

# Inspection Report

<b>Name of Service:</b>	<b>Camphill Care Home</b>
<b>Provider:</b>	<b>Beaumont Care Homes Limited</b>
<b>Date of Inspection:</b>	<b>15 July 2025</b>

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

## 1.0 Service information

<b>Organisation/Registered Provider:</b>	Beaumont Care Homes Limited
<b>Responsible Individual:</b>	Mrs Ruth Burrows
<b>Registered Manager:</b>	Mr Vasco Alves
<p><b>Service Profile</b> – This home is a registered nursing home, which provides nursing care for up to 72 patients. The home is divided into three units; the Glendun and Glenshesk Units where care is provided for people living with dementia and the Glenariff Unit where general nursing care is provided.</p> <p>There is a communal dining room and lounges in all the units and individual patient bedrooms. There are garden areas for patients to use when desired.</p>	

## 2.0 Inspection summary

An unannounced inspection took place on 15 July 2025 from 9.30am to 5.10pm by two care inspectors.

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 4 and 5 December 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to patients and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As a result of this inspection ten of the previous areas for improvement were assessed as having been addressed by the provider.

One area for improvement under the standards is second time and two are carried forward for review at the next inspection.

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.

### **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 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.

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**

Patients told us that staff offered choices to patients throughout the day, which included preferences for getting up, and going to bed, what clothes they wanted to wear, food and drink options and where and how they wished to spend their time.

Patients 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. Patients' comments included: "Staff treat me well" and "It is very good; staff treat me well there is always someone about".

Staff spoken with told us they enjoyed working in Camphill Care Home and that the manager was approachable and that they felt well supported in their role.

We did not receive any questionnaire responses from patients or their visitors or any responses from the staff online survey.

### **3.3 Inspection findings**

#### **3.3.1 Staffing Arrangements**

Safe staffing begins at the point of recruitment. A review of recruitment records evidenced that pre-employment checks were completed including full employment history and evidence of staff registration with the Nursing and Midwifery Council (NMC) was included.

Checks were made to ensure that staff maintained their registrations with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

Patients said that there was enough staff on duty to help them. Staff said there was good teamwork, 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.

Observation of the delivery of care evidenced that the number and skills of the staff on duty met patients' needs.

### 3.3.2 Quality of Life and Care Delivery

Staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner and by offering personal care to patients discreetly.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

A restrictive practice register was maintained and reviewed monthly. However, while the use of physical restraint was monitored, the use of chemical restraint was not; this was discussed with the manager and identified as an area for improvement.

Patients may require special attention to their skin care. For example, some patients may need assistance to change their position in bed or get pressure relief when sitting for long periods of time. These patients were assisted by staff to change their position regularly. A review of records evidenced gaps in the recording of the position change. This was discussed with the manager and an area for improvement was identified.

Where a patient was at risk of falling, measures to reduce this risk were put in place. In addition, falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented. Review a patient's care records, following a fall, evidenced that the post fall's observations and updating of risk assessments were recorded.

Patients had good access to food and fluids throughout the day and night. Nutritional risk assessments were completed monthly to monitor for weight loss or weight gain. Nutritional care plans were in line with the recommendations of the speech and language therapists and/or the dieticians. Patients were safely positioned for their meals and the mealtimes were well supervised. Menus were displayed and picture menus were available for use as required.

Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs.

Patients confirmed that activities took place in the home. An activities planner was available for review. Activities included games, arts and crafts, life story and movies. Activity records were maintained however, not for all patients and gaps were observed in others. This was discussed with the manager and an area for improvement was identified.

Patients spoken with told us they enjoyed living in the home and that staff were friendly. One patient told us, "I am very well, staff treat me well".

### **3.3.3 Management of Care Records**

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

Care plans reviewed, for those patients living with dementia, were not fully person centred or sufficiently detailed. Care plans for those patients who required bespoke one to one care were not in place. This was discussed with the manager and an area for improvement was identified. Patients' care records were held confidentially.

Deficits were identified in regards to the wound care records, details were discussed with the manager and an area for improvement was identified.

Nursing staff recorded regular evaluations about the delivery of care on both a monthly and daily basis. However, these evaluations lacked detail about how the patient spent their day and did not consistently evidence oversight by the nursing staff of the supplementary care records such as food and fluid intakes, bowel records or repositioning records. This was discussed with the manager and an area for improvement was stated for a second time.

### **3.3.4 Quality and Management of Patients' Environment**

The home was mostly clean and tidy and patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

Fire safety measures were in place to protect patients, visitors and staff in the home. Actions required from the most recent fire risk assessment had been completed in a timely manner.

There was evidence that systems and processes were in place to manage infection prevention and control, which included policies and procedures and regular monitoring of the environment, and staff practice to ensure compliance.

### **3.3.5 Quality of Management Systems**

There has been no change in the management of the home since the last inspection. Mr Vasco Alves has been registered manager in this home since 16 November 2019.

Staff commented positively about the manager and described them as supportive, approachable and always available to provide guidance. Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place.

There was a system in place to manage any complaints received. A compliment's log was maintained and any compliments received were shared with staff.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further. Patients and their relatives spoken with said that if they had any concerns, they knew who to report them to and said they were confident that the manager or person in charge would address their concerns.

#### 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
<b>Total number of Areas for Improvement</b>	2*	6*

\* the total number of areas for improvement includes one standard that has been stated for a second time and two which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Vasco Alves, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 13 (4)  <b>Stated:</b> First time  <b>To be completed by:</b> 24 October 2023	<p>The registered person shall ensure that personal medication records and medication administration records correlate and reflect the prescriber's most recent instructions.</p> <p>Ref: 2.0</p> <p><b>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.</b></p>
<b>Area for improvement 2</b>  <b>Ref:</b> Regulation 12 (1) (a) (b)  <b>Stated:</b> First time  <b>To be completed by:</b> 1 October 2025	<p>The registered person shall ensure that the record keeping in relation to wound management is maintained appropriately and in accordance with legislative requirements, minimum standards and professional guidance.</p> <p>Ref: 3.3.3</p> <p><b>Response by registered person detailing the actions taken:</b>            Supervision has been completed with the Registered Nurses in relation to the expectation documentation required relating to wound care.            A monthly wound audit is completed and the Registered Manager/Deputy will complete a weekly governance audit on all wounds to ensure ongoing compliance.            The management of wound care will be monitored by the Operations Manager as part of the Regulation 29 visit.</p>
<b>Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 29  <b>Stated:</b> First time  <b>To be completed by:</b> With immediate effect (24 October 2023)	<p>The registered person shall ensure that handwritten medicine administration records include the start/full date of administration to facilitate a clear audit trail.</p> <p>Ref: 2.0</p> <p><b>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.</b></p>
<b>Area for improvement 2</b>  <b>Ref:</b> Standard 4  <b>Stated:</b> Second time	<p>The registered person shall ensure that the monthly care plan reviews and daily evaluations of care are meaningful, patient centred and contain oversight of the supplementary care records.</p> <p>Ref: 2.0 &amp; 3.3.3</p>

<p><b>To be completed by:</b> 1 October 2025</p>	<p><b>Response by registered person detailing the actions taken:</b> During August 2025, all Registered Nurses attended care plan coaching. This coaching incorporated the requirement for meaningful evaluations and progress notes, which reflect their knowledge and oversight of the supplementary care records.</p> <p>Compliance will be monitored through the completion of the care plan audits and as part of the Home Manager's walk about audit. Oversight will continue as part of the Regulation 29 visit by the Operations Manager.</p>
<p><b>Area for improvement 3</b></p> <p><b>Ref:</b> Standard 18</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 1 September 2025</p>	<p>The registered person shall ensure the current restrictive practice audit is enhanced to include the use of chemical restraint.</p> <p>Ref: 3.3.2</p> <p><b>Response by registered person detailing the actions taken:</b> The chemical restraint audit was fully implemented following the inspection and is ongoing. Any identified deficits noted on completion of the audit will generate a time bound action plan which will be reviewed and verified by the Home Manager.</p> <p>Compliance will be monitored during the course of the Regulation 29 visit by the Operations Manager.</p>
<p><b>Area for improvement 4</b></p> <p><b>Ref:</b> Standard 23</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 30 September 2025</p>	<p>The registered person shall ensure the repositioning records are accurately recorded and reflect the position change.</p> <p>Ref: 3.3.2</p> <p><b>Response by registered person detailing the actions taken:</b> Supervision has been completed with care staff in relation to the accurate recording of the repositioning records using the correct codes. Repositioning charts will be spot checked by the Registered Nurses to ensure that these are accurately completed and will be monitored as part of the Home Manager's walk about. Compliance will be monitored as part of the Regulation 29 visit by the Operations Manager.</p>
<p><b>Area for improvement 5</b></p> <p><b>Ref:</b> Standard 11</p> <p><b>Stated:</b> First time</p>	<p>The registered person shall ensure records are maintained of the activity offered and outcome of this activity for the individual patients.</p> <p>Ref:3.3.2</p>

<p><b>To be completed by:</b> 1 October 2025</p>	<p><b>Response by registered person detailing the actions taken:</b> The Activities Leaders have received supervision in relation to the completion of records to ensure that these records detail the activity offered and the outcome of the activity for the individual patient. These records will be monitored as part of the Home Manager's walk about and as part of the Operations Manager's, Regulation 29 visit to the Home.</p>
<p><b>Area for improvement 6</b></p> <p><b>Ref:</b> Standard 25</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 30 September 2025</p>	<p>The registered person shall ensure detailed patient centred care plans are in place sufficiently detailed care plans are in place for patients living with dementia and for those in receipt of one to one supervision.</p> <p>Ref:3.3.3</p> <p><b>Response by registered person detailing the actions taken:</b> The importance of maintaining person centred care records was discussed with the Registered Nurses. All care plans for the residents receiving one to one care were reviewed following the inspection and updated where necessary. The care plans for residents with dementia are planned to be fully reviewed, and completed in further detail by the end of September. Compliance will be monitored as part of the care plan audit process and as part of the Regulation 29 visit to the Home.</p>

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



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