



The Regulation and
Quality Improvement
Authority

Inspection Report

Name of Service: Whiteabbey Care Home
Provider: Beaumont Care Homes Limited
Date of Inspection: 20 May 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:	Mr Frank Mudie
Service Profile: Whiteabbey Care Home is a nursing home registered to provide nursing care for up to 59 patients. The home is divided into two units over two floors. A dining room and communal lounges are located on both floors.	

2.0 Inspection summary

An unannounced inspection took place on 20 May 2025, from 9.50am to 2.30pm. 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. 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. 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 patients were administered their medicines as prescribed. However, one new area for improvement was identified in relation to the secure storage of and access to medicines.

Whilst a new area for improvement was identified, there was evidence that with one exception, patients were being administered their medicines as prescribed. The area for improvement identified at the last medicines management inspection, in relation to the management of medicines on admission to the home, was assessed as met.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, 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).

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

One relative spoken with briefly, told us that although their relative had been admitted recently, they were satisfied with the care received in the home.

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.

Staff said they had worked hard to implement and sustain improvements identified at the previous medicines management inspections and had received help and support from management to do so. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

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. A couple of minor discrepancies were highlighted for immediate corrective action and on-going vigilance (see also section 3.3.4).

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 distressed reactions, pain, thickening agents, insulin and warfarin, were reviewed. 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. One care plan needed to be updated with a recent dose change, this was addressed 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 each administration.

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

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 and nutritional supplements 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. One record of administration needed the prescribed consistency added, this was addressed immediately. The patient was receiving the correct consistency.

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. Supplementary insulin administration records were in use and the date of opening was recorded on individually labelled insulin pen devices.

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. Blood tests had been carried out at the identified times, warfarin had been administered as prescribed and a patient specific care plan was in place. A small number of obsolete dosage regimen sheets were held on file. Assurances were provided that these would be cancelled/archived promptly. The patient was receiving the correct dose.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined.

An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. The associated care plan needed to be updated to reflect the current regimen, it was agreed that this would be addressed immediately. Records of administration of the nutritional supplement and water were maintained. Stocks of nutritional supplement were stored in the patient's bedroom, the manager agreed to complete a risk assessment and ensure that the room temperature is monitored and recorded. The manager agreed to review training received by nurses in this area and pursue opportunities as necessary.

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 upstairs was observed to be securely locked to prevent any unauthorised access. However, the storage area downstairs was accessible to all, since the code to the door was attached to the door and the medicines refrigerator and the cupboard containing medicines for disposal were unlocked. All medicine storage areas must be securely locked and accessible only by essential staff. The manager was reminded that all medicines awaiting collection for disposal should be stored securely to prevent unauthorised access. An area for improvement was identified.

Storage areas 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.

It was agreed that inhaler spacer devices would be stored covered for infection prevention and control purposes.

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 and medicines were observed to be administered in a timely manner on the day of the inspection. 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 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 action plans had been implemented 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 mostly been accurately completed and administered as prescribed, one transcribing error had resulted in the administration of an incorrect dose, this was highlighted to the nurse and manager and immediate action was taken (see also section 3.3.5).

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 two medicines. The audits were discussed in detail with the nurses on duty and the manager for on-going monitoring and medication incident notification reports were submitted to RQIA as necessary (see also section 3.3.4).

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 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.

	Regulations	Standards
Total number of Areas for Improvement	5*	6*

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

The new area for improvement and details of the Quality Improvement Plan were discussed with Mr Frank Mudie, 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: From the date of inspection 20 May 2025	<p>The registered person shall ensure that all medicine storage areas are securely locked and accessible only by authorised staff.</p> <p>Ref: 3.3.2</p> <p>Response by registered person detailing the actions taken: The code that was evident at the treatment room door on the ground floor has been removed. Staff have been advised that this is an unacceptable practice and should not be repeated. Staff have also received supervision in relation to ensuring the fridge and all cupboards are locked when not in use. Compliance will be monitored as part of the Home Managers walkaround and the Regulation 29 visit.</p>
Area for improvement 2 Ref: Regulation 27 (2) (c) Stated: First time To be completed by: 23 July 2024	<p>The registered person shall ensure that equipment provided at the nursing home is in good working order, properly maintained and suitable for the purpose for which it is to be used.</p> <p>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.</p> <p>Ref: 2.0</p>
Area for improvement 3 Ref: Regulation 27 (2) (d) Stated: First time To be completed by: 23 July 2024	<p>The registered person shall ensure the environmental deficits identified on inspection are addressed without delay. A suitable and achievable time bound program for this work should be submitted, along with the returned QIP, for information and comment.</p> <p>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.</p> <p>Ref: 2.0</p>

<p>Area for improvement 4</p> <p>Ref: Regulation 14 (2) (a) (c)</p> <p>Stated: First time</p> <p>To be completed by: 23 July 2024</p>	<p>The registered person shall ensure that all areas of the home to which patients have access are free from hazards to their safety.</p> <p>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.</p> <p>Ref: 2.0</p>
<p>Area for improvement 5</p> <p>Ref: Regulation 13 (7)</p> <p>Stated: First time</p> <p>To be completed by: 23 July 2024</p>	<p>The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection.</p> <p>This area for improvement relates to the following:</p> <ul style="list-style-type: none"> • donning and doffing of personal protective equipment • appropriate use of personal protective equipment • staff knowledge and practice regarding hand hygiene • management of laundry. <p>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.</p> <p>Ref: 2.0</p>
<p>Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022</p>	
<p>Area for improvement 1</p> <p>Ref: Standard 11</p> <p>Stated: Second time</p> <p>To be completed by: 23 July 2024</p>	<p>The registered person shall ensure that the activity provision to all patients is understood to be an integral part of the care process and is planned and delivered to suit the patients' preferences and individual needs.</p> <p>Activity care records should evidence a meaningful record of the activity provision to all patients and a record of the patient's involvement in the activity where appropriate.</p> <p>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.</p> <p>Ref: 2.0</p>

<p>Area for improvement 2</p> <p>Ref: Standard 4.9</p> <p>Stated: First time</p> <p>To be completed by: 23 July 2024</p>	<p>The registered person shall ensure that personal care records are accurately maintained.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>
<p>Area for improvement 3</p> <p>Ref: Standard 46.2</p> <p>Stated: First time</p> <p>To be completed by: 23 July 2024</p>	<p>The registered person shall ensure that the environment in the home is managed to minimise the risk and spread of infection.</p> <p>This area for improvement specifically relates to the cleaning of the environment.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>
<p>Area for improvement 4</p> <p>Ref: Standard 44.11</p> <p>Stated: First time</p> <p>To be completed by: 23 July 2024</p>	<p>The registered person shall ensure that all proposed changes to the use of any area, the use of any room or the layout of the premises are notified to RQIA in writing for consideration prior to the changes taking place.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>
<p>Area for improvement 5</p> <p>Ref: Standard 16.11</p> <p>Stated: First time</p> <p>To be completed by: 23 July 2024</p>	<p>The registered person shall ensure that all complaints are managed in keeping with this standard and appropriate records are retained.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>

<p>Area for improvement 6</p> <p>Ref: Standard 4.1</p> <p>Stated: First time</p> <p>To be completed by: 23 July 2024</p>	<p>The registered person shall ensure that the infection prevention and control and environmental audit processes are effective.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>
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