The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Joymount House

Provider: Northern Health and Social Care Trust

Date of Inspection: 31 October 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:	Northern Health and Social Care Trust
Responsible Individual:	Ms Jennifer Welsh
Registered Manager:	Ms Gillian McBride
Service Profile: Joymount House is a registered residential care home which provides health and social care for up to 40 residents. The home is based over three floors and provides general health and social for residents over the age of 65. There are a range of communal areas throughout the home which residents can use.	

2.0 Inspection summary

An unannounced inspection took place on 31 October 2025, from 10.00am to 1.50pm. 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 records 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 patient centred care plans, the admission process and medicine availability.

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).

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 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.

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.

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. 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, however, resident-centred care plans were not in place. Records of administration included the reason for and outcome of most administrations. Staff were reminded that the reason for and the outcome should be recorded for every administration.

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. Care plans were in place and reviewed regularly. One care plan needed updated with the name of the most recently prescribed pain relief medication. This was discussed with staff for immediate action.

Care plans were in place when residents required insulin to manage their diabetes and this was managed by district nursing. All in-use insulin pens were labelled to denote ownership however the date of opening was not recorded on the pens. The date of opening should be recorded on insulin pens to facilitate audit and disposal at expiry. It was agreed that this would be discussed with the district nursing team.

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.

Although blood tests had been carried out at the identified times and warfarin had been administered as prescribed, one resident specific care plan was not in place and one care plan required more detail added.

Care plans for medicines being self-administered and specialist medicines were not in place.

An area for improvement in relation to care plans for distressed reactions, warfarin, self-administration and specialist medicines 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.

All medicines were available for administration as prescribed on the day of the inspection. However, records reviewed showed that a small number of medicine doses had been omitted on a number of occasions as the medicines were not available in the home. This had not been escalated to management for immediate action and investigation to prevent a recurrence. Medicines must be available for administration as prescribed. An area for improvement was identified (see Section 3.3.5).

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. 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. 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.

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 some medicines to facilitate audit and disposal at expiry.

Where dates of opening had not been recorded for residents on short breaks there were accurate records of receipt including the quantity received and date of receipt, this facilitated the audit process.

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 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.

Records reviewed for residents on short breaks indicated that staff had not received written confirmation of one resident's current prescribed medicines from their GP. Medicines were being administered in accordance with information provided by family. An area for improvement was identified.

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 advised that they 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 manager was reminded that the non-administration of medicines due to stock supply issues is a medication incident which must be reported to the prescriber for advice and reported to the appropriate authorities including RQIA.

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 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*	3*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with the 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:** 31 October 2025	The registered person shall review the admission process for residents admitted from their home to ensure that a current and up to date list of medication is obtained from the general practitioner. Ref: 3.3.4
	Response by registered person detailing the actions taken: This has been added to the admission checklist and an email has been sent to all social work leads to advise that when booking short breaks an up to medication list from the resident's GP is essential for each admission .
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 31 October 2025	The registered person shall ensure that medicines are available for administration as prescribed. Ref: 3.3.2
	Response by registered person detailing the actions taken: All medication required by the resident is received by the home on admission. When a medication is not received staff will contact family, GP and social worker if necessary. An audit trail of ordering, checking on the progress of the order and receiving the medication can be found in the medical room for each resident. This will be audited monthly.
Area for improvement 3 **Ref:** Regulation 21 (1) (b) **Stated:** First time **To be completed by:** 22 February 2024	The registered person shall ensure pre-employment checks evidence that a physical and mental health assessment or self-certification has been completed prior to an individual commencing employment in 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
Area for improvement 4 **Ref:** Regulation 20.10 **Stated:** First time	The registered person shall ensure environmental audits are robust in identifying deficits; where deficits are identified a timebound action plan should be developed and signed off when completed.

To be completed by: 31 March 2025	**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 6 **Stated:** First time **To be completed by:** 31 October 2025	The registered person shall ensure resident – centred care plans are in place for the management of warfarin, distressed reactions, self-administration of medication and specialist medicines. Ref: 3.3.1
	Response by registered person detailing the actions taken: Person centred care plans are in place for all residents on as and when medication, warfarin, distressed reactions and speciialist medications and are held in the "risk assessment" section of their care plan.This was shared with all staff with responsibility for medication via email.
Area for improvement 2 **Ref:** Standard 27 **Stated:** First time **To be completed by:** 28 April 2025	The registered person shall submit a rolling refurbishment plan to RQIA outlining the plan for repairs and timeframes relating to: • Sinks in residents' bedrooms • Furniture in the rehab and smoke room and; • Ceiling tiles
	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 27.11 **Stated:** First time **To be completed by:** 3 March 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

Please ensure this document is completed in full and returned via the Web Portal

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