The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Sir Samuel Kelly Memorial Eventide Home

Provider: Salvation Army Trustee Company (The)

Date of Inspection: 22 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:	SALVATION ARMY TRUSTEE COMPANY(THE)
Responsible Individual:	Mrs Glenda Roberts
Registered Manager:	Mrs Sharon Boyd

Service Profile –
Sir Samuel Kelly Memorial Eventide Home is a residential care home registered to provide health and social care for up to 56 residents. The home is registered to provide general health and social care for up to 22 residents over the age of 65, up to 30 residents living with dementia, a maximum of 2 residents with a mental health diagnosis and a maximum of 2 residents who are terminally ill.

The home is based across two floors and separated into six wings; Lavender, Daisy, Primrose, Poppy, Bluebell and Buttercup. There are a number of communal spaces across the home. Residents have access to lounges and day rooms across the building.

2.0 Inspection summary

An unannounced inspection took place on 22 July 2025, from 10.30am to 3.30pm. The inspection was completed by two pharmacist inspectors 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 an area for improvement identified at the last care inspection. The remaining 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. Residents were administered their medicines as prescribed. However, improvements were necessary in relation to management of medicines for distressed reaction, the management of warfarin, the recording of thickened fluids and staff competency.

An area for improvement in relation to staff competencies has been stated for a second time. New areas for improvement were identified in relation to management of medicines for distressed reactions, warfarin and the recording of thickened fluids. Details, including 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).

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.

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

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.

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?

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.

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 pain 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.

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 resident-centred care plans were in place. 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. Records of administration did not include the reason for and outcome of each administration. An area for improvement was identified.

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 was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing which included the recommended consistency level were maintained. However, the prescribed thickening agent was not recorded on one personal medication record and records of administration were not maintained by care staff. An area for improvement was identified.

The management of warfarin was reviewed. Warfarin is a high risk medicine which requires regular blood testing. The dose of warfarin prescribed depends on the blood test result. Blood tests had been carried out at the identified times and warfarin had been administered as prescribed. A resident specific care plan was in place but the dose of warfarin needed updated. Written confirmation of the dosage regimen was not obtained from the prescriber. An area for improvement was identified.

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 one medicine had been omitted on a number of occasions as the medicine was not available in the home. Action had been taken by staff to obtain supply of medication. Assurance was provided that the medication would be obtained on the day of inspection.

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

A sample of the medicines administration records was reviewed. Records were found to have been accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing monitoring. Records were filed once completed and were readily retrievable for review.

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. Staff were reminded that all controlled drugs in the controlled drug record book should be reconciled each day.

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 medicines to facilitate audit and disposal at expiry.

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.

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. However, one discrepancy noted during the medication audit was highlighted to the manager for investigation and reporting, an incident report detailing the action taken to prevent a recurrence was received on 22 July 2025. The inspector signposted staff to the RQIA provider guidance in relation to the statutory notification of medication related incidents available on the RQIA website.

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 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 they 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. Medicines management policies and procedures were in place. A sample of medicine competencies were reviewed. These were not reflective of each individual's competency. An area for improvement was restated.

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	3*	5*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Sharon Boyd, 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:** First time **To be completed by:** 22 July 2025	The registered person shall review the management of warfarin to ensure written regimen confirmation is obtained and care plans are kept up to date. Ref: 3.3.1 **Response by registered person detailing the actions taken:** GP/treatment room nurse has been advised that the results and required dose of Warfarin needs to be emailed to SSK. This document can then be uploaded onto the Atlas medication system. If there are any changes to the dose two team leaders will change this on the Atlas system.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 22 July 2025	The registered person shall ensure that records of administration of thickening agents are accurately maintained by care assistants and include the recommended consistency level. Ref: 3.3.1 **Response by registered person detailing the actions taken:** Any resident on thickener now has a personalised record sheet which staff will have to complete each time thichener is used. All staff have been reminded of the importance of this recording as it is a prescribed medication. Team leaders will ensure this record sheet is reviewed each shift.
Area for improvement 3 **Ref:** Regulation 29 (4) (a) **Stated:** First time **To be completed by:** 25 February 2025	The registered person shall ensure when completing the monthly monitoring visits that there is evidence of attempts to capture relatives/visitors views on the running of 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 30.3 **Stated:** Second time	The registered person shall ensure the assessments in place to determine staff's competency in the management of medications are an accurate assessment of each staff's assessment. Ref: 3.3.6

To be completed by: 22 October 2025	**Response by registered person detailing the actions taken:** All staff who administer medication have had their medication competency assessments completed again. They have been completed by the Deputy manager and her assistant and are personalised to each staff member.

Area for improvement 2 **Ref:** Standard 10 **Stated:** First time **To be completed by:** 22 July 2025	The registered person shall review the management of medicines prescribed 'when required' for distressed reactions to ensure the reason for and outcome of each administration is recorded. Ref: 3.3.1
	Response by registered person detailing the actions taken: On the Atlas hanset staff are recording the reason for administration and the outcome after the PRN medication has been given. Head of Care and Assistant Head of Care will check that this has been recorded.
Area for improvement 3 **Ref:** Standard 25 **Stated:** Second time **To be completed by:** 25 February 2025	The registered person shall ensure the duty rota identifies: • The full name of the staff member working • The shift patterns working
	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 27.11 **Stated:** First time **To be completed by:** 25 February 2025	The registered person shall ensure no structural changes or changes to the use of the registered building are made without approval from RQIA.
	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 27.11 **Stated:** First time **To be completed by:** 25 February 2025	The registered person shall ensure that rooms are used within their original stated purpose. If required, a variation should be submitted to RQIA outlining the proposed change in purpose of the rooms or the rooms reverted back to their original stated purpose.
	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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