The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Glenowen Court

Provider: Radius Housing Association

Date of Inspection: 10 September 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:	Radius Housing Association
Responsible Individual:	Mr Greer Wilson
Registered Manager:	Mrs Emma Hewitt
Service Profile: Glenowen Court is a residential care home registered to provide health and social care for up to 44 residents living with dementia. The home occupies three floors with shared living and dining areas on each floor.	

2.0 Inspection summary

An unannounced inspection took place on 10 September 2026, from 9.55am to 3.35pm. 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 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 the management of thickening agents, monitoring of refrigerator temperatures and the management of inhaled medicines.

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 management and staff for their assistance during 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 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.

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. A small number of minor discrepancies were highlighted to staff for immediate corrective action and on-going 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, Parkinson's and epilepsy 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.

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. Two care plans needed updating with details of the prescribed medication. This was discussed with the manager who agreed to update the care plans following the inspection.

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. However, records of prescribing did not detail the thickening agent and administration records were not accurately maintained. An area for improvement was identified.

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. The care plan for one new admission had not yet been completed. This was discussed with the senior carer who provided assurance the care plan would be completed following the inspection.

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 areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each resident could be easily located. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for the storage of controlled drugs and the safe disposal of medicines.

Medicines which require cold storage must be stored between 2ºC and 8ºC to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. This monitoring was in place, however the maximum temperature was often above 8ºC, corrective action had not been taken and the thermometer had not been reset. An area for improvement was identified.

One inhaler device did not have its cap replaced after use, another was stored attached to the spacer device. This was discussed with the senior carer and manager for correction and ongoing vigilance.

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, with the exception of thickening agents. (see section 3.3.1) 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 most medicines to facilitate audit and disposal at expiry. Some inhaler devices did not have a date of opening recorded this was highlighted to the manager for ongoing monitoring. (see section 3.3.5)

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 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 inhaled medicines. Dates of opening were not always recorded on inhaled medicines to facilitate audit. An area for improvement was identified. The audits were discussed in detail with the manager for on-going 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 Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	5*

* the total number of areas for improvement includes two which were carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Emma Hewitt, 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 Care Standards for Residential Homes, December 2022	
Area for improvement 1 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 10 September 2026	The registered person shall review the management of thickening agents to ensure that accurate records of administration are maintained. Ref: 3.3.1
	Response by registered person detailing the actions taken: The management, administration and documentation arrangements at the home have been reviewed to ensure all staff are knowledgeable, competent and records are up to date. This will be subject to audit as part of the homes medication audit processes.
Area for improvement 2 **Ref:** Standard 32 **Stated:** First time **To be completed by:** 10 September 2026	The registered person shall ensure that corrective action is taken if the medicines refrigerator temperature is outside of the recommended range and that the thermometer is reset after each recording. Ref: 3.3.2
	Response by registered person detailing the actions taken: A new standard operating procedure has been put in place to advise senior staff of the recommended actions to be taken if a temperature reading is outside the recommended range, 2-8 C.
Area for improvement 3 **Ref:** Standard 33 **Stated:** First time **To be completed by:** 10 September 2026	The registered person shall review the management of inhaled medicines to address the shortfalls identified in this report. Ref: 3.3.5
	Response by registered person detailing the actions taken: A review of the management of inhaled medicines has been completed and actions shared with the senior team responsible for medication administration and management. This will be subject to audit as part of the homes medication audit processes.

Area for improvement 4 **Ref:** Standard 6.6 **Stated:** First time **To be completed by:** 14 October 2025	The Registered Person shall ensure that residents care plans contain sufficient detail to ensure care needs are met. This is stated in relation to : • The management of weight loss. • Care plans for one to one supervision should contain sufficient detail on the specific supervision arrangements to guide staff.
	Action required to ensure compliance with this standardwas 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 27 **Stated:** First time **To be completed by:** 2 December 2025	The Registered Person shall ensure the cupboard doors in the identified bedrooms are repaired or replaced.
	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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