The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Cloughreagh House

Provider: Southern Health and Social Care Trust

Date of Inspection: 18 & 20 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:	Southern Health and Social Care Trust (SHSCT)
Responsible Individual:	Mr Steve Spoerry
Registered Manager:	Mrs Kathleen Patricia McBeth
Service Profile: This home is a registered Residential Care Home which provides health and social care for up to 23 residents. The home provides care for residents living with dementia and for those needing general residential care. Residents' bedrooms are located over two floors in the home. Residents have access to an internal gym for rehabilitation, lounge areas and dining room. The home has an external garden for residents to enjoy.	

2.0 Inspection summary

An unannounced care inspection took place on 20 August 2026, from 9.50am to 2.30pm by a care inspector and on 18 August 2026, from 10am to 3.45pm, by a pharmacist 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 14 August 2025; 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 residents and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of residents and that staff were knowledgeable and well trained to deliver safe and effective care.

Residents were observed to be relaxed, comfortable and content in their home environment, and staff interactions were warm, positive and respectful.

Staff described positive teamwork within the home and told us that the management team were supportive, approachable and readily available to provide guidance when needed.

While care was found to be delivered in a safe and compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery.

As a result of this inspection, three areas for improvement from the previous care inspection were assessed as having been addressed by the provider. One area for improvement was not met and was stated for a second time, in relation to suitable facilities for staff working in the home. The areas for improvement identified at the previous medicines management inspection, in relation to care plans for the administration of insulin and care plans when a resident is prescribed medication for administration on a "when required" basis for the management of distressed reactions, were assessed as met. However, the area for improvement in relation to care plans and risk assessments for the self-administration of medicines was not met and was stated for a second time. Improvements were also necessary in relation to the management of pain and ensuring that residents have a continuous supply of their medicines.

Full details, including new areas for improvement identified, can be found in the main body of this 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 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. 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

Residents told us they were happy living in the home, they felt well looked after and listened to by staff and management. Resident's comments included "staff are kind and decent people", "staff are brilliant and keep me well informed" and "the staff are patient".

One relative spoken with spoke highly of the care and services provided in the home.

Staff spoke positively in terms of the provision of care in the home and their roles and duties. Feedback from staff regarding the management team was positive, with staff describing them as accessible, supportive and responsive.

Two questionnaire responses were received from residents following the inspection. They all confirmed they were satisfied with the care and services provided in the home.

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.

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 residents. There was evidence of robust systems in place to manage staffing.

Residents said that there was enough staff on duty to help them. Staff said there was good teamwork and that they felt well supported in their role. Discussion with staff confirmed that they felt staffing levels were appropriate to support the delivery of safe and effective care.

It was noted that there was enough staff in the home to respond to the needs of the residents in a timely way; and to provide residents with a choice on how they wished to spend their day. For example; if they wished to have a lie in or if they preferred to eat their breakfast later than usual.

3.3.2 Quality of Life and Care Delivery

All care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the relevant information about the residents, especially any changes to care, that they needed to assist them in their caring roles. Staff confirmed that the handover process provided clear and timely information to support the delivery of safe, person centred care.

Staff interactions with residents were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed throughout the home. Staff were knowledgeable of individual resident's needs, their daily routine, wishes and preferences.

Staff were observed to be prompt in recognising residents' needs and any early signs of distress or illness, including those residents who had difficulty in making their wishes or feelings known.

Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs. Staff were also observed offering residents choice in how and where they spent their day or how they wanted to engage socially with others.

At times some residents 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 residents and to manage this aspect of care.

Residents may require special attention to their skin care. Care records accurately reflected the residents' assessed needs and input from other professionals such as the District Nursing team.

Examination of care records and discussion with the manager confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. For example, residents were referred to their GP if required.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

Observation of the lunchtime meal served in the main dining room confirmed that enough staff were present to support residents with their meal and that the food served appeared appetising and nutritious. Residents told us they were satisfied with the quality of the food and valued having a choice of meals to meet their preferences.

Residents described their days as busy and purposeful, with opportunities to participate in rehabilitation activities alongside Physiotherapists and Occupational Therapists. They also spoke positively about having time to relax and engage in activities of their choice such as reading, watching TV and having visits with their loved ones.

Observation of the planned activity, which was a board game, confirmed that staff knew and understood resident's preferences and wishes and how to provide support for residents to participate in group activities.

3.3.3 Management of Care Records

Residents' needs were assessed by a suitably qualified member of staff at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents' needs and included any advice or recommendations made by other healthcare professionals.

Care records were person centred, mostly well maintained, regularly reviewed and updated to ensure they continued to meet the residents' needs. Care staff recorded regular evaluations about the delivery of care. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate.

Residents care records were held confidentially.

3.3.4 Quality and Management of Residents' Environment

The home was clean, tidy and comfortable for residents. The temperature within the home was comfortable and appropriate for the summer months. Residents' bedrooms were well maintained and presented to a good standard for the home's intermediate care model.

Communal areas were well decorated, suitably furnished and homely.

It was identified that staff did not have access to a designated breakout area. As highlighted at the last care inspection, a partitioned section of the residents' dining space was being utilised by staff for this purpose, which is not an appropriate environment for staff to take breaks. RQIA were informed that this has been escalated to the SHSCT's Estate's Department for their review and action. An area for improvement has been stated for a second time.

Review of records and observations confirmed that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

Fire safety measures were in place and well managed to ensure residents, staff and visitors to the home were safe.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Kathleen McBeth has been the registered manager in this home since 6 August 2013.

Staff expressed high levels of satisfaction with the management team and spoke positively about their leadership and support.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the manager responded to any concerns raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided in the home.

Audits reviewed were comprehensive, appropriately completed and demonstrated effective oversight of key areas within the home.

Staff told us that they would have no issue in raising any concerns regarding residents' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further.

3.3.6 Medicines Management

Prescribing, monitoring and review of medicines

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 majority of 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. A number of minor discrepancies were highlighted to nurses for immediate corrective action and ongoing vigilance.

Copies of 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.

The management of pain was reviewed. Medicine records were well maintained. However, care plans did not contain sufficient detail to direct the required care. An area for improvement was identified.

A care plan and risk assessment were not in place for self-administered medication. An area for improvement identified at the last medicines management inspection was stated for a second time.

Supply and storage of medicines

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that 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. However, on the day of inspection one medicine had been out of stock for three days, resulting in three missed doses for the resident. This had not been escalated to management for immediate corrective action and investigated to prevent a recurrence. The medicine ordering system should be reviewed to ensure that medicines are available for administration as prescribed. An area for improvement was identified.

The medicines 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 at a maximum of 25°C. Satisfactory arrangements were in place for medicines requiring cold storage, the storage of controlled drugs and the safe disposal of medicines.

Administration of medicines

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 inspected were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

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 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. The audits completed at the inspection indicated that medicines were being administered as prescribed.

Transfer of medicines

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, including records of medicines received into the home, had been accurately completed and there was evidence that medicines were administered as prescribed.

Medication incidents

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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, including records of medicines received into the home, had been accurately completed and there was evidence that medicines were administered as prescribed.

Medicines training

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.

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	2*	2*

* the total number of areas for improvement includes two stated for a second time

Areas for improvement and details of the Quality Improvement Plan were discussed with Debbie Millar, 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 Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 27 (3) (a) **Stated:** Second time **To be completed by:** 1 December 2026	The registered person shall ensure that there are suitable facilities for staff in the home, including an area for breaks that does not impact on residents' communal space and safe storage for staff belongings. Ref: 2.0 & 3.3.4
	Response by registered person detailing the actions taken: Funding has been secured. Estate Services are developing plans for a staff room.

Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 18 August 2026	The registered person shall ensure that residents have a continuous supply of their prescribed medicines. Ref: 3.3.6
	Response by registered person detailing the actions taken: The Registered Manager will continue to audit practice as per the Trust Medicine Management Policies and Procedures to ensure full compliance. Medicine management including the replenishing of Medication supplies discussed at team meetings and in one-to-one formal supervision with staff.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (Dec 2022) (Version 1:2)	
Area for improvement 1 **Ref:** Standard 6 **Stated:** Second time **To be completed by:** 18 August 2026	The registered person shall ensure that whenever a resident self-administers medication, a self-administration of medicines and care plan risk assessment are in place. Ref: 2.0 & 3.3.6
	Response by registered person detailing the actions taken: The Registered Manager is working with the Trusts Medicine Management Specialist Team to develop supporting documentation for the safe Management of Medication which is self-administered by Residents. A Risk Assessment for the self-administration of injections has been implemented in the interim this will be retained with the residents Medication Administration Record.
Area for improvement 2 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 18 August 2026	The registered person shall ensure that resident centred care plans are in place to direct care when medicines are prescribed for the management of pain. Ref: 3.3.6
	Response by registered person detailing the actions taken: The Registered Manager will continue to audit care plans to ensure that they are resident centred and detailed in relation to pain management and that they are kept under review to monitor effectiveness.

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

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