

Inspection Report

Name of Service: Carlisle Court Residential Home

Provider: Kathryn Homes Ltd

Date of Inspection: 8 January 2026

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:	Kathryn Homes Ltd
Responsible Individual:	Mrs Tracey Anderson
Registered Manager:	Ms Diana Pahome
Service Profile: Carlisle Court Residential home is a residential care home registered to provide health and social care for up to 60 residents living with dementia. The home is separated into two units across two floors. A separately registered nursing home occupies the same building.	

2.0 Inspection summary

An unannounced inspection took place on 8 January 2026, from 10.00am to 2.15pm. The inspection was completed by two pharmacist inspectors 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 inspection also reviewed the area 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.

Mostly satisfactory arrangements were in place for the safe management of medicines. 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. However, improvements were necessary in relation to the secure storage of medicines, the safe storage of controlled drugs and ensuring medicines are not used after expiry.

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

The area for improvement in relation to the management of warfarin, identified at the last medicines management inspection, was assessed as met. Details, including new areas for improvement identified and the areas for improvement carried forward, 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.

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?

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. A small number of minor discrepancies were 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, thickening agents and insulin was reviewed. Where relevant, 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 warfarin was reviewed. Warfarin is a high-risk medicine, which requires regular blood testing. The dose of warfarin prescribed depends on the blood test result. Although no warfarin was in use at the time of the inspection, robust systems were in place to ensure that running balances were maintained and that the date of opening was recorded to facilitate audit.

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. One delay in obtaining one antibiotic was discussed with the manager for review.

The majority of 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. However, one medicines trolley was observed unlocked in an unlocked and unattended office. An area for improvement was identified.

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 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. Records were filed once completed and were readily retrievable for audit/review. Staff were reminded that handwritten additions to medicine records should be verified and signed by two members of staff and include the month and year.

Controlled drugs are medicines, which 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 the majority of controlled drugs. However, one controlled drug, temazepam, which must be stored in the controlled drugs cupboard, was stored on the trolley. An area for improvement was identified.

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. Care plans were in place when this practice occurred. Written consent / prescriber authorisation for one medicine to be crushed was not in place. This was highlighted to staff who immediately followed this up with the prescriber and pharmacist for review.

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 action plans had been implemented and addressed.

The date of opening was recorded on medicines to facilitate audit and disposal at expiry. Two eye preparations, which expired four weeks after opening, remained in use. These were disposed of immediately. An area for improvement was identified.

The manager agreed to ensure that issues identified during the inspection are reviewed within the audit system.

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.

One medicine had been prescribed in liquid form and then the hospital prescribed the same medicine in tablet form. Both forms of the medicine had been administered. This was highlighted to the manager, who agreed to investigate and update the inspector; a report and incident notification were received on 9 January 2026. Appropriate actions had been taken to prevent a recurrence.

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 the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a 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 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 improvements.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	4*	1*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Diana Pahome, Registered 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 Residential Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 13 (4) Stated: First time To be completed by: 8 January 2026	The registered person shall ensure that medicines are safely and securely stored and that medicine trolleys are locked when unattended. Ref: 3.3.2
	Response by registered person detailing the actions taken: The creams are stored in a separate trolley in the home. The key, which was previously on a separate set, is now held by the senior carer on the units central set of keys. When not in use, the trolley is stored in the treatment room. Supervisions have been carried out with all senior carers. Evidence of this is available for review. This is monitored by the Registered Person during daily walkabouts.
Area for improvement 2 Ref: Regulation 13(4) Stated: First time To be completed by: 8 January 2026	The registered person shall ensure that controlled drugs requiring safe storage are stored in the controlled drugs cupboard. Ref: 3.3.3
	Response by registered person detailing the actions taken: A controlled drugs have been highlighted on residents individual kardex's and a full list of all controlled drugs has been displayed in both treatment rooms for Senior Carers to follow. Supervision has been completed with all senior carers on the safe storage of controlled drugs in the home. Registered manager carries out spot checks of the storage of controlled drugs during her walkarounds of the home.
Area for improvement 3 Ref: Regulation 13 (4) Stated: First time To be completed by: 8 January 2026	The registered person shall ensure that robust systems are in place to remove expired medicines from use. Ref: 3.3.3
	Response by registered person detailing the actions taken: During the change over of monthly medicines, senior carers will now complete a checklist for each resident to ensure that all creams and eye drops are replaced after 28 days as guidelines. An audit will also be completed by the registered manager. Supervision has been completed with all senior carers.

Area for improvement 4 Ref: Regulation 14 2 (a) Stated: Second time To be completed by: 10 March 2025	The registered person shall ensure as far as reasonably practicable that all parts of the home which residents have access are free from hazards to their safety. 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 25.4 Stated: First time To be completed by: 8 July 2025	The registered person shall review the domestic staffing levels and the deployment of domestic staff across the home to ensure that cleaning duties across the home are successfully met. 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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