The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Meadows

Provider: Armagh Care Services

Date of Inspection: 10 February 2026

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:	Armagh Care Services
Responsible Individual:	Mr Daniel McHugh
Registered Manager:	Mr Daniel McHugh
Service Profile: Meadows is a nursing home registered to provide nursing care for up to 46 patients living with a learning disability. The home is situated within the main building and three adjacent bungalows each accommodating up to five patients. Patients have access to communal dining and living areas in each of the buildings, and a garden area.	

2.0 Inspection summary

An unannounced inspection took place on 10 February 2026, from 10.10am to 3.00pm. 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. Medicines were stored securely. Medicine records and medicine related care plans were mostly well maintained. There were processes in place to ensure that staff were trained and competent to manage medicines and the audits that were completed indicated that patients were administered their medicines as prescribed. However, improvements were necessary in relation to the audit of medicines management, including ensuring that the date of opening is recorded on medicines and the management of medicines refrigerator temperatures.

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.

Five completed patient questionnaires were received following the inspection. These provided positive responses regarding the management of medicines and the care provided. No responses to the staff survey were received.

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.

The management of distressed reactions, pain, thickening agents, insulin and warfarin 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.

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.

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 temperature of the main medicine storage area was monitored and

recorded to ensure that medicines were stored appropriately. It was agreed that the temperature would additionally be recorded for all other medicine storage areas on a daily basis, room thermometers were already in place. Satisfactory arrangements were in place for the storage of controlled drugs and the safe disposal of medicines.

Medicines that require cold storage must be stored between 2^{o}C and 8^{o}C 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. This monitoring was in place; however, the minimum temperature was often recorded below 2^{o}C and corrective action had not been taken. 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 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. 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 that 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.

Occasionally, patients 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 patient's care plan. Written consent and care plans were in place when this practice occurred.

Although an audit tool was in place, the audits completed by management and staff had not been completed regularly recently and had not identified/addressed the issues identified at this inspection. The manager should review the audit system to ensure robust procedures are in place, which cover all aspects of the management and administration of medicines, including those identified. Any shortfalls identified should be detailed in an action plan and addressed. An area for improvement was identified.

The date of opening was not recorded on all medicines. It was often recorded on medication administration records, but not consistently. This did not facilitate clear audit trail. 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.

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.

There have been no medicine related incidents reported to RQIA since the last medicines management inspection. Management and staff were familiar with the type of incidents that should be reported. The inspector signposted staff to the RQIA provider guidance in relation to the statutory notification of medication related incidents available on the RQIA website.

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.

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. 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 Standards.

	Regulations	Standards
Total number of Areas for Improvement	2*	5*

* 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 nurse 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time **To be completed by:** 30 June 2025	The registered person shall review the management of falls in the home in relation to the following: 1. the home's falls policy is in line with best practice/guidance 2. where a risk of falls is identified, a dedicated fall's care plan is in place. 3. falls' risk assessments and care plans are reviewed and updated following any fall in the home. 4. The monitoring of a patient following a fall is in line with the home's fall's policy and procedures. 5. A 24-hour post fall's review is conducted to ensure that the correct actions are taken and the correct persons notified after the fall.
	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 2 **Ref:** Regulation 16 (2) (b) **Stated:** First time **To be completed by:** With immediate effect (22 May 2025)	The registered person shall ensure that patient care records are reviewed on return from a period of time in hospital to ensure that they remain relevant to current care needs. **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 30 **Stated:** First time **To be completed by:** 10 February 2026	The registered person shall take robust action to ensure the medicines refrigerator remains within the recommended temperature range of 2 to 8ºC. Ref: 3.3.2 **Response by registered person detailing the actions taken:** A new thermometer was purchased on 16/02/26 and is in place.
Area for improvement 2 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 24 February 2026	The registered person shall ensure that robust audit procedures are in place, which cover all aspects of the management and administration of medicines, including those identified. Ref: 3.3.3 **Response by registered person detailing the actions taken:** Monthly audit takes placed which is based on RQIA Medicene Management Audit Tool.
Area for improvement 3 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 10 February 2026	The registered person shall ensure that the date of opening is recorded on all medicines to facilitate a clear audit trail. Ref: 3.3.3 **Response by registered person detailing the actions taken:** All staff are aware that the date of opening is recorded on all mediccines to facilitate a clear audit trail.

Area for improvement 4 **Ref:** Standard 23 Criteria (2) **Stated:** First time **To be completed by:** With immediate effect (22 May 2025)	The registered person shall ensure that where a risk of pressure damage is identified, a pressure management care plan is developed to guide staff on how to maintain skin integrity. **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 46 Criteria (2) **Stated:** First time **To be completed by:** With immediate effect (22 May 2025)	The registered person shall ensure that staff remain bare below the elbow in areas where care is provided in order to ensure effective hand hygiene. **Those staff met with during the inspection were bare below the elbow. However, action required to ensure compliance with this standard was not fully reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 2.0

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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