

Inspection Report

Name of Service: Colorado

Provider: Colorado

Date of Inspection: 25 June 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:	Colorado
Responsible Person:	Mr Marcus Scott
Registered Manager:	Ms Trudie Helen Scott
Service Profile: This home is a registered residential care home, which provides health and social care for up to nine residents requiring residential care in frail elderly over 65 years of age; physical disability over and under 65 years of age and up to a maximum of four residents living with mild to moderate dementia. All resident areas are on the ground floor level and residents are accommodated in single bedrooms. Residents have access to communal areas and an outdoor space.	

2.0 Inspection summary

An unannounced inspection took place on 25 June 2026, from 9.30 am to 1.35 pm by a care inspector and from 10.30am to 1.00pm by a pharmacist inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 17 September 2025, and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

Review of medicines management found that satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records were well maintained. There were auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed.

It was evident that staff promoted the dignity and well-being of residents. Residents said that living in the home was a good experience and were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

As a result of this inspection, one area for improvement was assessed as having been addressed by the provider. One area for improvement has been stated for a second time. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

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 provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, 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. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Residents spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Residents' comments included: "I really enjoy living here", "The staff couldn't do enough for you", "If I need anything I only have to ask", "I couldn't ask for a better home" and "The staff are all excellent".

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.

Five questionnaire responses were received from residents during the inspection. The respondents confirmed that they were satisfied with the care and services provided in the home.

Comments included: “Excellent care provided”, “First class”, “Couldn’t be better”, “My needs are met”, “Homely”, “Very good care always” and “Caring community”.

Following the inspection eight staff and one relative responded to the online survey. All respondents were very satisfied with the overall provision of care. Comments included: “I have been amazed at the level of care and kindness shown to all service users and other members of staff”, “I believe the training I have received has been highly effective and ensures the best quality of care for all service users”, “Very homely place”, “Very good place to work with great training and communication from management” and “Residents are happy as well as their relatives”.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of residents. There was evidence that the manager had systems in place to manage staffing.

Review of the most recent Northern Ireland Social Care Council (NISCC) check completed by the manager evidenced that one care assistant was not registered within the required timeframe from commencing employment. Details were discussed with the manager and an area for improvement was identified.

Observation of the delivery of care evidenced that residents’ needs were met by the number and skills of the staff on duty.

Residents said that staff were very attentive. Staff said there was good teamwork and that they felt well supported in their role and that they were satisfied with the staffing levels.

It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

3.3.2 Quality of Life and Care Delivery

Staff interactions with residents were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual residents’ needs, their daily routine, wishes and preferences.

It was observed that staff respected residents’ privacy by their actions such as discussing residents’ care in a confidential manner, and by offering personal care to residents discreetly. Staff were also observed offering residents choice in how and where they spent their day or how they wanted to engage socially with others.

Examination of care records and discussion with the manager confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Observation of the lunch time meal and discussion with residents, staff and the manager evidenced that there were robust systems in place to manage residents' nutrition and mealtime experience. A menu was on display offering a choice of two meals.

Residents commented positively about the food provided within the home with comments such as: "The food is actually excellent", "Plenty of choices", "There is something different on the menu every day" and "Good food".

An activity board was available within the home detailing a list of activities for the week. Residents commented very positively about the provision of activities. Comments included: "There is always something to do here", "The entertainment is very good here", "The staff are very kind, caring and friendly" and "I really enjoy the activities here".

3.3.3 Management of Care Records

Residents' needs were assessed by a suitably qualified member of staff at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents' needs and included any advice or recommendations made by other healthcare professionals.

Care records were person centred and staff recorded regular evaluations about the delivery of care. Some minor discrepancies were identified and discussed in detail with the manager who agreed to have these records updated. Following the inspection, written confirmation was received that relevant action had been taken to address this.

Residents care records were held confidentially.

3.3.4 Quality and Management of Residents' Environment

The home was fresh smelling, neat and tidy and residents' bedrooms were found to be personalised with items of memorabilia and special interests. Bedrooms and communal areas were clean, tidy and comfortable. Outdoor spaces and gardens were well maintained with areas for residents to sit

A number of environmental shortfalls were identified requiring either repair and/or replacement; details were discussed with the manager who agreed to have these reviewed. Following the inspection, written confirmation was received that relevant action had been taken to address these findings.

Observation of the environment and discussion with the manager evidenced that the bath had been removed since the last care inspection. An area for improvement was identified to have a bath installed.

Corridors and fire exits were clear from clutter and obstruction. A fire risk assessment (FRA) had been completed on the 15 October 2025. There were no actions required following this assessment.

There was a good supply of personal protective equipment (PPE) within the home. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

3.3.5 Medicines management

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 staff for immediate corrective action and on-going vigilance.

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.

The management of 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.

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 and care plans were in place. One care plan needed updated to ensure it was person centred and the manager agreed to action this immediately following the inspection. 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 and staff confirmed that they would record the reason for and outcome of each administration.

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. Two residents required care plans to be implemented and the manager agreed to action this immediately following the inspection. The audits completed indicated that medicines were administered as prescribed.

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 tidy and organised so that medicines belonging to each resident could be easily located. The temperature of the medicine storage area was 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.

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. Records were found to have been accurately completed. 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 manager agreed to implement a bound controlled drug record book.

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 inspector shared an audit tool to aid the development of a more in depth medicine audit. The date of opening was recorded on medicines to facilitate audit and disposal at expiry.

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.

There had been no recent admissions/readmissions to the home. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the resident's medicines and this was shared with the GP and community pharmacist.

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 medicines were being administered as prescribed.

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.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent.

3.3.6 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Ms Trudie Helen Scott is the Registered Manager of this home since 9 April 2020. Staff said that the manager was very approachable and accessible.

A system was in place to ensure accidents and incidents were notified, if required, to residents' next of kin, the trust and to RQIA.

Review of a sample of environment audits evidenced that deficits were being identified by management and an action plan implemented, however, there was no timeframe for completion or follow up to ensure that the actions had been completed. This was discussed with the manager and an area for improvement has been stated for a second time.

The home was visited each month by the registered person to consult with residents, their relatives and staff and to examine all areas of the running of the home. Written reports were completed following these visits and available within the home.

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	2*

* The total number of areas for improvement includes one standard that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Trudie Scott, 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 Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 20 (1) (c) (ii) Stated: First time To be completed by: 26 June 2026	The registered person shall implement a robust system to ensure that relevant staff are registered with NISCC within the required timeframe. Ref: 3.3.1
	Response by registered person detailing the actions taken: A robust system has been implemented to ensure that all relevant staff are registered with the Northern Ireland Social Care Council (NISCC) within the required timeframe. A registration monitoring system is now in place, with the Registered Manager maintaining and regularly reviewing a NISCC registration tracker. Registration status and renewal dates are monitored routinely, and reminders are issued in advance to ensure registrations remain current. Compliance is also monitored through regular audits to ensure all relevant staff continue to meet NISCC registration requirements.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022)	
Area for improvement 1 Ref: Standard 20 Stated: Second time To be completed by: 26 July 2026	The registered person shall ensure that environmental audits are completed to evidence any deficits identified, action taken, time frame for completion and follow up. Ref: 2.0 and 3.3.6
	Response by registered person detailing the actions taken: A comprehensive environmental audit system has been implemented. Environmental audits are now completed on a regular basis and clearly document any deficits identified, the actions required, the person responsible, the agreed timeframe for completion, and evidence of follow-up to confirm that actions have been completed. The Registered Manager reviews completed audits to ensure that identified issues are addressed promptly and that ongoing compliance with environmental standards is maintained.

Area for improvement 2 Ref: Standard E30 Stated: First time To be completed by: 26 August 2026	The registered person shall ensure that a bath is installed within the home. Ref: 3.3.4 Response by registered person detailing the actions taken: Arrangements have been made for the installation of a bath within the home, and this work is currently in progress. The Registered Person is liaising with the relevant contractors to ensure the installation is completed as soon as practicable. Progress is being monitored closely to ensure the project is completed within the agreed timeframe and that the bathing facility will be available to meet residents' assessed needs and preferences upon completion.
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