The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: River House

Provider: Presbyterian Council of Social Witness

Date of Inspection: 30 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:	Presbyterian Council of Social Witness
Responsible Individual:	Mr Dermot Parsons
Registered Manager:	Miss Rebecca McMaster

Service Profile:

River House is a registered residential care home which provides health and social care for up to 29 residents. The home provides care for individuals requiring general residential care and for individuals living with dementia.

Bedrooms are located over two floors and all residents have access to the communal lounge areas, bathrooms, a large dining room and a garden area at the rear of the home.

2.0 Inspection summary

An unannounced inspection took place on 30 October 2025, from 10:15am to 3.35pm. 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 and the majority of medicine records were well maintained. There were auditing processes in place to ensure that staff were trained and competent to manage medicines. However, areas for improvement were identified in relation to: care plans for distressed reactions; recording the date of opening on medicines; hand-written medication administration records; the management of medication refusals and the management of medicines on admission. 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. The areas for improvement identified at the last medicines management inspection were assessed as met.

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).

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 manager and regional manager 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

The manager advised that staff had the appropriate training to look after residents and meet their needs. They said that the team communicated well and they were readily available to discuss any issues and concerns should they arise.

The manager advised that all staff were familiar with how each resident liked to take their medicines. They said that medication rounds were tailored to respect each resident's individual 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?

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

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, warfarin 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 records and 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. Protocols had recently been implemented to enable staff to record the reason for and outcome of each administration. However, detailed care plans were not in place. An area for improvement was identified.

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 for three out of the four records reviewed. It was agreed that a care plan would be written immediately following the inspection.

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. There was evidence that blood tests had been carried out at the identified times and warfarin had been administered as prescribed. Assurances were provided that further detail on the management of warfarin would be added to the resident specific care plan 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 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 organised so that medicines belonging to each resident could be easily located. Satisfactory arrangements were in place for monitoring the temperature of the medicine storage area, medicines requiring cold storage and the storage of controlled drugs.

Dates of opening had not been recorded on several medicines including eye preparations, liquid medicines and external medicines. On some eye preparations, the date of opening indicated that they remained in use past their expiry. Review of the medication administration records showed that the eye preparations were not currently required; they were removed for disposal. The date of opening should be recorded on all medicines to facilitate audit and disposal at expiry. An area for improvement was identified.

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. 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 audit/review. Two staff had not verified and signed hand-written updates on the pre-printed medication administration records to ensure accuracy. An area for improvement was identified.

A number of residents regularly refused eye preparations and inhaled medicines. Staff advised that the GPs were aware, however, records of these referrals were not available. The regular refusal of prescribed medicines should be referred to the prescriber for guidance and documented in the residents' care plans. 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. The majority of records for controlled drugs were maintained to the required standard. However, the balance recorded for two controlled drugs had not been brought to zero when they were returned to the community pharmacy for disposal. This was highlighted to the manager for discussion with staff and on-going vigilance.

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 had been provided by the GP and clear guidance was recorded on the medication label. It was agreed that the care plan for one resident would be updated immediately following the inspection.

A comprehensive audit tool was available for use by the manager. Review of a recent audit indicated that although the audit tool covered the areas identified for improvement at this inspection, the issues had not been identified. This was discussed in detail with the manager and regional manager and guidance on completing an effective audit was provided.

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 not in place to manage medicines at the time of admission. Written confirmation of prescribed medicines had not been obtained from the GP at or prior to admission, hand-written medication administration records had not been verified by two members of staff to ensure accuracy and medicines had not been accurately receipted into the home. An area for improvement was identified. The manager contacted the GP practice during the inspection to obtain an up to date list of prescribed medication.

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 manager advised that 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 trails completed at the inspection indicated that the majority of medicines were 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 and regional 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 received training and been deemed competent. Medicines management policies and procedures were available in the treatment room.

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	7*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Rebecca McMaster, Manager, and the regional 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:** 30 October 2025	The registered person shall ensure the date of opening is recorded on all medicines to facilitate audit and disposal at expiry. Ref: 3.3.2
	Response by registered person detailing the actions taken: The Service Manager, has completed individual supervisions with all senior staff, covering the importance of opening dates. The Service Manager is completing weekly drug audit trails to monitor opening dates. The aligned Regional Manager completes a drug audit trail during the Monthly Monitoring Visit.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 30 October 2025	The registered person shall ensure that the regular refusal of prescribed medication is referred to the prescriber for review, and recorded in a care plan. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Service Manager has discussed the regular refusal of medication protocol with all senior staff during 1-1 supervision. All medication refusals, will be recorded on the daily Handover, ensuring that regular refusals are being highlighted and the prescriber is contacted should regular ommissions are occurring.
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 30 October 2025	The registered person shall ensure that safe systems are in place for the management of medicines on admission as detailed in the report. Ref: 3.3.4
	Response by registered person detailing the actions taken: A pre admission checklist has been implemented which acts a checking mechanism to ensure that a medication summary and medical history are received from the aligned GP. This is then reviewed as part of the care plan audit process.

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:** 30 October 2025	The registered person shall ensure that care plans are in place for the management of distressed reactions. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Service Manager and senior staff have completed all care plans for the Service Users who are prescribed medications for distressed reactions.
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 30 October 2025	The registered person shall ensure that hand-written updates on the medication administration records are verified and signed by two staff. Ref: 3.3.3
	Response by registered person detailing the actions taken: The service manager, has included handwritten updates, to be verified and signed by two staff, on the Medication Administration Records, within the individual Senior staff supervsions that occurred after the pharamcy inspection feedback. This is monitored by the Service Manager,during the weekly medication drug audit trails, as well as a deep dive in the Monthly medication audit. The aligned Regional Manager, completes a drug audit trail during the Montly Monitoring Visit, which will also ensure, that all handwritten records are verified and signed by two staff,within the Medication Administration Records.
Area for improvement 3 **Ref:** Standard 8 **Stated:** First time **To be completed by:** 9 May 2025	The registered person shall ensure that all records are kept up to date, legible and accurate. This area for improvement relates to post fall observation records.
	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 12.10 **Stated:** First time **To be completed by:** 31 May 2025	The registered person shall ensure that, all care plans are up to date and where appropriate there is evidence of resident involvement in the care planning process. **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 **Stated:** First time **To be completed by:** 31 October 2025	The registered person shall ensure that the premises and grounds are safe, well maintained and remain suitable for their 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
Area for improvement 6 **Ref:** Standard 29.1 **Stated:** First time **To be completed by:** 31 August 2025	The registered person shall ensure that the recommendations made following the fire risk assessment (FRA) are scheduled for implementation in accordance with the time frame listed in the FRA action 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 7 **Ref:** Standard 29.6 **Stated:** First time **To be completed by:** 31 August 2025	The registered person shall ensure that all staff participate in a fire evacuation drill at least once a year. **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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