The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Oak Tree Manor Residential Home

Provider: Kathryn Homes Ltd

Date of Inspection: 16 & 21 October 2025

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:	Kathryn Homes Ltd
Responsible Individual:	Mrs Tracey Anderson
Registered Manager:	Miss Veronica Sousa

Service Profile:
This home is a registered residential care home, which provides health and social care for up to 53 residents living with dementia. The home is divided into three units (Rowan, Cedar and Seymour) over two floors.

There is a separately registered nursing home, which occupies the same building, and the registered manager for this home manages both services.

2.0 Inspection summary

An unannounced inspection took place on 16 October 2025, between 9.30am and 5.30pm, by two care inspectors, and on 21 October 2025, from 10.00am to 3.30pm, by a pharmacist 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 October 2024 and the last medicines management inspection on 5 November 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

It was established that staff promoted the dignity and well-being of residents and that staff were knowledgeable and well trained to deliver safe and effective care.

Residents said that living in the home was a good experience. Residents unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care plans were largely well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. However, improvement was necessary in relation to the management of insulin and the maintenance of the personal medication record and care plan.

Whilst an area for improvement was identified, there was evidence that with the exception of a small number of medicines, residents were being administered their medicines as prescribed.

As a result of this inspection, ten areas for improvement were assessed as having been addressed by the provider. Full details of the inspection findings, including the 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 residents, 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

Residents spoken with described staff as 'very good' and 'the best'. Residents' comments included; "they are very good to me here" and "I like it here; I would never leave."

Residents told us that their relatives could visit whenever they wished; residents' relatives told us that they were always made feel welcome when they visited the home.

Discussion with residents and staff confirmed that residents were able to choose how they spent their day. For example, residents could choose where the wished to have their meal and what daily activity they wished to attend.

Residents also told us that they were encouraged to participate in regular resident meetings, which provided an opportunity for them to comment on aspects of the running of the home. For example, planning activities and menu choices. A review of records confirmed that resident meetings were taking place.

Comments regarding residents laundry and communication with families were shared with the management team for review and action if required.

Staff said they had worked hard to implement and sustain improvements identified at the last medicines management inspection and had received help and support from senior management to do so. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each resident liked to take their medicines. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

No additional feedback was received from residents, relatives or staff following 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 residents. There was evidence of robust systems in place to manage staffing.

Residents said that there was enough staff on duty to help them. Staff said there was good teamwork and that they were satisfied with the staffing levels.

A review of the duty rota indicated that the person in charge of the home in the manager's absence had not been consistently identified on the rota. An area for improvement was identified.

It was noted that there was enough staff in the home to respond to the needs of the residents in a timely way; and to provide residents with a choice on how they wished to spend their day. For example, staff were observed supporting residents to attend the daily activity, staff were also observed taking time to chat with residents' throughout the day.

All staff have received individual, formal supervision; however, there was no evidence of a formal staff appraisal. 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 residents. Staff were observed to be prompt in recognising residents' needs and any early signs of distress or illness, including those residents who had difficulty in making their wishes or feelings known.

Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs. For example, during the lunchtime experience staff were observed using encouragement and gentle respectful support to encourage residents' to have their meal.

It was observed that staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly. Staff were also observed offering resident choice in how and where they spent their day or how they wanted to engage socially with others.

At times, some residents 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 residents and to manage this aspect of care.

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

Where a resident was at risk of falling, measures to reduce this risk were put in place. Examination of care records and discussion with the staff and manager confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. For example, residents were referred to the Trust's Specialist Falls Service, their GP, or for physiotherapy.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents 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 in all three units, review of records and discussion with residents, staff and the manager indicated that there were robust systems in place to manage residents' nutrition and mealtime experience.

Staff understood that meaningful activity was not isolated to the planned social events or games. An activities schedule was in place for residents to take part in if they wished to do so.

A review of records confirmed that residents participated in regular resident's meeting, which provided an opportunity for them to comment on aspects of the running of the home. For example, planning activities and menu choices.

Arrangements were in place to meet residents' social, religious and spiritual needs within the home.

A review of records and discussion with both residents and relatives indicated dissatisfaction concerning the systems in place relating to laundry. This was discussed with the management team during feedback and an area for improvement was identified.

3.3.3 Management of Care Records

Residents' needs were assessed by a suitably qualified member of staff at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents' needs and included any advice or recommendations made by other healthcare professionals.

Residents care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the residents' needs. Care staff recorded regular evaluations about the delivery of care. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate.

3.3.4 Quality and Management of Residents' Environment

The home was clean, tidy and residents' bedrooms were personalised with items important to the resident. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. Some areas of the home were showing signs of wear and tear, for example, some items of furniture were chipped or marked. The manager confirmed that further improvements had been planned for over the upcoming months. Progress with this will be reviewed at a future inspection.

Review of records and discussion with the manager confirmed that environmental and safety checks were carried out on a regular basis. For example, fire safety checks, resident call system checks, electrical installation checks and water temperature checks.

There was evidence 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.

Residents and staff commented positively about the manager and described her as supportive and approachable.

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 evidence that the manager 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.

Compliments to the home were shared with the staff team. Compliments included, "Staff at Oak Tree Manor go above and Beyond," and "The best bunch at Oak Tree, they have been brilliant."

3.3.6 Medicines Management

Prescribing, monitoring and review of medicines

Residents in residential care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times residents' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist.

The format for records of incoming medicines had been amended since the last inspection and were appropriately maintained. Staff were reminded to attach any loose records, for new residents, to the pre-printed book for easy retrieval.

Personal medication records were in place for each resident. 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 other healthcare professionals, for example, may use them at medication reviews or hospital appointments.

The personal medication records reviewed were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. A small number of minor discrepancies were highlighted to staff for immediate corrective action and on-going vigilance.

Copies of residents' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

All residents 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.

The management of distressed reactions, pain, thickening agents, insulin, warfarin and antibiotics, was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed.

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

Some residents 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 resident 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 resident.

The management of thickening agents and nutritional supplements was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing, which included the recommended consistency level, were maintained. One personal medication record needed updating with the most recent recommendation, this was addressed immediately. The resident was receiving the correct consistency.

Care plans were in place when residents required insulin to manage their diabetes. There was sufficient detail to direct staff if the resident's blood sugar was outside of the recommended range. However, although the administration of insulin was managed by district nurses, the personal medication records and care plans did not match the current prescription. An area for improvement was identified.

The management of warfarin was reviewed. Warfarin is a high-risk medicine, which requires regular blood testing. The dose of warfarin prescribed depends on the blood test result. Dose changes and records were managed in a mostly satisfactory manner; however, staff were reminded that two staff should sign the record when doses are transcribed, according to the expected procedure in the home.

Where residents had been in hospital and had hydroxycobalamin injections prescribed on the personal medication record, the manager agreed to contact the GP to confirm if these were still prescribed and to initiate a new district nurse referral for administration, if necessary.

Supply and storage of medicines

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the resident'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.

Records reviewed showed that medicines were available for administration when residents required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner. One medicine was unavailable on the day of the inspection, the manager confirmed following the inspection that the prescriber had been informed and that the medicine was available again later that day.

Staff were reminded that currently prescribed medicines should not be disposed of as 'overstock' and that care should be taken when ordering/communicating with community pharmacy, to avoid unnecessary wastage.

The medicine storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each resident could be easily located. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage, the storage of controlled drugs and the safe disposal of medicines.

Administration of medicines

It is important to have a clear record of which medicines have been administered to residents to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed and found to have been accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing monitoring. Records were filed once completed and were retrievable for audit/review.

Controlled drugs are medicines that are subject to strict legal controls and legislation. They commonly include strong painkillers. 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.

Management and staff audited the management and administration of medicines on a regular basis within the home.

There was evidence that the findings of the audits had been discussed with staff and addressed. The date of opening was recorded on the majority of medicines to facilitate audit and disposal at expiry.

Transfer of medicines

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 at the time of admission or for residents returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

Medication 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 staff 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 inspector signposted staff to the RQIA provider guidance in relation to the statutory notification of medication related incidents available on the RQIA website.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with the staff on duty and the manager for on-going monitoring.

Medicines training

To ensure that residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that 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. Medicines management policies and procedures were in place.

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	1	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Veronica Sousa, Registered 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 21 October 2025	The registered person shall review the management of insulin, to ensure that the personal medication record and the care plan reflect the current prescription. Ref: 3.3.6
	Response by registered person detailing the actions taken: Kardex and Care plan have been reviewed to reflect current prescription of Insulin and same to be reviewed during monthly medication audits. Discussion of insulin prescription is held daily during flash meeting to ensure management of any changes is being carried out
Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022)	
Area for improvement 1 **Ref:** Standard 25 **Stated:** First time **To be completed by:** 16 October 2025	The registered person shall ensure that the duty rota clearly identifies the person in charge in absence of the manager. Ref: 3.3.1
	Response by registered person detailing the actions taken: Person in charge is identified on the duty rota, alongside a descriptive key when same is typed going forward and same reviewed by Home Manager when sigining off duty rota.
Area for improvement 2 **Ref:** Standard 24.5 **Stated:** First time **To be completed by:** 30 November 2025	The registered person shall ensure that all staff have formal recorded appraisal annually, with appropriate records retained Ref: 3.3.1
	Response by registered person detailing the actions taken: Appraisal tracker created and appraisals with development plans currently ongoing. Same to be completed annually.
Area for improvement 3 **Ref:** Standard 20.10 **Stated:** First time	The registered person shall ensure that the manager reviews the systems that are in place to ensure laundry is managed appropriately. Ref: 3.3.2

To be completed by: 31 October 2025	**Response by registered person detailing the actions taken**: Meeting with laundry assistants and housekeeper on 25.11.25. All residents have individual named baskets to transport clothing to rooms and the staff are now reviewing and relabelling as needed. Keyworker syste implemented who will review laundry weekly and as required. Any non-compliance will be addressed via HR processes

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