The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Fairhaven

Provider: Fairhaven Residential Homes Ltd

Date of Inspection: 12 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:	Fairhaven Residential Homes Ltd
Responsible Individual:	Mr Kevin McKinney
Registered Manager:	Miss Zoe Murray, not registered
Service Profile: Fairhaven is a residential care home registered to provide social care for up to 36 persons living with a learning disability, physical disability or mental health needs. The main building provides accommodation for up to 30 residents over three floors. There are two three bedded bungalows on the same site which can provide accommodation for up to six residents.	

2.0 Inspection summary

An unannounced inspection took place on 12 December 2025, from 10:20am to 2.10pm. 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.

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: secure storage of medicines, management of insulin, care plans for distressed reaction, audit, controlled drug records and medicines management at the time of admission. 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 Mr Kevin McKinney, Responsible Individual. It was decided that the home will 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).

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 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.

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.

With the exception of records for new admissions (see section 3.3.4), 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 staff for immediate corrective action and on-going vigilance. Copies of residents' prescriptions were not retained so that any entry on the personal medication record could be checked against the prescription. This was discussed with the manager who agreed to retain copies of prescriptions from the day of inspection onwards.

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. Records of administration included the reason for and outcome of each administration. It was acknowledged that these medicines were not used frequently. Care plans were in place; however, these were not resident centred and did not contain sufficient detail to direct staff. One resident's personal medication record and care plan required updating with the maximum daily dosage of the 'when required' medicine. This was discussed with the manager who agreed to review and update the care

plans and records following the inspection and make the necessary improvements. An area for improvement in relation to care plans 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 and reviewed regularly, however one care plan required updating with the residents most recent prescription. This was highlighted to the manager who agreed to update the care plan following the inspection.

Some residents 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 resident 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 resident.

The management of thickening agents and nutritional supplements was reviewed. Speech and language assessment reports and care plans were in place. For one resident the personal medication record did not contain the recommended consistency level, this was highlighted to the manager for correction at the time of inspection. Records of administration, which included the recommended consistency level, were maintained.

Care plans were in place when residents required insulin to manage their diabetes. However, there was not sufficient detail to direct staff if the resident's blood sugar was outside of the recommended range. One in-use insulin pen device was stored without a label to denote ownership. This was highlighted to the senior care assistant for immediate correction. An area for improvement 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.

It is important that medicine storage areas are securely locked to prevent any unauthorised access. During the inspection the medicines storage room was observed to have been unlocked, medicines were observed stored in baskets on the floor and medicines belonging to two residents were found to be stored in the same basket. Adequate storage space should be available to ensure that medicines are stored safely and securely to ensure the safe administration of medicines and prevent unauthorised access. An area for improvement was identified.

The temperature of the medicine storage area was monitored and recorded daily 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 maximum and minimum temperatures were recorded daily and were within the required range. However, the current temperature of the medicine refrigerator was not recorded. This was highlighted to the manager who agreed to begin recording the current temperature from the day of inspection onwards.

Satisfactory arrangements were in place for the storage of controlled drugs.

The manager and staff were reminded that medicines awaiting collection for disposal should be stored securely to prevent unauthorised access and collected in a timely manner. Assurances were provided that this would be addressed immediately.

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.

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 controlled drug record book should be bound and have numbered pages to ensure records are stored securely. Whilst controlled drugs records were observed to be accurately maintained, the controlled drug book was not bound and pages were not numbered. An area for improvement was identified

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, the audits carried out have not identified the issues raised at this inspection. The date of opening was not recorded on all medicines to facilitate audit and disposal at expiry. An area for improvement was identified.

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.

Records reviewed indicated that staff had received written confirmation of the resident's current prescribed medicines from their GP or via hospital discharge letter. When receiving medicines,

the quantity supplied had not been recorded to facilitate audit. In addition, discrepancies on the personal medication records were observed for one patient. It was unclear if their medicines were being administered as prescribed. The manager was asked to investigate these discrepancies and submit a notification to RQIA. A response was received on 6 January 2025, the manager provided assurance that the personal medication records had now been updated and the medicines were being administered as prescribed. 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 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. In addition, some audits could not be completed as the date of opening had not been recorded. The audit findings 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*	8*

* the total number of areas for improvement includes six that have been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Zoe Murray, Manager, and Mr Kevin McKinney, 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 Residential Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 12 December 2025	The registered person shall ensure that medicines are stored securely. This area for improvement is made in relation to: • Ensuring the treatment room is kept locked when not in use. • Ensuring adequate shelving and secure cupboard space is available to store medicines safely and securely within the treatment room. • Ensuring medicines awaiting disposal are stored securely. Ref: 3.3.2
	Response by registered person detailing the actions taken: The treatment room lock has been updated to a keypad lock ensuring it remails locked at all times. Planning to ensure adequate shelving and cupboard space is ongoing to ensure the safest way of securing the medicines in the treatment room. Medicines awaiting disposal are securely stored in dedicated section in treatment room

Area for improvement 2 **Ref:** Regulation 27 (2) (c) **Stated:** Third time **To be completed by:** 10 September 2025	The registered person shall ensure that all areas of the home are free from risks and hazards. This is stated in reference to the access to the cleaning chemicals.
	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 27 (4) (b) **Stated:** Second time **To be completed by:** 10 September 2025	The registered person shall ensure that the practice of wedging open of fire doors ceases with immediate effect.
	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 13 (a) (b) **Stated:** First time **To be completed by:** 30 October 2025	The registered person shall ensure the fall's protocol for the home is reviewed in line with best practice guidance and post falls' observations are recorded accordingly.
	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:** 12 December 2025	The registered person shall ensure that care plans are resident centred and contain the necessary detail to direct the required care. This area for improvement is made in relation to care plans for medicines for distressed reactions. Ref: 3.3.1
	Response by registered person detailing the actions taken: All residnets with prescribed medications care plans have been updated and person centred to ensure more detail to direct the required care

Area for improvement 2 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 12 December 2025	The registered person shall review the management of insulin and ensure that insulin pen devices are appropriately labelled and that care plans are resident centred and contain the necessary detail to direct the required care. Ref 3.3.1
	Response by registered person detailing the actions taken: **insulin pen devices are now appropriately labelled and care plans are centred to each resident to contain the necessary detail to direct the required care, diabetes nurse has been contacted and currently arranging a training session for care staff in relation to management of insulin pen devices**
Area for improvement 3 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 12 December 2025	The registered person shall ensure that an effective audit process is in place and that the date of opening is recorded for all medicines to facilitate audit and disposal at expiry. Ref: 3.3.3
	Response by registered person detailing the actions taken: Updated audit document in place to ensure all opening dates are recodred at the time of opening
Area for improvement 4 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 12 December 2025	The registered person shall ensure that the controlled drug record book has suitably bound and numbered pages. Ref: 3.3.3
	Response by registered person detailing the actions taken: New controlled drug record book has been sourced and in place, it has numbered pages and is suitably bound
Area for improvement 5 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 12 December 2025	The registered person shall ensure that the processes for managing medicines at the time of admission is reviewed and the issues identified in this report are addressed. Ref: 3.3.1 & 3.3.4
	Response by registered person detailing the actions taken: A updated clear and detailed process has been reviewed and disccused with staff to directly follow in the management of medicines at the time of admission

Area for improvement 6 **Ref:** Standard 19.2 **Stated:** Second time **To be completed by:** 10 September 2025	The registered person shall ensure all necessary pre-employment checks are in place prior to the commencement of employment.
	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 23.4 **Stated:** First time **To be completed by:** 10 November 2025	The registered person shall ensure staff receive training in relation to the care of residents with a learning disability and mental health needs.
	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 8 **Ref:** Standard 22.6 **Stated:** First time **To be completed by:** 10 September 2025	The registered person shall ensure that any record retained in the home that details residents' information is securely stored.
	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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