The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Hollygate Lodge

Provider: Hollygate Care Services Ltd

Date of Inspection: 17 September 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:	Hollygate Care Services Ltd
Responsible Person:	Mr Mark Craig Emmerson
Registered Manager:	Mrs Melessa Buchanan
Service Profile: Hollygate Lodge is a residential care home registered to provide health and social care for up to 38 residents with a range of needs including, general health and social care to those over 65 years of age, residents living with dementia and residents with a learning disability. The home is based across three buildings on the same site. There is a range of communal areas throughout the home.	

2.0 Inspection summary

An unannounced inspection took place on 17 September 2026, from 10.00am to 2.10pm. 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 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 well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines. However, improvements were necessary in relation to ensuring a continuous supply of medication and the disposal of medication at expiry.

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).

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

Nine resident questionnaires returned following the inspection indicated that residents were satisfied with how their medicines were managed. Comments included: "I would be offered pain relief if I needed it".

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 and medicines were administered in accordance with individual resident preference. Staff also said that they prioritised residents who required pain relief and time-critical medicines during each medicine round.

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.

The management of distressed reactions, pain, insulin and Parkinson's 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 medicine doses had been omitted on a number of occasions for one resident whose eye drops were not available in the home. This had not been escalated to management for immediate action and investigation to prevent a recurrence. Medicines must be available for administration as prescribed. An area for improvement was identified.

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.

One bottle of in use eye drops was found to have expired, this was highlighted to the deputy manager for immediate disposal and replacement. 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. Most of the records were found to have been accurately completed. A small number of missed signatures were brought to the attention of the deputy manager for ongoing monitoring. 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, with the exception of one in use bottle of eye drops (see section 3.3.2).

Where residents self-administered their medication a patient centred care plan and risk assessment was in place.

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. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

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 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 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. 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	2*	3*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with the person in charge, 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:** First time **To be completed by:** 17 September 2026	The registered person shall ensure that residents have a continuous supply of their medications. Ref: 3.3.2
	Response by registered person detailing the actions taken: When residents are being admitted to the Home from a community setting, management requests that the resident or their representative provide a 28 day supply of medication, including PRN medications, and that these are within their expiration date to be used prior to admission to the Home. If medication is found to be expired on admission to the Home, this will be reported immediately to a GP for advice and guidance and escalated via the appropriate reporting procedures if replacement stock is unable to be sourced on the same day.
Area for improvement 2 **Ref:** Regulation 21 (1) (b) Schedule 2 (3) **Stated:** First time **To be completed by:** 10 September 2026	The registered person shall ensure that pre-employment checks evidence receipt of a reference from the person's present or most recent employer, prior to 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
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:** 17 September 2026	The registered person shall review the systems in place to ensure that expired medicines are immediately removed form stock. Ref: 3.3.2
	Response by registered person detailing the actions taken: One bottle of opened eyedrops were found to have expired the day before inspection and were replaced immediately. The Home manager completes a comprehensive audit of medications each month using an auditing tool provided by our partnership pharmacy. Senior care assistants will be trained to complete this audit tool to ensure continued completion in the absence of management so that any expired medications are removed from

	use promptly. All items with an expiry date outside of the normal 28 day cycle will be added to the diary to ensure they are not overlooked.
Area for improvement 2 **Ref:** Standard 25.3 **Stated:** First time **To be completed by:** 10 September 2026	The registered person shall ensure the person in charge of the home in the absence of the manager is clearly documented on the duty rota.
	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 25 **Stated:** First time **To be completed by:** 10 September 2026	The registered person shall ensure there is a system in place to review the staffing levels in the home on a regular basis.
	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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