

Inspection Report

Name of Service: Trevenna Lodge

Provider: Trevenna Lodge

Date of Inspection: 18 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:	Trevenna Lodge
Responsible Individual:	Mr Tom Corr
Registered Manager:	Mr Tom Corr, not registered
Service Profile: Trevenna Lodge is a residential care home registered to provide health and social care for up to 9 residents with physical disability under 65 years of age and frail elderly over 65 years of age. Bedrooms are located over two floors. Residents have access to a lounge, dining room, conservatory and garden.	

2.0 Inspection summary

An unannounced inspection took place on 18 September 2025, from 10.00am to 1.30pm. 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. One area for improvement identified at the last care inspection was reviewed and the remaining areas for improvement 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 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 the majority of medicines as prescribed. However, improvements were necessary in relation to monitoring and recording medication room temperatures.

One area for improvement in relation to medicine administration identified at the last care inspection was assessed as met and the remaining areas for improvement identified at the last care inspection were carried forward for review at the next 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

One questionnaire returned from a relative indicated that they were satisfied with how their relative's medicines were managed.

A health care professional who visits the home indicated that residents have a choice of where to have their procedures or medicines administered.

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 and medicines were administered in accordance with individual resident preference.

No 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?

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 they may be used by other healthcare professionals, for example, 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.

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 specialist medicines 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. One care plan needed updated in line with the most recent prescription. Assurances were provided that this would be actioned immediately.

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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located. Satisfactory arrangements were in place for medicines requiring cold storage, the storage of controlled drugs and the safe disposal of medicines.

Medicines must be stored at the manufacturers' recommended temperature in order to ensure their stability and efficacy; this is usually at or below 25°C for medicines recommended to be stored at room temperature. Temperatures of the medication storage area were not being monitored or recorded. An area for improvement was identified.

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. Most of the records were found to have been accurately completed. One missed signature was brought to the attention of the manager for ongoing monitoring. 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. There were satisfactory arrangements in place for the management of controlled drugs. Staff were reminded to ensure that full details of the receipt are recorded in the controlled drug record book.

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. 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.

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 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 very small number of medicines. The audits were discussed in detail with the staff on duty and the manager for on-going monitoring.

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 the 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.

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

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

	Regulations	Standards
Total number of Areas for Improvement	4*	7*

* the total number of areas for improvement includes 10 which were carried forward for review at the next inspection.

The area for improvement and details of the Quality Improvement Plan were discussed with the person in charge, 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 Residential Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 21 (1) (a) Stated: First time To be completed by: 3 October 2024	The registered person shall ensure that anyone employed to work in the home is recruited in accordance with current legislation.
	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
Area for improvement 2 Ref: Regulation 21 (1) (a) Stated: First time To be completed by: 3 October 2024	The registered person shall ensure that staff recruitment records are accurate and up to date prior to commencing employment.
	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
Area for improvement 3 Ref: Regulation 15 (2) (b) Stated: First time To be completed by: 10 October 2024	The registered person shall ensure that the assessment of residents needs is revised at any time and in any case not less than annually, to reflect the needs of the resident.
	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
Area for improvement 4 Ref: Regulation 16 (1) Stated: First time To be completed by: 17 October 2024	The registered person shall ensure that care plans are completed to reflect the resident' current needs, including any relevant medical conditions, social, religious and spiritual needs.
	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 Residential Homes, December 2022	
Area for improvement 1 Ref: Standard 30 Stated: First time To be completed by: 18 September 2025	The registered person shall ensure that the room temperature of the medication storage area is monitored daily and records maintained. Ref: 3.3.2
	Response by registered person detailing the actions taken: Room temperatures are now being physically recorded as required (document reviewed by Care Inspector 17 th October 2025).
Area for improvement 2 Ref: Standard 20 Stated: First time To be completed by: 10 October 2024	The registered person shall ensure that the privacy arrangements for the identified resident are reviewed.
	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 12.4 Stated: First time To be completed by: 3 October 2024	The registered person shall ensure that a daily menu is displayed in a suitable format and in an appropriate location.
	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 4 Ref: Standard 6.3 Stated: First time To be completed by: 31 October 2024	The registered person shall ensure that the resident or their representative, where appropriate, sign the care plan along with the person responsible for completing it and the manager. Is the resident or their representative is unable to sign or chooses not to sign, this is recorded.
	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 5 Ref: Standard 20 Stated: First time	The registered person shall ensure that a system is implemented to oversee the effective management of residents' weights.
	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.

To be completed by: 10 October 2024	Ref: 2.0
Area for improvement 6 Ref: Standard 20 Stated: First time To be completed by: 3 November 2024	The registered person shall ensure that effective quality assurance audits are completed to assess the delivery of care in the home. With specific reference to: • care records • environment
	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 7 Ref: Standard 1.6 Stated: First time To be completed by: 31 October 2024	The registered person shall ensure that the views and opinions of relatives regarding the running of the home are sought formally at least once a year.
	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

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