The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Willow Grove Care Home

Provider: Kathryn Homes Ltd

Date of Inspection: 6 November 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:	Mrs Michelle Marie Devlin

Service Profile –
This home is a registered nursing home which provides nursing care for up to 27 patients who have a dementia. Patients have access to communal living and dining spaces. There is a garden which surrounds the home.

The nursing unit is on the first floor of the building. There is a residential care home on the ground floor and the manager of the nursing unit manages both services.

2.0 Inspection summary

An unannounced inspection took place on 6 November 2025 from 9.55am to 4.50pm 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 16 October 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 safe, effective and compassionate care was delivered to patients and the service was well led.

Patients spoke positively when describing their experiences of living in the home. Refer to Section 3.2 for more details.

As a result of this inspection, all areas for improvement from the previous care inspection were assessed as having been addressed. Two new areas for improvement in relation to wet floor signage and bowel management were identified. Details, including new areas for improvement, can be found in the main body of the report and the Quality Improvement Plan 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 told us that they were happy living in the home and that staff treated them well. One patient said, "I am happy here; the staff are very good. We get plenty to eat and drink and the food's good". Another commented, "I like it here; the staff are nice". Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. We received no questionnaire responses from patients or their relatives.

Staff told us that they were happy working in the home and enjoyed engaging with the patients. They felt that they worked well together and were supported by management to do so. There was no responses from the staff online survey.

A relative consulted was positive when speaking of their loved one's care. They told us, "They (the staff) have done all they can for (name). We have no complaints. They are very good".

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. Newly appointed staff were supervised well and supported through their induction period.

Checks were made to ensure nurses maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

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

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 friendly. Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences. Patients spoke fondly on their interactions with staff.

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.

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 patients choice in how and where they spent their day or how they wanted to engage socially with others.

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about patients' needs, especially changes to care. Staff were satisfied with the communication in the home and felt that they communicated well with one another.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and records of repositioning were maintained. Where a patient had a wound, a care plan was in place to guide staff on how to treat the wound and wound evaluations completed to monitor the effectiveness of the treatment.

Patients were assessed on admission of their risk of falling. Those deemed at risk had a dedicated fall's care plan developed to instruct staff on how to mediate the risk/s. A review of accident records in the home evidenced that the correct actions were taken following a patient falling in the home and the correct persons notified of the accident. Falls were reviewed on a monthly basis for patterns and trends in an attempt to further reduce the incidences of falls occurring in the home.

Patients had good access to food and fluids throughout the day and night. Snacks and fluids were served to patients from a tea trolley in between mealtimes. These trolleys were appropriately supervised when on the floor.

Patients were safely transferred and positioned for their meals and the mealtimes were appropriately supervised. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs. Food was only served when the patients were ready to eat their meal. The meals served appeared appetising and nutritious. Staff were aware of the actions to take should a patient refuse their meal.

Continence needs were assessed and planned on admission. Continence care plans included the equipment and levels of assistance required to meet the patients' needs. However, the process in place to monitor bowel management was not robust. One patient was identified to have no bowel movements for seven days prior to action being taken. This was discussed with the manager and identified as an area for improvement.

The activity therapist oversaw the activity provision in the home. They knew the patients well. Information on the doors leading to patients' bedrooms identified the patient's interests and hobbies. There was a programmed of activities displayed at the reception area. Christmas decorations were in the process of being displayed. Preparations were in place to celebrate the Christmas period. Patients attended monthly patient meetings and activities were always on the agenda for discussion and new ideas. Minutes of the meetings were maintained. Each patient's activity engagements were recorded within their care records.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse at the time of their admission to the home. This included patients admitted for short stay respite care. Following this initial assessment, care plans were developed to direct staff on how to meet the patients' needs. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate. Risk assessments and care plans were reviewed regularly to ensure that they remained reflective of patient need.

Care records were stored securely. Computers with access to the patients' care records were locked or turned of when staff were not present.

Supplementary care records were maintained to evidence care delivery in areas, such as, personal care delivery, food/fluid intake, continence management and records were kept of any checks staff made on patients.

Nurses completed daily progress notes to monitor and evaluate the care delivered to the patients in their care.

3.3.4 Quality and Management of Patients' Environment Control

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. There were no malodours in the home.

Fire safety measures were in place to protect patients, visitors and staff in the home. Corridors and fire exits were clear of clutter and obstruction should the need to evacuate occur and fire extinguishers were easily accessible. Staff had attended fire training and fire safety checks were regularly conducted. There were no actions identified from the most recent fire risk assessment.

Three rooms with wet flooring were identified where there was no signage in place warning any persons entering the rooms of the potential slip hazards. This was discussed with the manager and identified as an area for improvement.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. The home was clean and staff were observed to embed infection control training into practice through their use of personal protective equipment and hand hygiene.

3.3.5 Quality of Management Systems

Mrs Michelle Devlin has been the Registered Manager of the home since 23 March 2015. Staff commented positively about the manager and described her as supportive and approachable.

In the absence of the manager there was a nominated nurse-in-charge (NIC) to provide guidance and leadership. The NIC was clearly identified on the duty rota.

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.

The number of complaints to the home was low. There was a robust system in place to manage any complaints received. All 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. Patients spoken with said that if they had any concerns, they knew who to report them to and said they were confident that the manager or person in charge would address their concerns.

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	2	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Michelle Devlin, 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time **To be completed by:** 6 December 2025	The registered person shall review bowel management in the home to ensure accurate recording and nurses' knowledge of the process in place where concerns are identified. Ref: 3.3.2
	Response by registered person detailing the actions taken: All care plans have been reviewed in relation to bowel management. During the daily flash meeting nurses will update Home Manager on residents bowel movements so as to ensure appropriate action is taken by the nurses in administering laxatives . Nurses have also been advised to record in the daily progress notes each day on Goldcrest and on 24 hour shift report what day a resident is from their last bowel movement so appropriate action can be taken.
Area for improvement 2 **Ref:** Regulation 14 (2) (a) and (c) **Stated:** First time **To be completed by:** With immediate effect (6 November 2025)	The registered person shall ensure that the appropriate signage is displayed when floors are wet to warn patients, visitors and staff of slip hazards. Ref: 3.3.4
	Response by registered person detailing the actions taken: Supervision has taken place with all domestic staff to ensure the wet floor sign is put in place when they wash a floor. This is being monitored during the daily walk around.

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