Inspection Report

Name of Service: Cranley Lodge

Provider: Cranley Lodge

Date of Inspection: 9 September 2025 & 16 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:	Cranley Lodge
Responsible Individual:	Mr Brian Adam
Registered Manager:	Mrs Elaine Thompson

Service Profile:
Cranley Lodge is a residential care home registered to provide health and social care for up to 60 residents living with dementia.

The home is divided in to two suites, the Nightingale Suite on the ground floor and the Alexandra Suite on the first floor. Residents have access to communal bathrooms, lounges, dining rooms and an outdoor area.

2.0 Inspection summary

An unannounced inspection took place on 9 September 2025, from 10.00am to 2.20pm and on 16 September 2025, from 11.00am to 12.00pm. The inspection was completed by a pharmacist inspector and a finance inspector. The inspection focused on medicines management and the management of residents' finances and property within the home.

The inspection was undertaken to evidence how medicines and residents' finances 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 management of residents' finances. The inspection also reviewed the areas for improvement identified at the last medicines management inspection. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

The two areas for improvement identified at the last medicines management inspection were assessed as met.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and 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 residents were administered their medicines as prescribed. An area for improvement was identified in relation to records regarding insulin.

No new areas for improvement were identified during the finance inspection. One area identified within Section 3.3.7 of this report will be reviewed at the next RQIA inspection.

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

Residents were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the residents well.

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 areas for improvement identified at previous inspections, 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.

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 residents 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 resident liked to take their medicines. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

RQIA received five completed questionnaires from residents and staff following the inspection. All respondents were positive regarding the management of medicines and the care provided in the home.

No responses to the separately issued 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?

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.

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 mostly 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. For residents prescribed insulin, this had been omitted from personal medication records. It was explained that this was an oversight due to this medicine being administered by district nurses. Personal medication records must include all prescribed medicines. An area for improvement was identified. A small number of minor discrepancies were also highlighted 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 and insulin, was reviewed. Care plans contained sufficient resident-specific detail to direct the required care. Medicine records were mostly well maintained (see above regarding records for insulin). The audits completed indicated that medicines were administered as prescribed. Records included the reason for and outcome of each administration of 'when required' medicines.

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 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.

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 and the storage of controlled drugs.

Satisfactory arrangements were in place for the safe disposal of medicines.

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 residents to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. Records were found to have been accurately completed. Handwritten records included the start date and two staff signatures to verify their accuracy. Records were filed once completed and were readily 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.

Occasionally, residents may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the resident's care plan. Written consent and care plans were in place when this practice occurred.

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.

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.

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. There was evidence that any discrepancies had been followed up in a timely manner to ensure that the correct medicines were available for administration. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

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.

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 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 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.

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

3.3.7 Management of residents' finances and property

It is the policy of the home for residents to manage their own monies. However, in line with The Residential Care Homes Regulations (NI) 2005, a safe place was available for residents to

deposit items for safekeeping when required. A review of records confirmed that no monies or valuables were held on behalf of residents at the time of the inspection.

Discussions with staff confirmed that no bank accounts were used to retain residents' monies and no member of staff was the appointee for any resident, namely a person authorised by the Department for Communities to receive and manage the social security benefits on behalf of an individual.

Two residents' finance files were reviewed. Written agreements were retained within both files. The agreements were up to date with the details of the weekly fee paid by, or on behalf of, the residents and a list of services provided to residents as part of their weekly fee. Both agreements were signed by the resident, or their representative, and a representative from the home.

Discussions with staff confirmed that no resident was paying an additional amount towards their fee over and above the amount agreed with the Trusts.

Discussions with staff confirmed that no transactions were undertaken on behalf of residents by members of staff. Residents, or their representatives, paid the hairdresser and podiatrist directly for services provided. Items, such as toiletries, were purchased by residents or provided by the residents' family members.

A review of two residents' files evidenced that property records were in place. The records were updated with additional items brought into the residents' rooms following admission. There was no recorded evidence to show that the personal possessions were checked, at least quarterly.

Staff informed the inspector that the system for recording residents' personal property was currently under review and provided assurances that a revised system would be implemented by 30 September 2025. The property records will be reviewed again at the next RQIA inspection.

Discussion with the manager confirmed that no transport scheme was in place at the time of the inspection.

4.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	2*	3*

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

The area for improvement and details of the Quality Improvement Plan were discussed with Mrs Elaine Thompson, Registered Manager, as part of the inspection process. The timescale for completion commences from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 9 September 2025	The registered person shall ensure that all prescribed medicines, including insulin and other medicines administered by other healthcare professionals are included on personal medication records. Ref: 3.3.1
	Response by registered person detailing the actions taken: All medication records have been updated to reflect all medications prescibed by the GP which include the insulin prescibed and administered by the district nurses.
Area for improvement 2 **Ref:** Regulation 14 (2) **Stated:** First time **To be completed by:** 10 April 2025	The registered person shall ensure that all areas of the home to which residents have access to are free from hazards to their safety. This area of improvement is with reference to the management of denture cleaning tablets.
	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. Ref: 2.0
Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 27 **Stated:** Second time **To be completed by:** 31 May 2025	The registered person shall ensure that the areas identified at this inspection in regard to the home's environment are addressed.
	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. Ref: 2.0
Area for improvement 2 **Ref:** Standard 8 **Stated:** First time **To be completed by:** 30 April 2025	The registered person shall ensure that all records are kept up to date, legible and accurate. This area for improvement relates to post fall observation records.
	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. Ref: 2.0

Area for improvement 3 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 30 April 2025	The registered person shall ensure that the environment is managed to minimise the risk of infection to residents, staff and visitors. This area for improvement is in relation to the deep cleaning of the kitchenette, shower chairs and commodes.
	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. Ref: 2.0

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