

Inspection Report

Name of Service: Redburn Clinic

Provider: Spa Nursing Homes Ltd

Date of Inspection: 21 April 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:	Spa Nursing Homes Ltd
Responsible Individual:	Mr Christopher Arnold
Registered Manager:	Mr Michael Bagood
Service Profile: Redburn Clinic is a registered nursing home which provides general nursing care for up to 27 patients. The home is also registered to care for patients with a physical disability. Patients' bedrooms are located over three floors and patients have access to communal lounges and a dining area.	

2.0 Inspection summary

An unannounced inspection took place on 21 April 2026, from 10.00am to 3.15pm. 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. Medicine records were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines. However, improvements were necessary in relation to the monitoring of the medicine refrigerator temperatures and the medicines administration process.

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.

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.

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).

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 mostly 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. One minor discrepancy was highlighted to the manager 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 pain, insulin and thickening agents 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.

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. Records of administration included the reason for and outcome of each administration. One

care plan required updating with the details of the current prescribed medication. This was discussed with the manager who agreed to update the 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 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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was monitored to ensure that medicines were stored appropriately, however review of the records evidenced some gaps in recording, this was discussed with the manager for ongoing monitoring. On the day of inspection, the storage area temperature was within the recommended range.

It is important that oxygen cylinders are stored securely and that signage is in place. Signage was in place in the treatment room, however it was not in place where oxygen cylinders were stored in the ground floor nursing station. This was highlighted to the manager for corrective action.

Medicines which require cold storage must be stored between 2°C and 8°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. The refrigerator temperature was not recorded and reset each day; this does not provide evidence that the temperature is maintained within the required range at all times. An area for improvement was identified.

Satisfactory arrangements were in place for the storage of controlled drugs and safe disposal of medicines. However, one tub of thickening agent belonging to a patient who was no longer in the home was identified in the medicines trolley, this was highlighted to the manager for immediate disposal.

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 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. The date of opening was recorded on most medicines to facilitate audit and disposal at expiry.

It is important that nurses follow safe medication administration processes to ensure that medicines are administered to the right patient at the right time and the appropriate records are maintained. This includes administering medicines to each patient directly from their dispensed supply and signing the record of administration immediately after the medicine has been administered to the specific patient. Failure to follow this process may mean that medicines are administered to the wrong patient in error and records of administration are not accurately maintained.

Morning medicines were observed being prepared for five patients at the same time. This practice is unsafe and increases the likelihood of a medication error. Nurses must follow safe processes for the administration of medicines. This was brought to the attention of the nurse and manager to address urgently. 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.

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 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 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 Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	1	5*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Michael Bagood, Registered 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 13 (4) Stated: First time To be completed by: 21 April 2026	The registered person shall ensure medicines are prepared immediately prior to their administration for each patient. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Registered Manager will ensure that medication management practices in accordance with organisational policy is followed. The Registered Manager has reminded all nursing staff that medicines must be prepared immediately prior to administration for each resident. The Registered Manager has completed supervision with nursing staff regarding medication preparation and continues to monitor this through spot checks and observation of practice.
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: 21 April 2026	The registered person shall ensure that maximum, minimum and current refrigerator temperatures are recorded each day and that the thermometer is reset after each reading. Ref: 3.3.2
	Response by registered person detailing the actions taken: The Registered Manager has addressed with all nursing staff the requirement to record maximum, minimum and current refrigerator temperatures daily and to reset the thermometer after each reading. The Registered Manager will continue to monitor compliance with temperature readings.
Area for improvement 2 Ref: Standard 41.7 Stated: First time To be completed by: 31 December 2025	The registered person shall ensure competency and capability assessments are completed for all staff who take charge of the nursing home in the absence of the manager.
	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 4.1 Stated: First time To be completed by: 9 December 2025	The registered person shall ensure that there is a system in place to monitor the completion of care records following a patient's admission to the home. 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 4.7 Stated: First time To be completed by: 31 December 2025	The registered person shall ensure that patients' care plans are reviewed regularly. 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 4 Stated: First time To be completed by: 31 December 2025	The registered person shall ensure that there are detailed care plans and risk assessments in place for patients who vape. 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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