The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Rosemary Lodge Care Home

Provider: Healthcare Ireland No 2 Ltd

Date of Inspection: 27 August 2026

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Registered Provider:	Healthcare Ireland No 2 Ltd
Responsible Person:	Ms Amanda Mitchell
Registered Manager:	Mrs Una Brady, not registered
Service Profile: Rosemary Lodge Care Home is a residential care home registered to provide residential care for up to 44 residents with a range of needs. The home is situated over two floors. There is a range of communal areas throughout the home and residents have access to an enclosed garden.	

2.0 Inspection summary

An unannounced inspection took place on 27 August 2026, from 10.00am to 3.20pm. 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 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 areas for improvement in relation to the security of medicine trolleys and the management of controlled drugs identified at the last medicines management inspection were assessed as met. However, an area for improvement in relation to records of incoming medicines has been stated for a second time. New areas for improvement were identified in relation to outgoing medicines, medicine storage temperatures and the confirmation of medicines on admission.

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. Details of the inspection findings, including areas for improvement carried forward for review at the next inspection and new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

From discussions with staff and observation of interactions with residents, 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 said they had worked hard to implement and sustain improvements identified at the last medicines management inspection and had received help and support from senior management to do so. 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.

Three responses to the staff survey were received following the inspection. These indicated that the staff were very satisfied with the care provided and the management of medicines in the home.

No completed questionnaires were received 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 to confirm that they were accurate. Staff were reminded that two staff should verify all additions/changes to personal medication records, including supplementary antibiotic records. A small number of minor discrepancies were highlighted to staff for immediate corrective action and ongoing vigilance.

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, thickening agents and insulin was reviewed.

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 care plans were in place. A couple of minor amendments to care plans, to clarify the care directed, were discussed and agreed. 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.

There had been no recent records of administration. Staff advised that the expectation is that records of any administration 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.

Some residents may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the resident should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the resident.

The management of thickening agents and nutritional supplements was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and included the recommended consistency level.

Care plans were in place when residents required insulin to manage their diabetes. There was sufficient detail to direct staff if the resident's blood sugar was outside of the recommended range. One personal medication record needed to be updated with the current prescribed insulin dose administered by district nurses. This was addressed during the inspection. The resident was receiving the correct dose.

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 securely locked when unattended, to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located.

Medicines must be stored at the manufacturers' recommended temperature in order to ensure their stability and efficacy. This is usually at a maximum of 25^{o}C for medicines stored at room temperature. The temperature of the medicine storage area was monitored and recorded daily, however records over the past year indicated that the temperature frequently exceeded 25^{o}C. An area for improvement was identified.

Satisfactory arrangements were in place for medicines requiring cold storage, the storage of controlled drugs and the safe disposal of medicines. Staff were reminded to ensure that the refrigerator thermometer is correctly reset each day after recording temperatures.
Some medicines were stored unnecessarily in the refrigerator and some discontinued medicines needed to be removed. This was addressed during the inspection.

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. In order to facilitate a clear audit trail records of medicines received into the home, prescribed, administered and returned to the community pharmacy must be accurately maintained.

Records of incoming medicines were in place; however, these did not always include records of medicines for residents on admission to the home or for acute medicines e.g. antibiotics. An area for improvement has been stated for a second time.

A sample of the medicines administration records was reviewed. Most of the records were found to have been accurately completed. A small number of missed signatures and gaps in running balances for medicines used 'when required', including analgesics, were observed. Records were in place for this purpose and the manager agreed to reinforce the need for accurate maintenance of these records to facilitate audit. Records were filed once completed and were readily retrievable for audit/review.

Records of outgoing medicines did not always include outgoing controlled drugs or the resident's full name. These records must be accurately maintained. An area for improvement was identified.

Controlled drugs are medicines 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 mostly satisfactory arrangements in place for the management of controlled drugs (see above regarding records of outgoing medicines). Staff were reminded to bring balances to zero when controlled drugs were transferred or disposed of.

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 the majority of medicines to facilitate audit and disposal at expiry. The manager agreed to further review the issues highlighted within this report within audit systems.

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 for residents admitted from or 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.

However, review of records for residents admitted from home or another care home indicated that staff had not always received written confirmation of the resident's current prescribed medicines from their GP. Medicines were being administered in accordance with information provided by family or the previous care home. There is a potential that information may not be accurate/complete. An area for improvement was identified.

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 the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with the staff on duty and the manager for ongoing monitoring.

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 Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	4*	6*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Una Brady, 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 13 (4) **Stated:** Second time **To be completed by:** 27 August 2026	The registered person shall ensure that records of incoming medicines are accurately maintained. Ref: 2.0 & 3.3.3
	Response by registered person detailing the actions taken: Receipt of medications book in place. Staff have been advised to ensure that all medication coming into the Home must be receipted in this book. At least monthly audits will be carried out by management team to ensure compliance. Senior management will also review within reg 29 visits
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 27 August 2026	The registered person shall ensure that records of outgoing medicines are accurately maintained as detailed in the report. Ref: 3.3.3
	Response by registered person detailing the actions taken: Staff have been advised that all outgoing medications must be recorded into Medication Returns book including controlled drugs. At least monthly audits will be completed by management team.Senior Management will also review within Reg 29 visits

Area for improvement 3 **Ref:** Regulation 21 (1) (b) Schedule 2 (6) **Stated:** First time **To be completed by:** 27 November 2025	The registered person shall ensure that a full employment history is provided by staff, which includes explanations for any gaps in employment. This must be in place prior to any staff member commencing work in the home.
	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 4 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** 27 November 2025	The registered person shall ensure there is a whole home risk assessment in place regarding the management of denture cleaning tablets and cleaning products.
	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:** First time **To be completed by:** 27 September 2026	The registered person shall review the systems in place to ensure that the temperature of the medicine storage area is maintained at a maximum of 25^{o}C. Ref: 3.3.2
	Response by registered person detailing the actions taken: Daily temperatures is taken by SCA staff and they will report directly to Home Manager if temperature is above 25C. Ceiling fan to remain on at all times to help maintain temperature below 25C. Air conditioning unit is now requested via Estates team. Room temperature recordings will be audited at least monthly by management and senior management will review within Reg 29 visits
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 27 August 2026	The registered person shall ensure that prescribed medicines are confirmed in writing for all residents admitted to the home. Ref: 3.3.4
	Response by registered person detailing the actions taken: Admission checklist in place to prompt SCA staff to ensure that all residents admitted to the Home have their prescribed medications confirmed in writing by medical staff on discharge from hospital or GP for community based admissions. At least monthly audits will be carried out by management team to review this for any admissions and senior management will review within Reg 29 visits

Area for improvement 3 **Ref:** Standard 8.5 **Stated:** First time **To be completed by:** 27 November 2025	The registered person shall ensure post falls documentation accurately reflects the times residents were checked following the fall. This is with specific reference to post falls observations.
	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 5.5 **Stated:** First time **To be completed by:** 27 November 2025	The registered person shall ensure that risk assessments are reviewed on a regular basis and reflect changes in resident's needs. This is with specific reference to moving and handling and falls risk assessments.
	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 9.3 **Stated:** First time **To be completed by:** 27 November 2025	The registered person shall ensure that resident's weights are continually monitored and 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 6 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 27 November 2025	The registered person shall ensure risk assessments and care plans are in place to clearly reflect the management of cleaning products and denture cleaning tablets for residents, were this is appropriate.
	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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