The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Clandeboye Care Home

Provider: Beaumont Care Homes Limited

Date of Inspection: 5 June 2025

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:	Beaumont Care Homes Limited
Responsible Individual:	Mrs Ruth Burrows
Registered Manager:	Mrs Laura Patterson
Service Profile: Clandeboye Care Home is a nursing home registered to provide nursing care for up to 52 patients living with dementia. Patient accommodation is spread over two units on ground floor level. There is a range of communal areas throughout the home and patients have access to enclosed outdoor spaces.	

2.0 Inspection summary

An unannounced inspection took place on 5 June 2025, from 10.00am to 3.10pm. 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 inspection also reviewed the area for improvement identified at the last medicines management 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 generally well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. However, improvements were necessary in relation to the management of thickening agents and the length of the medicine round.

The area for improvement in relation to the management of distressed reactions, identified at the last medicines management inspection was assessed as met and two new areas for improvement were identified. Areas for improvement identified at the last care inspection were carried forward for review at the next inspection. Details can be found 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.

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 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 pain and insulin 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 for seven patients. Directions for use were clearly recorded on the personal medication record and patient-centred care plans were in place for the majority of patients. One patient required a care plan to be implemented and two patients' care plans needed updated to include the name of the prescribed medicine. The manager provided assurances that these would be actioned immediately. 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 the majority of administrations. The manager agreed to monitor this closely and also agreed to ensure that frequent use of these medicines would be referred to the prescriber for review.

Some patients 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 patient 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 patient.

The management of thickening agents was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included

the recommended consistency level were maintained for the majority of patients. However, one personal medication record and medicine administration record included the incorrect consistency level and one did not include the recommended consistency level. An area for improvement was identified.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside of the recommended range.

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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

The manager was reminded that medicines awaiting collection for disposal should be stored securely to prevent unauthorised access and collected in a timely manner.

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. Records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

The morning medicines round was not completed until 12.15pm in one unit and 12.20pm in the other unit. Medicines must be administered at the prescribed time. Measures should be implemented to ensure nurses are afforded protected time to complete the medication round in a timely manner. 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. 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.

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 medicines to facilitate audit and disposal at expiry.

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 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 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 their 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	2*	3*

* the total number of areas for improvement includes three which were carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Laura Patterson, 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 Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate and ongoing (5 June 2025)	The registered person shall review the management of thickening agents to ensure that records of prescribing and administration include the recommended consistency level. Ref: 3.3.1
	Response by registered person detailing the actions taken: This issue identified was immediately rectified on the day of inspection, these were recent admissions that did not have thickener levels on the Kardex or Marr sheet. Monitoring of same has been added to the Home's admission checklist and this also falls under the remit of our Monthly Medication Auditing Process. All residents in the Home as of 02/06/2025 have thickener levels written on their prescription Kardex and MARR sheets. Further monitoring will be maintained by the Operations Manager during the monthly Regulation 29 visit.
Area for improvement 2 **Ref:** Regulation 12 (4) **Stated:** Second time **To be completed by:** 30 April 2025	The registered person shall undertake a review of the menu with consultation, to ensure that patients are offered a choice of nutritionally balanced meals. This should include choices for those patients requiring a modified diet and make provisions for snacks. Records pertaining to the consultation stage should be retained for review at the next inspection.
	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 28 **Stated:** First time	The registered person shall ensure that measures are implemented to ensure nurses are afforded protected time to complete the medication round in a timely manner. Ref: 3.3.3
To be completed by: Immediate and ongoing (5 June 2025)	**Response by registered person detailing the actions taken:** A nurse meeting took place on 12/06/2025 to discuss the Pharmacy inspection outcome – A balance was required for the nursing staff where they are able to complete medication administration in a timely manner but also not rushed as rushing could also potentially lead to medication errors and discrepancies. The discussion at the nurses meeting had the following outcome: The Nurses are to wear red 'do not disturb' tunics whilst completing medication administration and ensure they enforce this if disturbed with non-emergency issues. The Administrator and Home Manager will take telephone calls where possible during the week to ensure reduced disturbance by taking messages and passing on non-emergency information post rounds. Outgoing calls are now prioritised in the diary via a colour code system and non-urgent calls can be made after 11am - such as calls for results etc. In situations where emails can be sent for ordering medication etc night nursing staff are to help facilitate this. Nurses also encouraged to seek support from pharmacists and GPs for review of prescribed medication and reduce polypharmacy if required. It is important to note that Medication rounds will not be rushed and nurses will continue to be allowed the time they need to safely and effectively administer medications to our residents and we hope that the amendments proposed will help deliver a more efficient medication round. The Home Manager will monitor daily during the walkabout audits and further monitoring will be maintained by the Operations Manager during the monthly Regulation 29 audit.

Area for improvement 2 **Ref:** Standard 12 **Stated:** Second time **To be completed by:** 11 March 2025	The registered person shall ensure that up to date daily menus are displayed in a format that is user friendly and accessible to patients.
	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 35.3 **Stated:** First time **To be completed by:** 11 March 2025	The registered person shall ensure monitoring and governance arrangements in relation to infection prevention and control (IPC) practices are effective in identifying shortfalls in staff practice.
	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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