The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Limetree House

Provider: Limetree Residential Limited

Date of Inspection: 13 August 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:	Limetree Residential Limited
Responsible Individual:	Ms Jo Browne
Registered Manager:	Mrs Andrea Walker
Service Profile: Limetree House is a residential care home registered to provide health and social care for up to 35 residents living with dementia. The home is divided across three floors with access to a lift. There are a range of communal areas throughout the home and residents have access to an outdoor patio area.	

2.0 Inspection summary

An unannounced inspection took place on 13 August 2026, from 10.20am to 2.30pm. 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 inspection also reviewed the areas 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. Medicines were stored securely. Medicine administration records and medicine related care plans were mostly well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines. The area for improvement from the last medicines management inspection in relation to care plans for medicines prescribed for use 'when required' for the management of distressed reactions was assessed as met. However, the area for improvement in relation to the removal of expired medicines from stock identified at the last medicines management inspection has been stated for a second time and new areas for improvement were identified in relation to the updating of personal medication records and the management of inhaler spacer devices.

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.

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.

Details of the inspection findings, including new areas for improvement identified, the restated area for improvement and the 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).

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 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.

Some personal medication records were not up to date with the most recent prescription and some were incomplete. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. An area for improvement was identified.

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 and insulin 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.

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.

Some inhaler spacer devices were observed which were not clean. These must be cleaned/replaced in line with the manufacturer's recommendations. An area for improvement was identified.

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. However, during the inspection, expired stock was available for use. Records indicated one administration of expired medicine had occurred. This was highlighted to the person in charge for immediate corrective action and ongoing vigilance. The area for improvement from the previous medicines management inspection in relation to the removal of expired medicines from stock was restated.

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.

There have been no medicine related incidents reported to RQIA since the last medicines management inspection. Management and staff were familiar with the type of incidents that should be reported. The inspector signposted staff to the RQIA provider guidance in relation to the statutory notification of medication related incidents available on the RQIA website.

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 Standards.

	Regulations	Standards
Total number of Areas for Improvement	2*	7*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Andrea Walker, 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 14 (2) (a) **Stated:** First time **To be completed by:** 5 February 2026	The registered person shall ensure that denture cleaning tablets and prescribed creams are stored safely and securely **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 30 **Stated:** First time **To be completed by:** 5 February 2026	The registered person shall ensure that notifiable events are submitted to RQIA in accordance with this regulation. **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 32 **Stated:** Second time **To be completed by:** 13 August 2026	The registered person shall review the systems in place to ensure that expired and/or unlabelled medicines are immediately removed from stock. Ref 2.0 **Response by registered person detailing the actions taken:** Whilst this area had been actioned previously, one medication was identified during the inspection which had expired and had gone unnoticed by staff. This was actioned immediately following the inspection and staff supervisions carried out with senior staff. Additional processes and prominent posters are now in place to ensure any expired and/or unlabelled medications are immediately removed from stock. This will be closely monitored by the Home Manager and Deputy Manager through the auditing process.
Area for improvement 2 **Ref:** Standard 31 **Stated:** First time	The registered person shall ensure that personal medication records are accurately maintained, up to date and obsolete medication records are cancelled and archived. Ref: 3.3.1

To be completed by: 13 August 2026	**Response by registered person detailing the actions taken:** Following this inspection, all personal medication records were reviewed and updated using MD Healthcare documentation and supervisions carried out with senior staff. All personal medication records are now up to date and accurate and all obsolete medication records have been removed. These areas will be closely monitored by the Home Manager and Deputy Manager through the auditing process.
Area for improvement 3 **Ref:** Standard 34 **Stated:** First time **To be completed by:** 13 August 2026	The registered person shall ensure inhaler spacer devices are cleaned and replaced in line with current best practice and the manufacturer's recommendations. Ref: 3.3.2
	Response by registered person detailing the actions taken: This was actioned immediately following the inspection and supervision carried out with senior staff. Processes are now in place to ensure that the inhaler spacer devices are cleaned and replaced in line with best practice and the manufacturers recommendations. This will be closely monitored by the Home Manager and Deputy Manager through the auditing process.
Area for improvement 4 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 12 February 2026	The registered person shall ensure that the system in place to monitor staff's compliance with mandatory training clearly includes all mandatory training and staffs attendance at this.
	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 8 **Stated:** First time **To be completed by:** 5 February 2026	The registered person shall ensure that post falls observations are completed within the timeframes required and record are accurately maintained to reflect this.
	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	The registered person shall ensure residents who have a DoLS in place, have a care plan which clearly reflects this and the reason for the DoLs. This should be kept under regular review.

Stated: First time **To be completed by:** 5 February 2026	**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 6.2 **Stated:** First time	The registered person shall ensure that care plans are in place for residents who wish for their bedroom door to be locked when not in use. This should clearly outline the rationale for this, best interest's decision-making if required and the monitoring arrangements.
To be completed by: 5 February 2026	**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

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