The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **The Grouse Care Home**

Provider: **Ann's Care Homes**

Date of Inspection: **18 December 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:	Ann's Care Homes
Responsible Individual:	Mrs Charmaine Hamilton
Registered Manager:	Mr Paul Gildernew
Service Profile – This home is a registered nursing home which provides nursing care for up to 28 patients within two separate buildings on the same site; the Annahugh Unit and the Redlion Unit. Patients cared for have mental health or physical disability needs. Patients have access to communal dining, lounge and garden areas.	

2.0 Inspection summary

An unannounced inspection took place on 18 December 2025 from 10.00am to 4.00pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

Patients said that they enjoyed living in the home and were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

There were no areas for improvement to review from the previous care inspection and this inspection resulted in no areas for improvement. It was evident that safe, effective and compassionate care was delivered in the home and the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

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 spoken with during the inspection told us that they were happy living in the home. One told us, "I am happy here. The staff are good and the food is good". We received no questionnaire responses from any patients. Patients could choose where to go to within the home and how to spend their day.

A relative told us that they were very happy with the care their loved one was receiving and said"It's brilliant here". We received no questionnaire responses from relatives.

Staff in both units told us that they were happy working in the home and enjoyed engaging with the patients. We received no responses from the online staff survey.

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. In addition to mandatory training, staff confirmed that they were further supported through staff supervision and appraisal. There was evidence of robust systems in place to manage staffing.

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

Regular staff meetings were conducted to aid with communication in the home.

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 and that they were satisfied with the staffing levels. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

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.

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 patient 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 their patients, especially changes to care, that they needed to assist them in their caring roles.

Pressure care and wound care had been managed well. Where a patient had more than one wound, each wound was care planned and evaluated separately. Supplementary care records recorded repositioning and any checks made on the patient. Staff nurses completed annual wound care competencies.
Some patients have to be deprived of their liberty (DoL) to keep them safe. Where this occurred, DoL authorisations were completed and monitored and DoL care plans were in place to clearly identify individual requirements such as supervision levels. Records were maintained of any healthcare communication or visit in relation to the DoL.

Falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented. All incidents occurring in the home were reviewed by management at the time of the incident and on a monthly basis.

Patients had good access to food and fluids throughout the day and night. Nutritional risk assessments were completed monthly to monitor for weight loss or weight gain. Nutritional care plans were in line with the recommendations of the speech and language therapists and/or the dieticians. Mealtimes were well supervised. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs.

Continence assessments were completed on admission and reviewed monthly. Where a patient had a catheter insitu; the catheter date due changed was diarised to ensure that it was done. Catheter packs were available in the home to aid in the change. Input and output records had been recorded well.

The home had been attractively decorated for Christmas, and Christmas activities had been planned. An activities board was displayed showing the planned daily activities scheduled. Patients had planned days out away from the home to go, for example, shopping.

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, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Patients care records were held confidentially.

Supplementary care records, such as, bowel management, food and fluid intake, repositioning and activity provision had been recorded well. Nursing staff recorded daily evaluations about the delivery of care.

3.3.4 Quality and Management of Patients' Environment Control

The home was clean and tidy and patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

Fire safety measures were in place to protect patients, visitors and staff in the home. Corridors and fire exits were free from clutter and obstruction.
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. Mr Paul Gildernew has been the Registered Manager in this home since 12 August 2020. The manager was supported by a deputy manager. Staff commented positively about the management team and described them as supportive, approachable and always available to provide guidance.

The Annual Quality Report was available and completed in November 2025. The report included feedback from the patients and detailed the actions taken in response to the feedback.

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 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

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr Paul Gildernew, Registered Manager, as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority

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