

Inspection Report

Name of Service: Bohill Residential Care Home

Provider: Healthcare Ireland (No. 4) Limited

Date of Inspection: 12 August 2025

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

1.0 Service information

Organisation:	Healthcare Ireland (No. 4) Limited
Responsible Individual:	Ms Andrea Louise Campbell
Registered Manager:	Mrs Andrea McCook
Service Profile:	
<p>Bohill Residential Care Home is a registered residential care home which provides health and social care for up to 18 residents living with dementia. The home is located on the first floor. There are a range of communal spaces throughout the home.</p> <p>There is a separate registered nursing home which occupies the same building; the registered manager for this home manages both services.</p>	

2.0 Inspection summary

An unannounced inspection took place on 12 August 2025, from 10.25am to 1.45pm. 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 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. 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 and residents were administered their medicines as prescribed. Medicines were stored securely; however, an area for improvement was identified regarding the temperature of the treatment room.

Whilst an area for improvement was 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 the new area for improvement and areas for improvement carried forward for review at the next inspection 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

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 resident liked to take their medicines and medicines were administered in accordance with individual resident's 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.

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 pain and thickening agents 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 be 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 included the reason for and outcome of each administration.

One residents care plan needed updated with the name and maximum dosage of the medication prescribed for distressed reactions. Assurances were provided that this would be addressed immediately after 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 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. With the exception of medicines which require cold storage, the majority of medicines must be stored at or below 25°C. A review of the daily treatment room temperature log indicated that the temperature had been above 25°C on most days in the previous four months. This had not been escalated to the manager for corrective action. 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 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. 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 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.

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 and 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.

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 the 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.

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 improvement.

4.0 Quality Improvement Plan/Areas for Improvement

An area for improvement have been identified where action is required to ensure compliance with Regulations

	Regulations	Standards
Total number of Areas for Improvement	4*	1*

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

The area for improvement and details of the Quality Improvement Plan were discussed with the regional manager and 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: Immediate and ongoing 12 August 2025	The registered person shall make ensure that the temperature of the treatment room is maintained at or below 25°C. Ref: 3.3.2 Response by registered person detailing the actions taken: The Treatment room temperature has been escalated to estates for review and the daily temperatures continue to be recorded and monitored. An internal fan has been introduced as an interim measure to assist with the reduction in treatment room temperature.
Area for improvement 2 Ref: Regulation 27 (2) (d) Stated: First time To be completed by: Immediate and ongoing (5 November 2024)	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement is made in relation to the snack kitchen. 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 13 (7) Stated: First time To be completed by: Immediate and ongoing (5 November 2024)	The registered person shall ensure that food is stored in keeping with regulation and best practice guidance. This area for improvement is made in relation to the snack kitchen. 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) (b) Stated: First time To be completed by: Immediate and ongoing (5 November 2024)	The registered person shall, having regard to the number and needs of the residents, ensure that all parts of the home are kept clean. This includes the oversight arrangements of the domestic provision within 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 27.1 Stated: First time To be completed by: 30 January 2025	The registered person shall conduct a review of the homes environment to identify the refurbishment required and complete a time bound action plan to address the issues identified. This plan should be shared with RQIA for review.
	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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The Regulation and Quality Improvement Authority

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