

# Inspection Report

26 October 2023



## Willow Grove Care Home

Type of Service: Nursing Home  
Address: 31 Ballygawley Road, Dungannon, BT70 1EL  
Telephone number: 028 8775 0101

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Assurance, Challenge and Improvement in Health and Social Care

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## 1.0 Service information

<b>Organisation/Registered Provider:</b> Kathryn Homes Ltd	<b>Registered Manager:</b> Mrs Michelle Marie Devlin
<b>Responsible Individual:</b> Mrs Tracey Anderson (Applicant)	<b>Date registered:</b> 23 March 2015
<b>Person in charge at the time of inspection:</b> Registered Nurses Chloe Girvan and Kirsty McKenzie. Ms Leanne McGaffin, Director of Operations & Safeguarding Lead for Kathryn Homes, arrived at 11.30am.	<b>Number of registered places:</b> 27
<b>Categories of care:</b> Nursing Home (NH) DE – Dementia.	<b>Number of patients accommodated in the nursing home on the day of this inspection:</b> 25
<b>Brief description of the accommodation/how the service operates:</b> Willow Grove Care Home is a registered nursing home which provides nursing care for up to 27 patients. The home is on the first floor of the building. Patients have access to communal lounges, a dining room and an outdoor space.  There is a residential care home which occupies the ground floor and the registered manager for this home manages both services.	

## 2.0 Inspection summary

An unannounced inspection took place on 26 October 2023, from 9.45am to 1.00pm. This was completed by a pharmacist inspector. The inspection focused on medicines management within the home.

The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

The areas for improvement identified at the last care inspection were not reviewed and are carried forward to be reviewed at the next care inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. 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. No new areas for improvement were identified.

Based on the inspection findings and discussions held, RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the management team with respect to medicines management.

RQIA would like to thank the staff for their assistance throughout the inspection.

### **3.0 How we inspect**

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing 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 previous inspection findings, incidents and correspondence. The inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector also spoke to the nurses on duty and management about how they plan, deliver and monitor the management of medicines in the home.

### **4.0 What people told us about the service**

The inspector met with two registered nurses and the Director of Operations & Safeguarding Lead for Kathryn Homes.

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.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no questionnaires had been received by RQIA.

## 5.0 The inspection

### 5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

Areas for improvement from the last inspection on 14 September 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
<b>Area for improvement 1</b> <b>Ref:</b> Regulation 20 (1) (a) <b>Stated:</b> First time	The registered person shall ensure that the deployment of staff is reviewed to ensure that the assessed needs of patients are met.	<b>Carried forward to the next inspection</b>
	<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>	
<b>Area for improvement 2</b> <b>Ref:</b> Regulation 20 (3) <b>Stated:</b> First time	The registered person shall ensure that a competency and capability assessment is completed for any nurse taking charge of the home in the absence of the manager. With specific reference to agency nurses.	<b>Carried forward to the next inspection</b>
	<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>	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		Validation of compliance
<b>Area for improvement 1</b> <b>Ref:</b> Standard 4 <b>Stated:</b> Second time	The registered person shall ensure that a care plan is implemented for any patient who has a tendency to refuse personal care delivery and contemporaneous records are maintained providing the details of the aspect of care refused along with any action taken to promote the effective delivery of care.	<b>Carried forward to the next inspection</b>
	<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>	

<b>Area for improvement 2</b> <b>Ref:</b> Standard 6.14 <b>Stated:</b> First time	The registered person shall ensure that patients have access to appropriate footwear at all times.	<b>Carried forward to the next inspection</b>
	<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>	
<b>Area for improvement 3</b> <b>Ref:</b> Standard 12 <b>Stated:</b> First time	The registered person shall review the meal time experience to ensure that there are adequate staff to assist patients and that the frequency between meals are reviewed.	<b>Carried forward to the next inspection</b>
	<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>	
<b>Area for improvement 4</b> <b>Ref:</b> Standard 4 <b>Stated:</b> First time	The registered person shall ensure that where a patient requires repositioning, charts are consistently signed and dated	<b>Carried forward to the next inspection</b>
	<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>	

## 5.2 Inspection findings

### 5.2.1 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 medical 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 the GP, the 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 at the inspection 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 state that they were accurate.

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.

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 nurses on 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 nurses 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 records; and care plans directing the use of these medicines were in place. Nurses knew how to recognise a change in a patient's behaviour and were aware of the factors that this change may be associated with. Records included the reason for and outcome of each administration.

The management of pain was discussed. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans and pain assessments were in place and reviewed regularly.

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. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Care plans were in place when a patient required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was too low.

### **5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?**

Medicines 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.



The records inspected showed that medicines were available for administration when patients required them. Nurses advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines 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. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

One in-use insulin pen device was not labelled and the date of opening was not recorded. This was discussed with the nurses and the Director of Operations & Safeguarding Lead for Kathryn Homes for corrective action.

Satisfactory arrangements were in place for the safe disposal of medicines.

### **5.2.3 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. The records were found to have completed to the required standard. The records were filed once completed.

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 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 plans. Written consent and care plans were in place when this practice occurred.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

### **5.2.4 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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

#### **5.2.5 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.

Management and nurses 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, an audit discrepancy was observed in the administration of one medicine. The discrepancy was drawn to the attention of the Director of Operations & Safeguarding Lead for Kathryn Homes and the nurses for corrective action.

#### **5.2.6 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. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

### **6.0 Quality Improvement Plan/Areas for Improvement**

	<b>Regulations</b>	<b>Standards</b>
<b>Total number of Areas for Improvement</b>	2*	4*

\* The total number of areas for improvement includes six which are carried forward for review at the next inspection.



This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Ms Leanne McGaffin, Director of Operations & Safeguarding Lead for Kathryn Homes, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
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<b>Area for improvement 2</b>  <b>Ref:</b> Standard 6.14	The registered person shall ensure that patients have access to appropriate footwear at all times.

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<p><b>Area for improvement 3</b></p> <p><b>Ref:</b> Standard 12</p>	<p>The registered person shall review the meal time experience to ensure that there are adequate staff to assist patients and that the frequency between meals are reviewed.</p>
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