

# Inspection Report

**Name of Service:** Kintullagh Care Home

**Provider:** Kathryn Homes Ltd

**Date of Inspection:** 6 May 2025

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

## 1.0 Service information

<b>Organisation/Registered Provider:</b>	Kathyrn Homes Ltd
<b>Responsible Individual:</b>	Tracey Anderson
<b>Registered Manager:</b>	Bronach Campbell- not registered
<p><b>Service Profile –</b> This home is a registered nursing home which provides nursing care for up to 61 patients. The home is divided into three units over two floors; the Willow and Beech units are on the ground floor with the Oak unit located on the first floor. Patients have access to communal lounges, dining rooms and garden space.</p>	

## 2.0 Inspection summary

An unannounced inspection took place on 6 May 2025 from 9.30 am to 5.00 pm by care inspectors.

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 8 and 9 May 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that compassionate care was delivered to patients. Details and examples of the inspection findings can be found in the main body of the report.

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. Refer to Section 3.2 for more details.

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 patient's, 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.

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 said they were happy with the care from staff, and there were enough staff if they needed them.

Patients mostly told us the food was very good and they had a choice of meal. However, one comment from a patient regarding their lunchtime meal was passed to the manager to address.

The patients also told us that staff offered choices to them throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Patients who were unable to share their opinions on life in the home said or indicated that they were well looked after and were observed to be at ease in the company of staff and to be content in their surroundings.

Most of the relatives / visitors spoken with on the day of inspection expressed no issues with the care their loved one receives in Kintullagh. One relative comment was shared with the management team for her appropriate action.

No feedback was received from the patient relative questionnaires or the staff questionnaires.

### **3.3 Inspection findings**

#### **3.3.1 Staffing Arrangements**

Safe staffing begins at the point of recruitment and continues through to staff induction. A review of two recruitment files for recently recruited staff evidenced that not all required documentation was in place. This was discussed with the manager and an area for improvement was stated for a second time.

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

Staff said there was good teamwork and that they felt well supported in their role and that they were satisfied with the staffing levels and that these had been recently reviewed and increased by management.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota evidenced who the person in charge was when the manager was not on duty. However, it was observed that some alterations had been made to the duty rota which were not made in line with best practice guidance and a small number of staff names were not fully recorded. An area for improvement was identified. This is also discussed in section 3.3.3.

Review of governance records provided assurance that there were systems in place to ensure staff were trained and supported to do their job and that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or Northern Ireland Social Care Council (NISCC) and that these registrations were monitored by the manager on a monthly basis.

### 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 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 seen to communicate well with patients; they were respectful, understanding and sensitive to patients' needs.

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.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position examination of the repositioning records showed these were recorded appropriately.

A number of patients' toothbrushes were observed to be unused and one was unclean. The provision of mouth care was discussed with the manager and will be reviewed further during the next inspection.

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.

The dining experience was an opportunity for patients to socialise. The menu was displayed in each of the units.

The importance of engaging with patients was well understood by the Manager and staff. Arrangements were in place to meet patients' social, religious and spiritual needs within the home. A number of patients and staff spoken with expressed the need for more activities. A review of activity records evidenced gaps in the recording of the provision of activities. This was discussed with the manager and an area for improvement was identified.

### 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.

Care records were observed to have been regularly reviewed. However; care plans in relation to mobility, continuous supervision and dementia care needs lacked detail. These deficits had not been picked up through the auditing processes. An area for improvement was identified.

Wound care records reviewed evidenced some improvement in the overall recording, however, one care plan had not been updated to reflect changes to the dressing regime and in some records the wound care evaluation lacked detail as to the progress of the wound. An area for improvement was stated for a second time.

A review of a number of records including supplementary care records and post falls observations as with the duty rota evidenced that in some cases these records were difficult to read and amendments had been not in keeping with professional guidance. As discussed in section 3.3.1 an area for improvement in relation to amendments to records was identified.

### 3.3.4 Quality and Management of Patients' Environment

Review of the home's environment and records confirmed that the manager did have a refurbishment / redecoration plan in place and there was evidence of ongoing decoration in the home.

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. It was observed that there was only vinyl gloves available in various areas of the home. The use of these gloves for personal care was discussed with the deputy manager who addressed this immediately and a choice of nitrile gloves was made available.

### 3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Ms Bronach Campbell has been the manager in this home since 9 April 2024. An application to register with RQIA has been received.

Review of a sample of records evidenced that there was a system in place for reviewing the quality of care, other services and staff practices. As discussed in section 3.3.2, an area for improvement in relation to the auditing of care records was identified.

There was a system in place to manage any complaints received. A compliments log was maintained and any compliments received were shared with staff.

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.

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

\* the total number of areas for improvement includes one under regulation and one under the standards that have been stated for a second time and one under regulation carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with, Bronach Campbell, Manager as part of the inspection process. The timescales for completion commence from the date of inspection.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 20 (1) (a)  <b>Stated:</b> First time  <b>To be completed by:</b> 24 June 2024	The registered person shall review the staffing arrangements in the home to include the levels of staff on duty; the deployment of staff and the working practices to ensure that the needs of patients are met. This is in particular reference to the morning routines and serving of breakfasts.  <b>Ref:</b> 2.0  <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 12 (1) (a) (b)  <b>Stated:</b> Second time  <b>To be completed by:</b> 31 July 2025	The registered person shall ensure that the record keeping in relation to wound management is maintained appropriately and in accordance with legislative requirements, minimum standards and professional guidance.  <b>Ref:</b> 2.0 and 3.3.3  <b>Response by registered person detailing the actions taken:</b> Wound audits ongoing monthly and increasing when need is noted. Daily checks ongoing by management. Supervisions completed with nurses. Nursing meeting held.
<b>Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 38  <b>Stated:</b> Second time  <b>To be completed by:</b> 1 August 2025	The registered person shall ensure all pre-employment checks are in place prior to the newly appointed staff member commencing in post. This is stated in reference, but not limited to, gaps in employment and reasons for leaving previous employment.  <b>Ref:</b> 2.0 and 3.3.1.  <b>Response by registered person detailing the actions taken:</b> New checklist put in place for date of police check to be included. New employment gaps monitoring form already in place and no issues in relation to this were found on the day.
<b>Area for improvement 2</b>  <b>Ref:</b> Standard 35.7  <b>Stated:</b> First time	The registered person shall ensure records maintained are legible any amendment made to any record in the home is made in accordance with best practice guidance and professional standards. This is stated in reference but not limited to supplementary care records, observation charts and the duty rota.

<p><b>To be completed by:</b> 30 June 2025</p>	<p>Ref: 3.3.1 and 3.3.3.</p> <p><b>Response by registered person detailing the actions taken:</b> Staff meeting held to reiterate the importance of legible handwriting as all records are legal documents. All changes to paper work must legible and initialed and this was reiterated to staff. Rotas are re-printed when there are changes and readable.</p>
<p><b>Area for improvement 3</b></p> <p><b>Ref:</b> Standard 11</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 1 September 2025</p>	<p>The registered person shall review the arrangements for activity provision in the home including in the absence of the activity co-ordinator. A contemporaneous record of activities delivered must be retained. Activities must be an integral part of the care process with daily notes reflecting these activities.</p> <p>Ref: 3.3.2.</p> <p><b>Response by registered person detailing the actions taken:</b> Meeting held with all staff to reiterate the importance of activities and documentation. Activity therapist now has to include on planners which lounge the activity is going to be held in if residents wish to stay in their unit, so that other residents can participate. Residents to be included in activity planning. "Bored board" in place to help with smaller activities when activity therapist is not on duty and lounge games left in an area that staff can access.</p>
<p><b>Area for improvement 4</b></p> <p><b>Ref:</b> Standard 35</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 1 September 2025</p>	<p>The registered person shall ensure that the home's current audit processes are reviewed to ensure they are effective. This is stated in reference, but not limited to, the care record audits</p> <p>Ref: 3.3.3.</p> <p><b>Response by registered person detailing the actions taken:</b> Care record audit completed monthly of 10% of residents. Care plan tracker in place. New audit of new admissions introduced-whereby an audit on the 4th day will be completed to ensure all risk assessments and care plans have been created.</p>

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



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