The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Oriel House

Provider: Oriel House

Date of Inspection: 27 June 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:	Oriel House
Responsible Individual:	Mrs Margaret Teresa Thompson
Registered Manager:	Mrs Tracey Bell, not registered
Service Profile: Oriel House is a residential care home registered to provide health and social care for up to eight residents. The home is registered to care for older people, or residents living with dementia or a physical disability. The home is divided over two floors with bedrooms on all floors. There is a communal lounge, dining room and bathroom on the ground floor.	

2.0 Inspection summary

An unannounced inspection took place on 27 June 2025, from 10.30am to 12.45pm. 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 inspection also reviewed the area for improvement identified at the last medicines management inspection.

The outcome of this inspection indicated that robust arrangements were not in place for some aspects of medicines management. Areas for improvement were identified in relation to: personal medication records, medicines administration records, monitoring the temperatures of the refrigerator, care plans and the auditing system. Whilst areas for improvement were identified, there was evidence that the majority of medicines were administered as prescribed.

Following the inspection, the findings were discussed with the senior pharmacist inspector in RQIA and with Margaret Teresa Thompson, Responsible Individual. It was decided that the home would be given a period of time to implement the necessary improvements. A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained. Failure to implement and sustain the improvements may lead to enforcement.

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 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 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

Three questionnaires were received from residents who were very satisfied with how their medicines were managed. Comments included 'friendly staff', 'staff are so caring and respectful' and 'staff always available when required'.

Questionnaires returned from relatives indicated that they were happy with the care their relatives received.

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.

No completed 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.

Some personal medication records were not up to date with the most recent prescription and some were incomplete. No photographs were in place for the personal medication records reviewed. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. An area for improvement was restated.

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.

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. One 'when required' medicine for distressed reactions was recently discontinued, however a review of records evidenced there was no resident-centred care plan in place for this medication.

Care plans were not in place when residents required insulin to manage their diabetes. Care plans for the management of diabetes should contain sufficient detail to direct staff if the resident's blood sugar is outside of the recommended range.

An area for improvement in relation to care plans for distressed reactions and insulin 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 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 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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately.

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. The current temperature of the medicine refrigerator was monitored most days; this does not provide evidence that the temperature is maintained within the required range at all times. An area for improvement was identified.

The date of opening should be recorded on all medicines to facilitate audit and disposal at expiry. The date of opening was not recorded on medicines, including those with a limited expiry once opened. One medicine which required refrigeration on opening was not being stored in the refrigerator. An area for improvement was identified.

Satisfactory arrangements were in place for 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. One medicine administration record had been inaccurately completed for the previous six days and another medicine administration record had not been fully completed for one medication. This was brought to the attention of the manager for investigation. Medication administration records must be accurately maintained. An area for improvement. 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 the medicine reconciliation book should be signed at the time of the handover check.

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. However, audits had not identified the issues identified at this inspection including dates of opening not being recorded and improper storage of one medicine (see Section 3.3.2.).

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 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 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 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	4*	4*

* the total number of areas for improvement includes one that have been stated for a second time and 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 Tracy Bell, 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:** Second time **To be completed by:** 27 June 2025	The registered person shall ensure personal medication records are accurately maintained. Ref: 3.3.1
	Response by registered person detailing the actions taken: All completed day of inspection
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 27 June 2025	The registered person shall ensure that medication administration records are accurately maintained. Ref: 3.3.3
	Response by registered person detailing the actions taken: All records updated day of inspection
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 27 June 2025	The registered person shall ensure that robust audit systems are in place to monitor all aspects of medicines management including recording dates of opening to facilitate disposal at expiry and correct storage. Ref 3.3.2 & 3.3.3
	Response by registered person detailing the actions taken: All updated day of inspection
Area for improvement 4 **Ref:** Regulation 29 (4)(a) **Stated:** First time **To be completed by:** 1 January 2025	The registered person shall ensure that the person carrying out the visits, interviews with their consent such of the residents, representatives and the persons working in the home, to form an opinion of the standard provided.
	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.

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:** 27 June 2025	The registered person shall ensure refrigerator temperatures are appropriately monitored to include current, minimum and maximum temperatures are recorded and action is taken if the temperature range is outside 2^0C - 8^0C. Ref: 3.3.2
	Response by registered person detailing the actions taken: Phamarcy delivered new temp gage on day of inspection
Area for improvement 2 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 27 June 2025	The registered person shall ensure person-centred care plans are in place for the management of insulin and distressed reactions. Ref: 3.3.1
	Response by registered person detailing the actions taken: Completed day of inspection
Area for improvement 3 **Ref:** Standard 6.6 **Stated:** First time **To be completed by:** 1 December 2024	The registered person shall ensure care plans are kept up to date and reflects residents' current needs. This is stated in relation to the impact of a locked keypad on DOL safeguards.
	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 6.3 **Stated:** First time **To be completed by:** 1 December 2024	The registered person shall ensure the resident or their representative signs their care plan.
	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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James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews