

Inspection Report

Name of Service: Blair Lodge

Provider: Corriewood Lodge Ltd

Date of Inspection: 17 April 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:	Corriewood Lodge Ltd
Responsible Individual:	Ms Paula Murray
Registered Manager:	Miss Hannah Elwood
Service Profile: Blair Lodge is a residential care home, which provides health and social care for up to 29 residents. The home is registered to care for residents living with a learning disability, and mental health needs. The home is divided in six units over two floors. The ground floor contains Oakland's, Brookvale and Eastleigh units. The second floor contains Montague, Bryansburn and Byfleet units.	

2.0 Inspection summary

An unannounced inspection took place on 17 April 2026, from 10.10am 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. 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 records 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 care plans for distressed reactions.

Whilst an area for improvement was identified, there was evidence that residents 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 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 did not receive any completed questionnaires or responses to the staff survey 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 pain and 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.

Residents will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the resident's distress and if the prescribed medicine is effective for the resident.

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Directions for use were clearly recorded on the personal medication record. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain and other factors. Records of administration included the reason for and outcome of each administration. However, the care plans reviewed did not contain enough detail to direct the required care. An area for improvement was identified.

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, the storage of controlled drugs and the safe disposal of medicines.

The manager was reminded that medicines awaiting collection for disposal should be 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 residents to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. 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 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.

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.

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.

Records of staff training in relation to medicines management, epilepsy awareness, buccal midazolam and anaphylaxis were available.

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	0	7*

* the total number of areas for improvement includes six that have been carried forward for review at the next inspection.

The area for improvement and details of the Quality Improvement Plan were discussed with Miss Hannah Elwood, 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 Care Standards for Residential Homes, December 2022	
Area for improvement 1 Ref: Standard 6 Stated: First time To be completed by: 17 April 2026	The registered person shall ensure that when medicines are prescribed 'when required' to manage distressed reactions, care plans are in place with sufficient detail to direct the required care. Ref: 3.3.1
	Response by registered person detailing the actions taken: All care plans have been updated detailing the specific directions for those who are prescribed PRN medications for distressed reactions.
Area for improvement 2 Ref: Standard 25.8 Stated: First time To be completed by: 1 November 2025	The registered person shall ensure that staff meetings take place on a regular basis and at least quarterly.
	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 12.3 Stated: First time To be completed by: 1 August 2025	The registered person shall ensure that all resident on a modified diet are offered a choice of meals, and 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 4 Ref: Standard 12.4 Stated: First time To be completed by: 1 September 2025	The registered person shall ensure that the menu is displayed in a suitable format and in an appropriate location for residents and their representatives. 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 6 Stated: First time To be completed by: 18 July 2025	The registered person shall ensure that each resident has an individual and up to date care plan. Specifically, care plans for one to one supervision should contain sufficient detail on the specific supervision arrangements to guide staff. The process of one to one provision should be regularly 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 6 Ref: Standard 6 Stated: First time To be completed by: 18 July 2025	The registered person shall ensure that each resident has an individual and up to date care plan. This is stated in relation to the required frequency of repositioning. 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 27 Stated: First time To be completed by: 1 September 2025	The registered person shall ensure that robust cleaning schedules are maintained and implemented. This is stated in relation to high dusting and cleaning under beds. 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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