The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Glendun Nursing Home

Provider: Glendun Nursing Home Ltd

Date of Inspection: 30 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:	Glendun Nursing Home Ltd
Responsible Individual	Mr David Leo Morgan
Registered Manager:	Mrs Katrina Mary O'Hara
Service Profile – This home is a registered nursing home which provides general nursing care and care for persons under 65 years with a physical disability. The home is registered for 31 patients. The home is divided over two floors with bedrooms on both floors, a communal dining room, lounge and bathrooms. There is a separate residential care home which occupies part of the first floor and the registered manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 30 September 2025, from 10.00 am to 5.45 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 care inspection on 3 November 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

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.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained.

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 who were able to share their opinions on life in the home said they were well looked after. Some patients had difficulty telling us about their care experiences. Patients who had communication difficulties looked relaxed in their environment and during interactions with staff.

Patients spoken with said that they were happy with the care and services provided to them. Patients described the staff as "good" and "nice." One patient said, "I can't complain".

Staff spoken with said that Glendun Nursing Home was a good place to work. Staff said that they were satisfied with staffing levels, teamwork was good, the management team was approachable and they enjoyed working in the home.

Following the inspection, no patient, patient representative or 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 robust systems in place to manage staffing.

Patients said that there was enough staff on duty to help them. Staff said there was good teamwork and that they felt well supported in their role.

There was a system in place to monitor that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC).

A review of the staff duty rota identified that the nurse in charge was not always identifiable. An area for improvement was identified.

There was limited evidence to confirm that all staff were receiving individual supervision at least once every six months. An area for improvement was identified.

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.

Patients looked well cared for and were seen to enjoy warm and friendly interactions with the staff. Staff were chatty, friendly and polite to the patients.

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.

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. 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 were assisted by staff to change their position regularly. However, examination of records evidenced that patients were not always repositioned as prescribed in their care plans. An area for improvement was identified.

Examination of care records and discussion with the staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. Review of records confirmed that staff took appropriate action in the event of a fall, for example, they commenced neurological observations and sought medical assistance if required.

However, review of a number of post fall documentation evidenced that they were not consistently completed in full, for example, patient body maps. An area for improvement was identified.

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.

Observation of the lunchtime meal served in the main dining room confirmed that enough staff were present to support patients with their meal and that the food served smelt and looked appetising and nutritious. It was observed that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. The patients commented positively about the food in Glendun Nursing Home.

The importance of engaging with patients was well understood by the manager and staff. A number of patients were observed participating in a game of Bingo. Other patients were observed in their bedrooms with their chosen activity such as reading, listening to music, watching television or waiting for their visitors to come.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home. The activity schedule was on display. It was positive to see that the activities provided were varied, interesting and suited to both groups of patients and individuals.

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.

Patients care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care.

Review of care records specifically for those patients who required wound care evidenced that the wound dressing records were not consistent with the patients prescribed care. An area for improvement was stated for a third time.

Review of care records for patients who had swallowing difficulties did not evidence a choking risk assessment. The records did contain eating and drinking recommendations from the Speech and Language Therapist and the patient's care plan reflected these recommendations. This was discussed with the management team to implement choking risk assessments for patients who would be deemed at risk. This will be followed up at the next care inspection.

3.3.4 Quality and Management of Patients' Environment

The home was warm and welcoming. Patients' bedrooms were personalised with items important to the patient. It was positive to see that the home recently had some painting completed to its exterior.

Internally it was apparent that work was required in parts of the home to ensure the homes environment was maintained and decorated to a good standard. Following the inspection the management team provided an updated refurbishment plan for RQIA to review. Progress with this refurbishment plan will be reviewed at the next inspection.

Review of records confirmed that environmental and safety checks were carried out, as required on a regular basis, to ensure the home's was safe to live in, work in and visit.

Review of records and observations confirmed that 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 has been no change in the management of the home since the last inspection. Mrs Katrina O'Hara has been the manager in this home since 21 December 2018.

Staff spoke positively about the management team stating they were approachable and accessible.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the management team responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

Patient care records were audited regularly by the manager, however; some of the audits reviewed did not evidence completion of associated action plans. An area for improvement was stated for a second time.

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	0	6*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with the management team, 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 Care Standards for Nursing Homes (December 2022)	
Area for Improvement 1 **Ref:** Standard 4 **Stated:** Third time **To be completed by:** 29 September 2025	The Registered Person shall ensure that where a patient has a wound: • specific wound care plans are developed and kept under regular review • wound dressing records are consistent in accordance with the prescribed care. Ref: 2.0 and 3.3.3
	Response by registered person detailing the actions taken: Staff to develop wound care plans and ensure dressing records are consistent in accordance with the presribed care.
Area for Improvement 2 **Ref:** Standard 35 **Stated:** Second time **To be completed by:** 30 September 2025	The Registered Person shall ensure care record audits evidence review and completion of associated action plans. Ref: 2.0 and 3.3.5
	Response by registered person detailing the actions taken: Registered person will review care record audits and ensure action plans are completed.
Area for Improvement 3 **Ref:** Standard 41 **Stated:** First time **To be completed by:** 30 September 2025	The Registered Person shall ensure that the staff duty rota is maintained in keeping with legislation and best practice guidance. Ref: 3.3.1
	Response by registered person detailing the actions taken: Registered person maintains staff duty riota in keeping with legislation with particular reference to ensuring that staff rotas are signed by Registered person.

Area for Improvement 4 **Ref:** Standard 40 **Stated:** First time **To be completed by:** 30 December 2025	The Registered Person shall ensure that staff have recorded individual, formal supervision no less than every six months. Ref: 3.3.1
	Response by registered person detailing the actions taken: Registered Person has put in place a Supervison schedule planner to include supervision of all staff.
Area for Improvement 5 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 29 September 2024	The Registered Person shall ensure that where a patient requires repositioning that this is completed in accordance with their care plan and reflected within supplementary charts. Ref: 3.3.2
	Response by registered person detailing the actions taken: Registered person has met with staff to ensure that staff understand the need to accurately complete repositioning charts in accordance with care plans.
Area for Improvement 6 **Ref:** Standard 22 **Stated:** First time **To be completed by:** 29 September 2024	The Registered Person shall ensure that post fall documentation is completed in full. This is stated specifically in relation to patient body maps. Ref: 3.3.2
	Response by registered person detailing the actions taken: Registered Person will ensure that all post fa;ll documentation is completed in full in particular to patient body maps.

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

The Regulation and Quality Improvement Authority

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James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews