

Inspection Report

Name of Service: Apple Blossom Lodge

Provider: Ann's Care Homes Ltd

Date of Inspection: 23 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/Registered Provider:	Ann's Care Homes Ltd
Responsible Individual:	Mrs Charmaine Hamilton
Registered Manager:	Mr Martin Anthony McKee
Service Profile: Apple blossom lodge is a nursing home registered to provide nursing care for up to 37 male patients. The home is divided into three units, one on the ground floor and two on the first floor. Patients have access to a range of communal spaces including lounges, dining rooms, an enclosed courtyard and an open garden area.	

2.0 Inspection summary

An unannounced inspection took place on 23 September 2025, from 10.10am to 4.20pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. However, improvements were necessary in relation to personal medication records and the reconciliation of controlled drugs.

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

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, and new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

RQIA would like to thank the staff for their assistance throughout the inspection.

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 service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection, information held by RQIA about this home was reviewed. This included 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.

3.2 What people told us about the service and their quality of life

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs. 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 patient liked to take their medicines. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

No completed questionnaires or responses to the staff survey were received following the inspection.

3.3 Inspection findings

3.3.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' 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.

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

Personal medication records were in place for each patient. 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 they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments.

Some personal medication records were not up to date with the most recent prescription and some were incomplete. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff did not use these records as part of the administration of medicines process. An area for improvement was identified. Some personal medication records were updated during the inspection.

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

All patients 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, warfarin, epilepsy 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.

Some patients 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 patient 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 patient.

The management of thickening agents and nutritional supplements was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained. One patient did not have the thickening agent listed on the medication administration record this was updated during the inspection.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside of the recommended range. One insulin pen was labelled to denote ownership but did not have the date of opening recorded to facilitate the audit and disposal at expiry. This was discussed with the manager for immediate action and on-going vigilance.

3.3.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient'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 patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

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 patient 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 and the storage of controlled drugs.

The manager was reminded that medicines awaiting collection for disposal should be stored securely to prevent unauthorised access and collected in a timely manner.

3.3.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

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

A sample of the medicines administration records was reviewed. Most of the records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book.

Review of records of receipt, administration and disposal of controlled drugs indicated that they had been administered as prescribed and the balances remaining in stock were correct. However, a review of the reconciliations carried out by two members of staff at each handover indicated that one balance had been recorded incorrectly for eight days. This suggests that staff did not perform a physical count of the stock each time. This was discussed with staff and the manager for immediate corrective action. An area for improvement was identified.

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 medicines to facilitate audit and disposal at expiry. One expired eye preparation was found on a medication trolley this was discarded and replaced during the inspection.

3.3.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

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.

There had been no recent admissions/readmissions to the home. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the patient's medicines and this was shared with the GP and community pharmacist.

3.3.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse 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.

There have been no medicine related incidents reported to RQIA since the last medicines management inspection. Management and staff were familiar with the type of incidents that should be reported. 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 medicines were being administered as prescribed.

3.3.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that they 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. Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

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*	5*

* the total number of areas for improvement includes four which were carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Martin McKee, 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 Home Regulations (Northern Ireland) 2005	
<p>Area for improvement 1</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p> <p>To be completed by: 23 September 2025</p>	<p>The registered person shall ensure that personal medication records are accurately maintained and up to date with the latest prescription.</p> <p>Ref: 3.3.1</p>
	<p>Response by registered person detailing the actions taken:</p> <p>The system used for personal medication records has been reviewed and the home has now changed over to the Goldcrest personal medication prescription record system. The goldcrest personal medication prescription portal will be updated and a new personal medication record will be printed and placed into the medication administration file. A monthly governance audit is now in place whereby once a month a review of all personal medication records will be carried out to ensure that they reflect the latest prescription and mars sheet . A supervision record has been carried out with all nurses to ensure they are aware of the system change, what their role is in maintaining the live document and awareness of the monthly audit.</p>
Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
<p>Area for improvement 1</p> <p>Ref: Standard 31</p> <p>Stated: First time</p> <p>To be completed by: 23 September 2025</p>	<p>The registered person should review the process for reconciling controlled drugs at shift handover to ensure that a physical count occurs on all occasions.</p> <p>Ref: 3.3.3</p>
	<p>Response by registered person detailing the actions taken:</p> <p>A supervision was carried out with the nurses to emphasize the importance of effective checking of the controlled drugs at shift handover and when counting these, both the underside and upperside of the pack are checked thoroughly to ensure that the tablets are in place.</p>

<p>Area for improvement 2</p> <p>Ref: Standard 4</p> <p>Stated: Second time</p> <p>To be completed by: 2 June 2024</p>	<p>The registered person shall ensure that care plans are developed to address any assessed needs of patients</p> <hr/> <p>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</p> <p>Ref: 2.0</p>
<p>Area for improvement 3</p> <p>Ref: Standard 4</p> <p>Stated: Second time</p> <p>To be completed by: 2 June 2024</p>	<p>The registered person shall ensure that care plans are re-written in the event of significant changes in the needs of patients, and that out of date records are appropriately archived.</p> <hr/> <p>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</p> <p>Ref: 2.0</p>
<p>Area for improvement 4</p> <p>Ref: Standard 23</p> <p>Stated: First time</p> <p>To be completed by: 2 June 2024</p>	<p>The registered person shall ensure that where a patient requires pressure area care, a care plan is in place detailing the recommended frequency of repositioning; and that this is accurately reflected and recorded in the corresponding repositioning chart.</p> <hr/> <p>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</p> <p>Ref: 2.0</p>
<p>Area for improvement 5</p> <p>Ref: Standard 12</p> <p>Stated: First time</p> <p>To be completed by: 2 June 2024</p>	<p>The registered person shall ensure that where a patient is at risk of dehydration a recommended daily fluid intake target is recorded within the patients care plan and daily fluid intake chart, with the action to take, and what stage, if the recommended daily fluid target has not been achieved.</p> <hr/> <p>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</p> <p>Ref: 2.0</p>

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



The Regulation and Quality Improvement Authority

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