The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Glasswater Lodge

Provider: Glasswater Lodge

Date of Inspection: 7 May 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:	Glasswater Lodge
Responsible Persons:	Mr Leslie John Reid and Mrs Sarah Reid
Registered Manager:	Mrs Sarah Reid
Service Profile: Glasswater Lodge is a residential care home registered to provide health and social care for up to 31 residents. Residents' bedrooms, communal lounges and the dining room are all located on one level and residents have access to a communal garden.	

2.0 Inspection summary

An unannounced inspection took place on 7 May 2026, from 10.15am to 2.30pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The findings of the medicines management inspection on 4 September 2025 evidenced that safe systems were not in place for some aspects of medicines management. Areas for improvement were identified in relation to the management of distressed reactions, care plans for pain management, crushing medicines to aid compliance, medicines for new admissions and controlled drugs records. The management team were given a period of time to address the issues identified. This follow-up inspection was undertaken to evidence if the necessary improvements had been implemented and sustained.

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, improvement was necessary in relation to the management of distressed reactions.

The areas for improvement in relation to care plans for pain management, crushing medicines to aid compliance, medicines for new admissions and controlled drugs records, identified at the last medicines management inspection, were assessed as met. However, the area for improvement in relation to the management of distressed reactions has been stated for a second time. No new areas for improvement were identified. Areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Details, including the area for improvement stated for a second time and areas for improvement carried forward for review at the next inspection, 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. 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. Whilst some improvements were observed, records of administration did not consistently include the reason for and outcome of each administration and resident-centred care plans did not contain sufficient detail to direct the required care. An area for improvement was stated for a second time.

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.

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. 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 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 incident, which had been reported to RQIA since the last inspection was discussed. There was evidence that the incident 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.

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

It was agreed that the findings of this inspection would be discussed with staff to facilitate ongoing improvement.

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	2*	3*

* the total number of areas for improvement includes one which is stated for a second time and four which were carried forward for review at the next inspection.

The area for improvement stated for a second time and details of the Quality Improvement Plan were discussed with the person in charge, 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 13 (7) **Stated:** Second time **To be completed by:** 31 December 2025	The registered person shall ensure the infection prevention and control issues identified during the inspection are managed to minimise the risk and spread of infection. This area for improvement is made in relation to the following area: - Equipment used by residents, for example, raised toilet seats and shower chairs that have evidence of rust must be repaired or replaced to allow effective cleaning.
	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
Area for improvement 2 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** 9 December 2025	The registered person shall ensure that all areas of the home to which residents have access are free from hazards to their safety and staff are made aware of their responsibility to recognise potential risks and hazards and how to report, reduce and eliminate the hazard.
	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 (December 2022) (Version 1.2)	
Area for improvement 1 **Ref:** Standard 6 **Stated:** Second time **To be completed by:** Immediate and ongoing (7 May 2026)	The registered person shall review the management of medicines prescribed to manage distressed reactions to ensure that: • a care plan is in place to direct care. • the reason for and outcome of each administration is recorded. Ref : 2.0 & 3.3.1
	Response by registered person detailing the actions taken: A care plan has been added to direct staff on when to use the medication for distressed reactions. This care plan has details on the residents behaviour which would indicate they may be coming distressed, it details other methods to use to try to calm them before using the mediaction and it also advises staff to record in the medication files the reason it was given and the outcome it had on the person.
Area for improvement 2 **Ref:** Standard 8 **Stated:** First time **To be completed by:** 31 December 2025	The registered person shall ensure that all records are kept up to date, legible and signed. This area for improvement relates to care plans, risk assessments and post fall observation records.
	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 29 **Stated:** First time **To be completed by:** 9 December 2025	The registered person shall sure that the practice of wedging open fire doors in the home ceases immediately.
	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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