The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Drapersfield House

Provider: Drapersfield Ltd

Date of Inspection: 23 September 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:	Drapersfield Ltd
Responsible Person:	Mrs Jill Canavan
Registered Manager:	Mrs Margaret Kolbohm
Service Profile – This home is a registered nursing home which provides nursing care for up to 45 patients. Accommodation is over three floors with shared communal areas on the ground floor.	

2.0 Inspection summary

An unannounced inspection took place on 23 September 2026 from 9.05am to 3.10pm. The inspection was conducted 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 two areas for improvement identified by RQIA during the last care inspection on 25 November 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

These two previous areas of improvement were met.

The home was found to be clean and well maintained to a good standard.

Patients said they were happy in the home, staff were kind and they enjoyed the meals.

Staff reported that there was good teamwork in the home and staff understood their roles and responsibilities. Staff were found to be knowledgeable in relation to the needs and preferences of the patients. Staff praised the management team and reported that they were approachable and responsive.

No areas for improvement identified as a result of this 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 said that they were well cared for in the home, staff were kind and attentive and they enjoyed the meals. Three patients made the following comments; "Every one of the staff are brilliant and all go the extra mile to help you. They work very hard and deserve all credit.", "It's a lovely home here. The staff are very good and the food is too good" and "I couldn't ask for better. I could be in a care home much closer to my home but I choose this one. The staff are all very respectful."

Those patients who could not articulate their views presented as comfortable and at ease.

Two visiting relatives said that they were very happy with the home and found staff to be kind and caring.

Staff spoke positively about their roles and duties, the care, teamwork, training and managerial support. Staff also said that they would have no concerns about reporting concerns with management and felt these would be taken seriously.

Comments received from six patients' questionnaires were all positive and included the following statements; "Everything in here makes me feel safe", "The home provides a very stable environment which meets my needs and any problems are dealt with quickly and efficiently. I feel cared for here" and "I have lots of company and do lots of activities each day."

Two returned staff questionnaires made the following comments; “I am very happy working in Drapersfield House. I have worked here for many years. There is always a happy, homely environment. Residents are well cared and looked after” and “The care is excellent. The residents are all very happy and well looked after.”

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, supervision and appraisal 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.

Staff said there was good team work and that they felt well supported in their role. A returned staff questionnaire made the following comment; “I feel I get good support from management, clinical lead and other staff members. Everyone works well together as a team to provide the best quality of care.”

An effective system to manage the registration of nursing staff with the Nursing & Midwifery Council (NMC) and care staff with the Northern Ireland Social Care Council (NISCC), was in place.

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 homely. Staff were knowledgeable of individual patients’ needs, their daily routine, wishes and preferences.

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.

Staff were observed to be prompt in recognising patients’ needs and any early signs of distress, including those patients who had difficulty in making their wishes or feelings known.

At times some patients may require the use of equipment that could be considered restrictive such as bedrails and alarm mats. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

Patients may require special attention to their skin care. These patients had care needs assessed on an up-to-date basis with care planning accurately reflected.

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. For example, patients referred to their GP if required.

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. There are referral arrangements for both Speech and Language Therapist (SALT) and Dietitian to assess individual patients' who have chewing or swallowing difficulties and any special nutritional requirements. These arrangements are included the care plans.

The daily menu was displayed in a written and pictorial format and included good provision of choice.

Review of associated documentation and general observations of care found that there was a good provision of activity in the home. A programme of planned activity in one of the communal lounges found that patients were in enjoyment from it and there was a nice atmosphere of humour and fun.

The genre of music played and television channels played was in keeping with patients' age group and tastes.

3.3.3 Management of Care Records

Patients' care records were maintained safely and securely.

A preadmission assessment is undertaken before a patient is admitted to the home. This is to ensure that the home can meet the assessed needs. Following admission care plans are developed to direct staff how to meet patients' needs. These included any advice or recommendations made by other health care professionals.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet patients' needs.

The general health and welfare of patients is monitored and recorded and timely referrals made to or advice sought from appropriate health and social care professionals as necessary and documented in patient records.

Daily evaluations of care were generally well written with issues of assessed need having a recorded statement of care / treatment given with effect of same.

3.3.4 Quality and Management of Patients' Environment

The home was clean and tidy, with an active programme of redecoration and refurbishment in place. Patients' bedrooms were comfortable and personalised. Communal areas were suitably furnished and comfortable. Bathrooms and toilets were clean and hygienic.

The grounds of the home were well maintained.

Cleaning chemicals were stored safely and securely.

The most recent fire safety risk assessment, dated 4 November 2025, had corresponding evidence recorded of the actions taken in response to the two recommendations made from it.

Fire safety training, fire safety drills and fire safety checks were maintained on a regular and up-to-date basis.

Review of records and observations confirmed that appropriate systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There is a management structure of support and availability as defined in the home's Statement of Purpose.

Mrs Margaret Kolbohm is the Registered Manager of the home. The Responsible Person, Mrs Jill Canavan, plays an active part in the day to day running of the home including on-call arrangements.

Patients and staff commented positively about the management team and described them as supportive and approachable.

There were processes in place to monitor the quality of care and other services provided to patients. Systems of audit and quality assurance were well maintained with action plans in place to address any issues identified.

Accidents and incidents are reported to the relevant stakeholders. Monthly audits of these events were in place to establish if there are any trends or patterns and if necessary follow action.

Records of the visits on the behalf of the responsible person were maintained in good detail and on an up-to-date basis. These records confirmed good governance arrangements for the home.

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 the management team, as part of the inspection process and can be found in the main body of the report.

The **Regulation** and **Quality Improvement** Authority

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