was identified.

A system to manage the registration of nurses and care staff was evident with records of monthly checks completed for the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

3.3.2 Quality of Life and Care Delivery

Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences. Staff addressed patients in a kind and caring manner. Patients said that staff looked after them well.

Staff confirmed that they received a detailed handover when they met at the beginning of each shift to discuss any changes in the needs of the patients.

Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs. 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 observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others. 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.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, staff supervision or mobility aids.

Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified. It was observed that patients were appropriately supervised with their meals.

A snack trolley was available at times throughout the day. Review of the snacks available showed little choice for patients including those who required their food to be modified. An area for improvement was identified.

Activities were provided for patients including group and one to one activities such as, listening to music, arts and crafts and outings. Patients were included in decision for what activities were provided through patient meetings where each individual was given an opportunity to give their ideas.

3.3.3 Management of Care Records

Patients' needs should be assessed by a nurse at the time of their admission to the home and initial assessment care plans developed to direct staff on how to meet patients' needs, however, this was not in place within time frames for one patient. An area for improvement has been identified.

Patients care records were held confidentially.

Care records reviewed identified concerns about the content of the monthly evaluations undertaken by nursing staff, as they lacked detail and were not always person centred. This area for improvement has been stated for a second time.

Care plan evaluations for epilepsy and physical health also lacked regular evaluation of the care provided to patients. An area for improvement was identified.

Care records for wound care were not regularly completed including daily wound assessment charts, body maps and photographs. An area for improvement was identified.

A new electronic records system was in use in the home, however, not all records were available to direct patient care on the new system and to record the outcomes of the care provision. An area for improvement was identified.

3.3.4 Quality and Management of Patients' Environment

The home was homely, tidy and free from malodours. While the home was generally clean, a number of areas such as, a dining room wall, radiator and window ledge required attention. This was discussed with the manager for her action and will be reviewed at a subsequent inspection.

It was also observed that a window in the lounge required repair to the opening mechanism. This was also brought to the attention of the manager for her action and will be reviewed at a future inspection.

Corridors and fire exits were noted to be free from obstruction and clutter ensuring a safe evacuation route for patients, staff and visitors in the event of a fire.

An activities games room was locked preventing patients the choice of using this space when desired. This was discussed with the manager who agreed to reassess this arrangement to allow patients to access this room. This will be reviewed at a future inspection.

A range of monthly infection prevention and control and environmental audits were in place to monitor the environment and staff practices. Personal protective equipment and hand hygiene facilities were readily available throughout the home.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Miss Helen Ward has been the new manager in this home since 4 December 2025.

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

The manager is currently undertaking further training on the 'My Home Life' course, which will benefit both staff and patients.

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. Compliments received were shared with staff.

The home was visited on a monthly basis to review the care and services provided in the home. The reports of these visits were reviewed and it was noted that the actions required were not always followed up in a timely manner. This was discussed with the manager and will be reviewed at a future inspection.

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	3*	7*

* the total number of areas for improvement includes one that has been stated for a second time and two which are 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.

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: 6 October 2025	The Registered Person shall ensure than insulin pens are individually labelled and dated when opened to facilitate audit and disposal at expiry. Ref: 2.0
	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
Area for improvement 2 Ref: Regulation 13 (4) Stated: First time To be completed by: 6 October 2025	The Registered Person shall ensure that antibiotics are administered as prescribed. Ref: 2.0
	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
Area for improvement 3 Ref: Regulation 19 (1) (a) Stated: First time To be completed by: 31 May 2026	The Registered Person shall ensure there is a current up to date record of the care and services provided to each patient. This is in relation to incomplete documentation on the home's electronic care record system. Ref: 3.3.3
	Response by registered person detailing the actions taken: Action plan discussed with all registrants to expedite care records from paper to electronic copies. This will be overseen by Manager and Acting Clinical Lead. Additional training provided for staff on navigating epicare system
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 4 Stated: Second time To be completed by: 31 May 2026	The Registered Persons shall ensure that the monthly care plan evaluations are person centred and informative, for example, moving and handling and personal care. Ref: 2.0 and 3.3.3
	Response by registered person detailing the actions taken: Care records will be updated on electronic system, staff will review solely on electronic system. Reviews that require no

	change will be upated with staffs response to advice of this and not a single "no change response"
Area for improvement 2 Ref: Standard 41 Stated: First time To be completed by: 28 May 2026	The Registered Person shall ensure that there are enough staff on duty over the 24-hour period to meet the needs of patients. Ref: 3.3.1
	Response by registered person detailing the actions taken: Commencement of additional full time care assitant and a further 3 part time to reduce defecits.
Area for improvement 3 Ref: Standard 41 Stated: First time To be completed by: 31 May 2026	The Registered Person shall ensure the rota includes the full names of all staff working, identification of the nurse in charge and a key code. Ref: 3.3.1
	Response by registered person detailing the actions taken: New rota template with key code devised and in circulation. Full names of staff noted and NIC identified on each duty. This co exists with the daily allocation sheet which identifies the NIC for each shift
Area for improvement 4 Ref: Standard 12 Stated: First time To be completed by: 28 May 2026	The Registered Person shall ensure residents are provided with a varied and nutritious selection of snacks throughout the day. Ref: 3.3.2
	Response by registered person detailing the actions taken: Fruit, low fat yougurts, jellys and puddings are are all available for residents as per their personal choice and request. This is in accordance with guidance from dietetics and diabetes nurse specialist
Area for improvement 5 Ref: Standard 4.1 Stated: First time To be completed by: 28 May 2026	The Registered Person shall ensure a holistic assessment is commenced on the day of admission and a detailed plan of care for each patient is in place within five days of admission to the home. Ref: 3.3.3
	Response by registered person detailing the actions taken: Delay in the reviewed care plan was due to a lack of information which was submitted by the NHSCT in respect of resident. Named nurse will be identified prior to admission and they will have support from Acting Clinical Lead in the completion of documentation

Area for improvement 6 Ref: Standard 4.7 Stated: First time To be completed by: 28 May 2026	The Registered Person shall ensure the patients care plan is reviewed regularly. This is in relation to epilepsy and physical health care plans. Ref: 3.3.3 Response by registered person detailing the actions taken: Care records will be updated on electronic system, staff will review solely on electronic system. Reviews that require no change will be updated with staffs response to advice of this and not a single "no change response" Paper copies will be ceased and archived to ensure there is one point of review.
Area for improvement 7 Ref: Standard 4 Stated: First time To be completed by: 28 May 2026	The Registered Person shall ensure wound care documents are in place and updated as required including: • Ongoing wound assessment charts • Body maps • Wound photographs Ref: 3.3.3 Response by registered person detailing the actions taken: In respect of the reviewed care plan this individual has capacity and does not consent to images of his wounds. Wound assessment charts to be completed as per care plan. Staff currently following TVN Plan. Staff to document on each attempt if there is refusal from the resident. This should be identified as a priority note on epicare. The process of including medical imagery to support wound care management will be utilised where applicable with all other residents.

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