The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Rosevale Lodge

Provider: Healthcare Ireland No 2 Ltd

Date of Inspection: 22 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:	Healthcare Ireland No 2 Ltd
Responsible Individual:	Ms Amanda Mitchell
Registered Manager:	Mrs Cheryl Palmer
Service Profile: Rosevale Lodge is a residential care home registered to provide health and social care for up to 36 residents over 65 years of age, living with dementia or with a past or present alcohol dependence. There are a range of communal areas throughout the home and residents have access to an outdoor area. There is a registered nursing home which occupies the same building and the registered manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 22 April 2026, from 10.00am to 2.00pm by a pharmacist inspector and from 10.00am to 2.45pm by a finance inspector. The inspection focused on medicines management and the management of residents' finances and property.

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

Review of medicines management found that 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.

Review of residents' finances and property indicated that mostly satisfactory systems were in place. However, an area for improvement was identified in relation to residents' agreements.

The area for improvement in relation to the secure storage of medicines identified at the last care inspection was assessed as met. Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, and the new area for improvement identified in relation to residents financial agreements, 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.

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 and resident-centred care plans were in place. Assurances were provided that clarity would be sought from the prescriber, if more than one medicine was prescribed 'when required' to manage distressed reactions, as to which was first line and that this would be clearly recorded on the personal medication record and care plan. 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. These medicines were administered infrequently and staff advised that records of administration would include the reason for and outcome of each administration.

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 to reflect the most recent prescription. It was agreed that this would be done immediately following the inspection.

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. Medicines, including topical creams, were observed to be stored securely. The temperature of the medicine storage area was 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.

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.

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.

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, action plans had been implemented 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 they staff are competent in managing medicines and that they are supported.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent.

3.3.7 Management of residents' finances and property

A safe place was provided within the home for the retention of service users' monies. There were satisfactory controls around the physical location of the safe place and the members of staff with access to it. A review of a sample of records of service users' monies held at the home showed that the record balances were accurate and up to date at the time of inspection.

No valuables were held for residents at the time of the inspection.

Records confirmed that reconciliations between the monies held on behalf of residents and the records of monies held were undertaken in line with the Residential Care Homes Minimum Standards (Dec 2022). The records of the reconciliations were signed by the member of staff undertaking the reconciliations and countersigned by a senior member of staff.

The home maintained a comfort fund for residents. These are monies donated to the home for the benefit of all residents. Record balances were accurate and up to date at the time of inspection. Purchases made from the comfort fund benefited all residents.

A sample of records of monies deposited at the home on behalf of two residents evidenced that the records were up to date at the time of the inspection. In line with good practice, the person depositing the monies was issued with a receipt.

A sample of records of payments to both the hairdresser and podiatrist was reviewed. In line with good practice, records were up to date and receipts were maintained.

The home manager confirmed that no member of staff was the appointee for any service user. Residents' families or Trusts managed the services users' finances and there was evidence that personal allowances were topped up when needed.

Two residents' files were reviewed; written agreements were retained within both files. The list of services provided to residents was included within the agreement. However, the agreements had not been updated to include the details of the weekly fee paid by, or on behalf of, the residents. In addition, one written agreement had not been signed by the resident, or their representative, nor a representative from the home. An area for improvement was identified.

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

4.0 Quality Improvement Plan/Areas for Improvement

One 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 Cheryl Palmer, 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 5 (2) (a) **Stated:** First time **To be completed by:** 31 May 2026	The registered person shall ensure the resident agreements are updated to include the current fees paid by, or on behalf of, the residents. All agreements should be signed by the resident, or their representative and a representative from the home. **Response by registered person detailing the actions taken:** A full review of all Residents Agreements has been completed, letters concerning current fees for 2026/27 have been issued to all residents next of kin or their representatives to be signed and returned to the Home Administrator. Return of the signed document will be monitored and followed up with a written reminder if not returned by 30.6.26. A matrix will be put in place to provide oversight of the dates the Agreements were issued and returned signed.
Area for improvement 2 **Ref:** Regulation 14 (1) (a) **Stated:** First time **To be completed by:** 11 March 2026	The registered person shall ensure as far as reasonably practical that all parts of the residential care home to which residents have access to are free from hazards to their safety, namely; • Food, fluids and toiletries in residents' bedrooms **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 Residential Care Homes Minimum Standards (Dec 2022)	
Area for improvement 1 **Ref:** Standard 12.4 **Stated:** First time **To be completed by:** 11 March 2026	The registered person shall ensure that the daily menu is displayed in a suitable format and in an appropriate location for residents at each meal time. **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 24.5 **Stated:** First time **To be completed by:** 11 June 2026	The registered person shall ensure staff have a recorded annual appraisal with their line manager yearly.
	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 27.1 **Stated:** First time **To be completed by:** 11 May 2026	The registered person shall ensure that the building is kept clean and hygienic at all times ensuring; • regular cleaning of chairs and equipment used by residents including bath seats, lap belts and alarm mats.
	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

Please ensure this document is completed in full and returned via the Web Portal

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

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