The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Corkhill Care Centre

Provider: Mr Gary George Watt

Date of Inspection: 29 July 2025

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:	Mr Gary George Watt
Responsible Person:	Mr Gary George Watt
Registered Manager:	Mrs Shona McKeown
Service Profile: Corkhill care centre is a nursing home registered to provide care for up to 37 patients living with physical disability, dementia, and/or nursing needs associated with old age. Patient areas are divided into three units over two floors. Rambler's Rest and Robin's Rest provide general nursing care. Angel's Cove provides care for patients with dementia. There are a range of communal areas throughout the home. There is a separate registered residential care home which occupies the same site and the registered manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 29 July 2025, from 10.30am to 3.30pm. 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 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 and patients were administered their medicines as prescribed. However, improvements were necessary in relation to recording room temperatures and medicines administration records.

Whilst areas for improvement were identified, there was evidence that patients were being administered their medicines as prescribed.

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients well.

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).

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 registration information, and any other written or verbal information received from patients, 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 patients 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 patient liked to take their medicines and medicines were administered in accordance with individual patient preference. Staff also said that they prioritised patients who required pain relief and time-critical medicines during each medicine round.

No completed questionnaires or responses to the staff survey 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?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' 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.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. 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 patients' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

All patients 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 epilepsy and specialist medicines were 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.

Patients 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 patient's distress and if the prescribed medicine is effective for the patient.

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 patient-centred care plans were in place. Staff knew how to recognise a change in a patient's

behaviour and were aware that this change may be associated with pain and other factors. Review of records of administration indicated that these medicines were used infrequently. The manager and staff were reminded that the reason for and outcome of each administration should be recorded.
The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans were in place and reviewed regularly. One care plan needed updated with the details of the most recently prescribed medication, it was agreed that this would be addressed following the inspection.

Some patients 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 patient 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 patient.

The management of thickening agents was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained. Two administration records needed the consistency level recorded. This was discussed with the manager for immediate action and on-going review.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside of the recommended range. One care plan needed updated with the details of the prescribed insulin, it was agreed that this would be addressed 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 patient'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 patients 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 patient could be easily located. All medication trolleys were observed to be locked to prevent unauthorised access, however two trolleys were not secured to the wall. This was discussed with the manager who agreed to replace the broken wall anchor with immediate effect.

Medicines must be stored at the manufacturers' recommended temperature in order to ensure their stability and efficacy; this is usually at or below 25°C for medicines recommended to be stored at room temperature. Review of the daily treatment room temperature records

evidenced temperatures had not been recorded in the previous two weeks in one treatment room and the temperature had not been recorded in all areas where medicine was stored. 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.

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 patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. Records were filed once completed and were readily retrievable for audit/review. A significant number of medicine administration records generated by staff in the home did not include the quantity of medication received into the home and had not been checked and signed by two staff members to verify that they were accurate. An area for improvement was identified.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. 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. While regular medicine audits were conducted, review of recently completed audits found that all aspects of medicines management were not being audited. A more robust audit system which covers all aspects of the management of medicines should be implemented. The RQIA inspection audit tool was shared with the manager of the home after the inspection.

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 patients 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 completed and there was evidence that medicines were administered as prescribed. One personal medication record for a recent

admission did not have the allergy status recorded. This was discussed with the manager for immediate corrective action.

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 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 patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that their 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.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

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*	3*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Shona McKeown, 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 29 July 2025	The registered person shall ensure medication administration records generated in the home are checked and signed by two trained members of staff to verify they are accurate. Ref: 3.3.3
	Response by registered person detailing the actions taken: The registered person will ensure MARS generated in the home are checked and signed by 2 trained members of staff to verify they are accurate.
Area for improvement 2 **Ref:** Regulation 27 (4) (d) (i) **Stated:** Second time **To be completed by:** 24 February 2025	The registered person shall ensure that the practice of wedging open fire doors ceases immediately, and that all staff are reminded of the correct use of these doors.
	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 3 **Ref:** Regulation 10 (1) **Stated:** Second time **To be completed by:** 17 March 2025	The registered person shall implement and maintain robust governance systems to ensure the safe and effective running of the home. This includes, but is not limited to, regular auditing of the environment for potential hazards, and infection prevention and control measures and practices. Deficits identified during the process of auditing should be addressed through an action plan that clearly states the action required, who is responsible, and expected timeframe for completion. There should be evidence that plans have been reviewed and signed off once the required actions have been taken.
	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 27 (2) (a) **Stated:** First time **To be completed by:** 31 March 2025	The registered person must clearly define the purpose of the identified room and communicate this to RQIA. The room must be used for the identified purpose.
	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 Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 32 **Stated:** First time **To be completed by:** 29 July 2025	The registered person shall ensure that room temperatures are recorded daily in medication storage areas. Ref: 3.3.2
	Response by registered person detailing the actions taken: The registered person will ensure room temperatures are recorded daily in medication storage areas.
Area for improvement 2 **Ref:** Standard 12.4 **Stated:** Second time **To be completed by:** 10 March 2025	The registered person shall ensure that the Malnutrition Universal Screening Tool (MUST) is completed for all patients at least monthly
	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 46.2 and 46.3 **Stated:** First time **To be completed by:** 10 March 2025	The registered person shall ensure that there is a system in place to monitor staffs' adherence to best practice in infection prevention and control. This is with specific reference to the storage of equipment and supplies. The system should evidence actions taken to address any shortfalls identified in staff practice and learning should be shared with relevant staff.
	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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