The Regulation and Quality Improvement Authority

Children's Home Inspection Report

IN047482

7 November 2025

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Service Type: Children's Home **Provider Type:** Health and Social Care Trust **Located within:** – Belfast Health and Social Care Trust	**Manager status:** Registered
Brief description of how the service operates: This home is registered as a small children's home as defined in The Minimum Standards for Children's Homes (Department of Health) (2023). The young people living in this home have had adverse childhood experiences, which has resulted in them requiring residential care. A time limited variation to the registration of the service to include learning disability as a category of care had been approved by RQIA prior to inspection.	

2.0 Inspection summary

An unannounced inspection took place on 7 November 2025, from 10.00am to 12.50pm. 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.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and medicines were administered as prescribed. However, improvements were necessary in relation to monitoring and recording the temperature of the medicine storage area.

Whilst an area for improvement was identified, there was evidence that with the exception of a small number of medicines young people were being administered their medicines as prescribed.

Details of the inspection findings and the new area 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 registration information, and any other written or verbal information received from young people, 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 young people 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 young person liked to take their medicines. They said medication rounds were tailored to respect each young person'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?

Young people should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times young peoples' 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.

Young people in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each young person. 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. However, a second member of staff had not checked and signed the personal medication records when they were written and updated to confirm accuracy. This was discussed with staff and the deputy manager for immediate corrective action and ongoing monitoring.

Obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly. This was addressed during the inspection. The audits completed at the inspection indicated that medicines were being administered in accordance with the most recent personal medication record.

Copies of prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

All young people 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 pain.

The management of pain was discussed. Staff advised that they were familiar with how each young person expressed their pain and that pain relief was administered when required. Care plans were in place.

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 young person'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 young people 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 young person could be easily located. Review of the daily temperature records indicated that the temperature of the medicine storage areas was not monitored and recorded each day. Temperatures of medicine storage areas must be monitored and recorded each day to ensure that medicines are stored appropriately at or below 25ºC. An area for improvement was identified.

A medicine refrigerator was available for use if needed. Guidance on the correct process for checking refrigerator temperatures and resetting the thermometer was provided to staff.

Satisfactory arrangements were in place for the storage of controlled drugs and the safe disposal of medicines.

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 young people 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 a controlled drug record book. Controlled drugs records were observed to be maintained to the required standard. The controlled drug reconciliation process was discussed with staff and guidance given.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The RQIA medicines management audit tool was shared with staff following the inspection.

The date of opening had not been recorded on all medicines to facilitate audit and disposal at expiry; however, audit trails could be completed as dates of opening had been recorded in other records.

3.3.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

Young 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 young people 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. Staff advised that they 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.

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 young people are well looked after and receive their medicines appropriately, staff who administer medicines to young people 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

An area for improvement has been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	1

The area for improvement and details of the Quality Improvement Plan were discussed with the person 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 Minimum Standards for Children's Homes (Department of Health) (2023)	
Area for improvement 1 **Ref:** Appendix 1 - Standard 3 **Stated:** First time	The registered person shall ensure that the room temperature of the medicine storage area is monitored daily and maintained at or below 25ºC. Ref: 3.3.2
To be completed by: 7 November 2025	**Response by registered person detailing the actions taken:** A thermometer has now been placed in the medicine storage area in the top floor office. Staff carry out daily temperature checks and sign a recording sheet to confirm the room temperature is below 25C. The sheet also details necessary steps to reduce the temperature if necessary. This is audited by the management team on a monthly basis.

Please ensure this document is completed in full and returned via the Web Portal

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