The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Rose Lodge**

Provider: **Rose Lodge Care Home (Lisburn) 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:	Rose Lodge Care Home (Lisburn) Ltd
Responsible Individual:	Mr Kevin McKinney
Registered Manager:	Ms Codrina Aioanei - not registered
Service Profile: Rose Lodge is a nursing home registered to provide general nursing and physical disability care for up to 48 patients. The home is divided into two units. The Dowling and Warnock Units are both are situated on the ground floor of the home. Patients have access to communal living and dining spaces as well as to the garden areas.	

2.0 Inspection summary

An unannounced inspection took place on 17 April 2026 from 9.15am to 5.00pm 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 13 January 2026; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to patients and the service was well led.

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

As a result of this inspection the area for improvement from the previous care inspection was assessed as having been addressed; two medicines management areas for improvement were carried forward for review at the next inspection and five new areas for improvement were identified. Details can be found in the main body of the report and in the quality improvement plan (QIP) in Section 4.

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, "I am happy here; the staff are very good. There is plenty to eat and drink and the food is good". Another commented, "I am very happy and very comfortable here. The staff check on me regularly". Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. We received no questionnaire responses from patients or relatives.

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 was no responses from the staff online survey.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. All appropriate recruitment safety checks had been verified prior to staff commencing in post. Newly employed staff completed a structured induction at the commencement of their employment which included mandatory training. A robust system was in place to ensure that all staff were compliant with pre-determined mandatory training

requirements. Staff told us that they were satisfied that the number and skill mix of staff on duty met the needs of the patients. Patients raised no concerns in relation to the staffing arrangements.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty and that staff responded to requests for assistance promptly in a caring and compassionate manner. Call bells sounding on the day of inspection were answered in a timely manner and an area for improvement in this regard has now been met.

Minutes of recent staff meetings were available to all staff to aid in the communication within the home.

Checks were made to ensure nurses maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

3.3.2 Quality of Life and Care Delivery

Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences. Interactions between staff and patients were noted to be caring and compassionate. Patients spoke fondly about the staff.

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. Patients told us that they had choice in where and how they spent their day, what they wore and what they had to eat.

Staff confirmed that they received a detailed handover at the commencement of their shift and the information shared included important aspects of patients' needs, especially changes to care.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

Patients who required special attention with skin care were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs. Where a patient had a wound, wound care records directed staff on how to treat the wound and wound evaluation records monitored the progress of the treatment.

Patients had identified fluid targets within their care records to maintain hydration. However, when these targets were not consistently achieved, actions indicated within the patient's care plan were not adhered to. This was discussed with the manager and identified as an area for improvement.

Patients had good access to food and fluids throughout the day and night. Patients were safely positioned for their meals and the mealtimes were appropriately supervised. Staff communicated well to ensure that every patient received their meals in accordance with their assessed needs. Food was only served when the patients were ready to eat their meal. The meals served appeared appetising and nutritious. It was good to note that patients' opinions on food provision were sought through a recent menu review and new dish suggestion questionnaire. Patients enjoyed their meal and spoke positively of the quality of their meal.

Continence assessments were completed on admission. Care plans were developed to identify how to meet each patient's continence and personal care needs. Supplementary records were completed to evidence the care given to patients. Improvements were required in the oversight of patients' bowel management records to ensure the patients received any required intervention. The continence care plan did not inform staff on the actions to take when outside of the normal bowel pattern. This was discussed with the manager and identified as an area for improvement.

Activities for patients were provided incorporating both group and one to one activities. Birthdays and annual holidays were celebrated. Planned activities included walking groups, reminiscence, bingo, movies, afternoon tea, sensory activities, music and arts and crafts. A recent residents' meeting included discussions on activities, food provision and the environment. The manager was planning a date for the next relatives' meeting.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse 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. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate. Risk assessments and care plans were reviewed regularly to ensure that they remained reflective of patient need. Care records were stored securely.

Supplementary care records were maintained to evidence the care delivered to patients. The records included personal care delivery, food and fluid intake, repositioning, checks made on patients and continence care.

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

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. There were no malodours in the home.

Externally the home was well maintained. There was an enclosed garden area to the back of the home where patients could sit outside.

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. However, a fire door was blocked from closing in the event of a fire bell sounding. This had been discussed at a previous care inspection and now identified as an area for improvement. In addition, the most recent Fire Risk Assessment was completed on 9 August 2023 and not repeated or reviewed since then. An area for improvement was identified.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. Although, during the inspection we observed unidentified patients' toiletries within two communal areas. This was discussed with the manager and identified as an area for improvement. 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 Codrina Aioanei has been managing the home since 5 November 2025 and is in the process of registering with RQIA as manager. Staff commented positively about the manager and described her as supportive and approachable.

In the absence of the manager there was a nominated nurse-in-charge (NIC) to provide guidance and leadership. The NIC was clearly identified on the duty rota.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. The manager had a suite of audits to complete. We discussed ways in enhancing the recording of these audits.

The number of complaints to the home was low. There was a system in place to manage any complaints received. We discussed ways of enhancing the recording of complaints. A compliments book was available with cards and emails of thanks. All compliments received were shared with staff.

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. Patients spoken with said that if they had any concerns, they knew who to report them to and said they were confident that the manager or person in charge would address their concerns.

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	5*	2

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Codrina Aioanei, Manager and Mr Kevin McKinney, Responsible Individual, 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	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 13 January 2026	The registered person shall review the management of insulin to ensure that safe systems are in place as detailed in the report. Ref: 2.0
	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.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 13 January 2026	The registered person shall ensure that medicines are safely and securely stored and that medicine trolleys are locked when unattended. Ref: 2.0
	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.
Area for improvement 3 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time **To be completed by:** 30 April 2026	The registered person shall review the management of hydration to ensure that realistic fluid targets are set and care is delivered as set out in the patients' care plans. Ref: 3.3.2
	Response by registered person detailing the actions taken: A full review of hydration management systems is beeing completed by the manager and nursing team. Fluid target guidance within care plans is beeing reviewed to ensure targets are realistic, person-centred and reflective of the patients' current clinical needs. Daily oversight arrangements have been implemented through flash meetings and nurse handovers to identify patients not achieving their fluid targets. Staff have been instructed to escalate concerns promptly to the nurse in charge for clinical review and intervention. Care plans and monitoring records have been updated to include clear actions required when patients are not meeting their fluid intake targets, including encouragement strategies, offering

	preferred drinks, increased monitoring, referral to GP/SALT where appropriate . The manager has discussed with senior staff food and fluid charts to monitor compliance, accuracy and completion of actions identified. Staff guidance and supervision have also been completed regarding accurate recording and escalation of concerns relating to hydration.
Area for improvement 4 **Ref:** Regulation 27 (4) (d) (i) **Stated:** First time **To be completed by:** With immediate effect (17 April 2026)	The registered person shall ensure that fires doors can close in the event of a fire alarm being activated. Ref: 3.3.4
	Response by registered person detailing the actions taken: Immediate action was taken on the day of inspection to ensure that all fire doors were free from obstruction and able to close fully in the event of the fire alarm sounding. Staff were reminded of fire safety responsibilities and instructed that fire doors must never be wedged or obstructed. The issue was discussed during staff handover and safety meetings. Increased environmental checks have been implemented by the nurse in charge and management team to monitor ongoing compliance. Weekly fire alarm tests continue to be completed and documented. Environmental walkarounds and fire safety audits are now undertaken by management to ensure continued compliance with fire safety requirements.
Area for improvement 5 **Ref:** Regulation 27(4) (a) **Stated:** First time **To be completed by:** 31 May 2026	The registered person shall review the Fire Risk Assessment to identify any changes to the fire risk and ensure that the assessment remains current. Ref: 3.3.4
	Response by registered person detailing the actions taken: The Fire Risk Assessment has now been completed on 27.04.2026 and remain reviewed by management and arrangements have been made to ensure ongoing scheduled review in line with fire safety requirements and any environmental or operational changes within the home. A system has been implemented to monitor review dates and ensure all fire safety documentation remains current and reflective of the environment and patient dependency needs. Regular fire safety checks, including weekly fire alarm testing, emergency lighting checks and environmental monitoring, continue to be completed and recorded. Staff remain compliant with mandatory fire safety training requirements.

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 30 April 2026	The registered person shall review the oversight of patient's bowel management records to ensure the patients received any required intervention. Actions taken should be documented as part of the daily evaluation of care. Ref: 3.3.2
	Response by registered person detailing the actions taken: A review of bowel management monitoring systems is beeing completed. Patients identified as requiring bowel monitoring now have clear guidance within their care plans outlining normal bowel patterns, escalation procedures and required interventions when concerns are identified.Ongoing process of monitoring. Daily oversight of bowel charts has been implemented through flash meetings, nurse handovers and clinical reviews to ensure timely intervention where patients have not opened their bowels within the expected timeframe. Staff have received guidance regarding accurate documentation, escalation and evaluation of bowel management concerns. Daily progress notes now include evaluation of interventions and outcomes where bowel monitoring is in place. The manager continue to monitor records to ensure compliance and required interventions are completed appropriately.
Area for improvement 2 **Ref:** Standard 46 **Stated:** First time **To be completed by:** With immediate effect (17 April 2026)	The registered person shall ensure that patients' toiletries are not left within communal areas in the home to make sure of no communal use. Ref: 3.3.4
	Response by registered person detailing the actions taken: Immediate action was taken on the day of inspection to remove all patients' toiletries from communal areas. Staff were reminded of infection prevention and control requirements and the importance of ensuring all personal toiletries remain individually stored and clearly identified for single patient use only. Environmental checks have been strengthened and are now included within walkarounds and infection prevention audits completed by management and the nurse in charge. Staff supervision and reminders have been completed to reinforce good infection prevention and control practices and to ensure ongoing compliance.

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