The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Corriewood Private Clinic

Provider: Corriewood Private Clinic Limited

Date of Inspection: 4 December 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:	Corriewood Private Clinic Limited
Responsible Individual:	Mr Ricardo Daniel Goncalves Oliveira
Registered Manager:	Mr Moses Abile
Service Profile: Corriewood Private Clinic is a nursing home registered to provide care for up to 79 patients. The home is divided into four units. Wild Forest and Annesley House which provide general nursing care. Spring Well which provides care for people with a learning disability and Oak Tree which provides care for people with a dementia. Patients have access to communal dining rooms, lounges and gardens from each unit.	

2.0 Inspection summary

An unannounced inspection took place on 4 December 2025, from 10.00am to 4.00pm. 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 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. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered the majority of their medicines as prescribed. However, improvements were necessary in relation to the management of distressed reactions, insulin management, storage of inhaler spacer devices and records of administration.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, patients 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).

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.

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 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. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

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?

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. A small number of minor discrepancies were highlighted for immediate corrective action and on-going vigilance.

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.

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. However, records of administration did not always include the reason for and outcome of each administration. An area for improvement was identified.

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.

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 for the majority of patients reviewed. One patient required their prescribed thickening agent to be added to the personal medication record and one patient required an administration record. These were discussed with nurses for immediate corrective action and ongoing monitoring.

The management of insulin was reviewed. Care plans were not in place when patients required insulin to manage their diabetes and two in use insulin pen devices were stored with an attached needle. An area for improvement was identified.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined.

An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff advised that they had received training and felt confident to manage medicines and nutrition via the enteral route. Assurances were provided that the rate of flow would be added to the personal medication records immediately 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. The temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. However, a number of unlabelled inhaler spacer devices were in use and there was no evidence of a regular cleaning schedule. This was discussed with the manager and nurses for immediate corrective action to comply with infection prevention and control measures. An area for improvement was identified.

Satisfactory arrangements were in place for medicines requiring cold storage, disposal of medicines and the storage of controlled drugs. Nurses were reminded to ensure the medicine refrigerator thermometer is reset daily.

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. Most of the records were found to have been accurately completed. However, administration records for some "when required" medicines with variable prescribed doses had been signed for as administered but not administered. In addition, when the prescribed dosage was variable, on some occasions the dose which had been administered was not clearly recorded. An area for improvement was identified.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong painkillers. 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/action plans had been implemented and addressed. The date of opening was recorded on the majority of 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 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 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. However, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with the nurses on duty and the manager for on-going monitoring. One discrepancy was discussed with the manager for investigation and a notification was received by RQIA on 5 December 2025, appropriate action had been taken to prevent a recurrence.

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 staff are competent in managing medicines and that they are supported.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent.

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 Standards.

	Regulations	Standards
Total number of Areas for Improvement	1*	6*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Moses Abile, Registered Manager and Mr Ricardo Daniel Goncalves Oliveira, Responsible Individual, 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 Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** From the date of inspection (16 & 17 September 2025)	The registered person shall ensure that all chemicals are securely stored to comply with Control of Substances Hazardous to Health (COSHH) in order to ensure that patients are protected from hazards to their health. **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 18 **Stated:** First time **To be completed by:** 4 December 2025	The registered person shall review the management of medicines prescribed “when required” to manage distressed reactions to ensure that the reason for and outcome of each administration is recorded. Ref: 3.3.1 **Response by registered person detailing the actions taken:** The management of prescribed “when required” (PRN) medications has been reviewed. As a result, a revised PRN medication recording sheet has been developed and implemented. This documentation now requires staff to clearly record the specific presenting behaviours or signs of distress that necessitate the administration of PRN medication, as well as an evaluation of the outcome and effectiveness of the intervention following administration.Compliance with this process is further supported through its inclusion in the daily walk around checks.

Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 4 December 2025	The registered person shall ensure that patient centred care plans are in place with sufficient detail to direct the required care when patients are prescribed insulin and that in use insulin pen devices are stored safely. Ref: 3.3.1
	Response by registered person detailing the actions taken: The care plans for all residents prescribed insulin have been reviewed and updated where required to ensure they accurately reflect current clinical needs and best practice. Staff have been reminded of the importance of adhering to safe medication administration principles, including correct insulin pen use. Ongoing monitoring of practice is overseen by the nurse in charge and management team to ensure continued compliance.
Area for improvement 3 **Ref**: Standard 46 **Stated:** First time **To be completed by:** 4 December 2025	The registered person shall ensure that inhaler spacer devices are individually labelled and that a regular cleaning schedule is implemented. Ref: 3.3.2
	Response by registered person detailing the actions taken: To support effective infection prevention and control and to ensure accurate identification of residents during medication administration, appropriate labelled storage bags have been procured for all residents prescribed inhaler spacer devices. Staff are required to clean spacer devices in accordance with infection prevention and control and manufacturer guidance. Following cleaning, devices are stored individually and clearly labelled. Compliance with this practice is monitored by the nurse in charge and management team as part of routine oversight and audits.
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 4 December 2025	The registered person shall ensure that accurate records of administration of “when required” medicines are maintained. Ref: 3.3.3
	Response by registered person detailing the actions taken: The management of medications prescribed as “when required” (PRN) has been formally reviewed to ensure accurate, consistent, and timely documentation. As part of this review, a revised PRN medication recording sheet has been developed and implemented. Monitoring of PRN medication records has also been incorporated into the daily walk around checks.

Area for improvement 5 **Ref**: Standard 44 **Stated:** First time **To be completed by:** 1 December 2025	The registered person shall ensure that the building is kept clean and hygienic at all times in accordance with infection control best practice and is decorated to a standard acceptable for patients. An action plan should be submitted to RQIA along with the response to the Quality Improvement 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
Area for improvement 6 **Ref**: Standard 46 **Stated:** First time **To be completed:** From the date of inspection (16 & 17 September 2025)	The registered person shall ensure that dispensers containing hand sanitiser are kept clean and hygienic at all times in accordance with infection control best practice in order to minimise the risk of infection for staff, residents and visitors.
	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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