The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Meadowview Care Home

Provider: Kathryn Homes Ltd

Date of Inspection: 3 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:	Kathryn Homes Ltd
Responsible Individual:	Mrs Tracey Anderson
Registered Manager:	Ms Charlotte Brazil
Service Profile: Meadowview Care Home is a residential care home registered to provide health and social care for up to 54 persons who are living with dementia. Care is provided over two floors and all residents are accommodated in single rooms with ensuite facilities. Residents also have access to communal lounges and dining areas.	

2.0 Inspection summary

An unannounced inspection took place on 3 February 2026, from 10.00am to 3.00pm. 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: the standard of maintenance of personal medication records, handwritten medicine administration records, warfarin management and cold storage. 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. It was decided that the home would be given a period of time to implement the necessary improvements. A further 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 management and staff for their assistance during 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. 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?

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.

Some personal medication records were not up to date with the most recent prescription. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff did not use these records as part of the administration of medicines process. An area for improvement was identified.

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 for four residents. Directions for use were clearly recorded on the personal medication record and resident-centred care plans were in place. 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. These medicines were used infrequently. However, when they were administered the reason for and outcome of each administration was not always recorded. This was highlighted to the manager for ongoing monitoring.

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.

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 was reviewed. Speech and language assessment reports and care plans were in place. One resident's record of prescribing and administration did not include the recommended consistency level. This was highlighted to the manager for immediate corrective action.

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. A resident centred care plan was in place. However, written confirmation of the current dosage regime was not in place and obsolete records had not been cancelled and archived. This could result in the wrong information being referred to in error. In addition, the date of opening was not recorded on warfarin and a daily stock balance was not maintained to facilitate a clear audit trail. 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.

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 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 the storage of controlled drugs and the safe disposal of medicines.

Medicines which 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. Temperatures were being monitored daily however, the thermometers were broken on the day of the inspection and corrective action had not been taken. In addition, review of records evidenced that the thermometers had not been being reset daily. 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. However, handwritten medicine administration records had not been signed and verified as accurate by two staff members and did not contain the full date. An area for improvement was identified.

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. One incorrect running balance for a Schedule 4 (Part 1) controlled drug was highlighted to the manager for corrective action and ongoing monitoring.

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 the majority of medicines to facilitate audit and disposal at expiry. It was agreed that the findings of this inspection would be included in 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 at the time of admission or 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. Medicines had been recorded accurately as received and there was evidence that medicines were administered as prescribed. However, discrepancies were identified on two personal medicine records. An area for improvement has been identified in relation to the standard of maintenance of personal medication records (see section 3.3.1).

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, as identified in Section 3.3.1 the administration of warfarin could not be audited.

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 they 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 Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	4*	5*

*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 Ms Charlotte Brazil, Registered Manager and other members of the management team, 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 Care Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate and ongoing (3 February 2026)	The registered person shall ensure that personal medication records are accurately maintained. Ref: 3.3.1 & 3.3.4
	Response by registered person detailing the actions taken: The registered person will ensure that all Kardex and Medication Administration Records are accurately maintained. Staff have been reminded to check that all medication entries correspond with pharmacy labels and GP prescriptions. Regular audits will be completed by the Home Manager/ Deputy Manager to ensure documentation is accurate, complete and up to date. Supervisions have been completed with CTL's to remind them of the importance of keeping accurate medication records. Medication competencies have been completed with all CTL's.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate and ongoing (3 February 2026)	The registered person shall review the management of warfarin to ensure safe systems are in place as detailed in the report. Ref: 3.3.1 & 3.3.5
	Response by registered person detailing the actions taken: The registered person will ensure safe management of Warfarin therapy. Warfarin records will include the most recent INR result, prescribed dose and date of the next blood test. A dedicated Warfarin record chart will be maintained and reviewed regularly to ensure accurate administration and monitoring. Spot checks are being completed daily by the Home Manager or Deputy Manager. Count of medication is being completed both on the MAR and the Warfaring sheet provided by the chemist, which is signed by 2 staff.

Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate and ongoing (3 February 2026)	The registered person shall ensure that the maximum, minimum and current temperatures of the medicine refrigerators are monitored and recorded daily and that the thermometer is reset. Appropriate action must be taken if the temperature recorded is outside the recommended range of 2-8ºC. Ref: 3.3.2
	Response by registered person detailing the actions taken: The registered person will ensure that medication fridges temperatures are monitored and recorded daily. Staff have been reminded that the temperature must remain within the recommended range. Any temperature outside this range will be reported immediately and appropriate action taken in line with the medication policy. Posters have been placed in each treatment room to remind staff to reset the thermometers daily and to retrain the staff on how to reset them. Supervisions have been completed with all CTL's.
Area for improvement 4 **Ref:** Regulation 14 (2) (c) **Stated:** First time **To be completed by:** As from the date of this inspection (12 November 2025)	The registered person shall ensure that all potential risks to residents are minimised. This relates specifically to securing of food, drinks, toiletries, cleaning products, and all store rooms, as well as the boiler room.
	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 Residential Care Homes Minimum Standards (Dec 2022)	
Area for improvement 1 **Ref:** Standard 32 **Stated:** First time **To be completed by:** Immediate and ongoing (3 February 2026)	The registered person shall ensure that handwritten medicine administration records are checked and verified as accurate by two trained members of staff and that they include the full date. Ref: 3.3.3
	Response by registered person detailing the actions taken: The registered person will ensure that any handwritten entries on MAR charts are clear, dated and double-signed in accordance with the home's medication policy. Staff have been reminded of the correct procedure to ensure accuracy and accountability. Home Manager and Deputy Manager are checking compliance on a weekly basis. Supervisions have been completed with all CTL's. Medication competencies have been renewed with all CTL's.
Area for improvement 2 **Ref:** Standard 23.3 **Stated:** First time **To be completed by:** 11 December 2025	The registered person shall ensure that there is improved staff compliance with first aid training.
	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 6.2 **Stated:** First time **To be completed by:** 25 November 2025	The registered person shall ensure that care records consistently reflect the prescribed care arrangements from professionals. This relates specifically to those who require a modified diet.
	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 35.1 **Stated:** First time **To be completed by:** As from the date of this inspection (12 November 2025)	The registered person shall ensure that there are adequate systems in place to have oversight of staff compliance with infection prevention and control. This relates specifically to the staff use of gel nails and overuse of gloves.
	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 17.10 **Stated:** First time **To be completed by:** As from the date of this inspection (12 November 2025)	The registered person shall ensure that the system for recording complaints is improved to detail the following: details of the investigation, outcome, level of satisfaction and resolution.
	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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