The Regulation and Quality Improvement Authority

# Inspection Report

**Name of Service:** **Rose Lodge**

**Provider:** **Rose Lodge Care Home (Lisburn) Ltd**

**Date of Inspection:** **21 October 2025**

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

## 1.0 Service information

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| **Organisation/Registered Provider:** | Rose Lodge Care Home (Lisburn) Ltd |
| **Responsible Individual:** | Mr Kevin McKinney |
| **Registered Manager:** | Ms Julie McAleavey – Not registered |
| **Service Profile –**<br>This home is a registered nursing home which provides general nursing and physical disability care for up to 48 patients. The home is divided into two units, Dowling and Warnock units – both are situated on the ground floor of the home. Patients have access to communal living and dining spaces as well as the garden areas. | |

## 2.0 Inspection summary

An unannounced inspection took place on 21 October 2025 from 9.35am to 4.30pm 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 30 May 2025.

As a result of this inspection, all areas for improvement from the previous care inspection were assessed as having been addressed by the provider. A new area for improvement was identified in relation to call bell response times. Full details can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

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

## 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 they were treated well by staff who were caring and supportive. Patients' comments included, "Its brilliant; staff are very good and the food's lovely". Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Relatives consulted during the inspection were positive in regards to the service provision in the home. One told us, "There is a lovely atmosphere in the home and its very well decorated (for Halloween). We are very happy with the care and satisfied that any concern raised would be dealt with". Another commented, "This home is leagues above the others. We were involved in the care planning. There is good entertainment here and it's always well decorated". We received one questionnaire response from a relative. The respondent was positive in relation to care delivery, but were concerned about the level of agency use, especially during the night, and the response times to call bells.

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 were no responses from the staff online survey.

## 3.3 Inspection findings

### 3.3.1 Staffing Arrangements

Staff told us that newly employed staff received a good induction to the home and that they had been trained well to perform their duties. A system was in place to ensure that staff completed their training.

The manager confirmed the staffing arrangements in the home and staff felt that there were sufficient staff on duty to take care of the needs of patients. Staff spoke positively on the teamwork in the home. However, patients, while speaking positively of the staff caring for them, raised concerns about the response times when call bells sounded and one raised concern around the constant sound of call bells in the unit. In addition, a relative identified call bell responses as a concern. During the inspection we noted prolonged delays in staff responding to call bells sounded by patients for assistance. This was discussed with the manager and identified as an area for improvement.

Staff were observed to deliver care 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. Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences. Patients spoke fondly on their interactions with staff. A relative told us, "We are very happy with the care; never had any concerns. We can come and go; I know the codes in/out". Another relative told us that they were happy with the care and were aware of an upcoming relatives meeting with the homes management.

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

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and the manager confirmed the measures they were implementing to ensure all pressure relief given during the day was recorded. This will be reviewed again at a subsequent care inspection.

Where a patient had a wound, the records reviewed evidenced that the wound care had been delivered in accordance with best practice. The manager audited wound care on a monthly basis.

A patient requiring one to one care had a care plan in place to guide staff on the care required for this arrangement. The manager maintained a restraint register to monitor the incidences of restrictive practices.

Following the previous care inspection, a new head cook and deputy manager met with patients to discuss the food provision in the home and made changes to the menu as a result. Patients confirmed at this inspection that the food provision had significantly improved. Menus were available to review the planned meals and any variations to the menu were recorded.

A nutritional risk assessment was completed monthly on each patient to monitor for weight loss and/or weight gain. Nutrition and hydration care plans were in place to identify nutritional needs and preferences. Records of food and fluid intake were recorded well and nurses monitored intakes as part of their daily evaluations. Staff were aware of the actions to take if a patient refused food or appeared dehydrated.

### 3.3.3 Management of Care Records

A nurse assessed patients' needs at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet the patients' needs. Risk assessments and care plans were reviewed regularly to ensure that they remained up to date. Care records were stored securely.

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

The home was warm, clean and comfortable. There were no malodours in the home. The home was well decorated for the Halloween season.

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.

Medicine fridge temperatures had been monitored daily and records indicated that they had been maintained between two and eight degrees centigrade.

Staff confirmed that the equipment in use was in good working order and that there were clear systems for reporting any faults and/or concerns with equipment.

Several audits were conducted to monitor staffs' practices on hand hygiene and use of personal protective equipment. Personal protective equipment and hand hygiene facilities were readily available throughout the home.

## 3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Ms Julie McAleavey has been covering the management of the home since 21 August 2025. Staff commented positively about the manager and described her as supportive, visible and approachable. Relatives and patients commented on the number of recent management changes in the home.

The manager had systems in place to monitor the quality of services provided within the home.

A review of incidents which had occurred in the home evidenced that RQIA had been appropriately informed of notifiable events.

A complaint's file was maintained to record any complaints received. Complaints were audited monthly and complaint's records included the nature of the complaint and any actions taken in response; including the actions taken to prevent a recurrence.

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

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

| | Regulations | Standards |
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| **Total number of Areas for Improvement** | 1 | 0 |

The area for improvement and details of the Quality Improvement Plan were discussed with Kevin McKinney, Responsible Individual and Julie McAleavey, 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**

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| **Area for improvement 1**<br><br>**Ref:** Regulation 12 (1) (a) (b)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>31 October 2025 | The registered person shall review call bell response times to ensure that patients receive assistance in a timely manner when they request this.<br><br>Ref: 3.3.4 |
| | **Response by registered person detailing the actions taken:**<br>Call bell responses were reviewed , and a monthly audit was introduced to monitor response time . The results of each audit are discussed with staff during safetu hudles , providing an opportunity to adress any concerns , highlight good practice and reinforce the importance of responding promptly to call bells. This ongoing review aims to improve resident safety , enhance communication and ensure consistent adherence to expected standards of care. |

The Regulation and Quality Improvement Authority

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