The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Tennent Street Care Home

Provider: Beaumont Care Homes Limited

Date of Inspection: 21 October 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 Aleyamma George

Service Profile:
Tennent Street Care Home is a nursing home registered to provide nursing care for up to 44 patients. The home is divided into three units over one floor; the Sandhurst Unit which provides care for past or present alcohol dependency, the Sandringham Unit which provides general nursing care and the Balmoral Unit which provides care for patients living with dementia.

Tennent Street Residential Care Home occupies the first floor of the building and the registered manager is responsible for both services.

2.0 Inspection summary

An unannounced inspection took place on 21 October 2025, from 10.20am to 3.30pm. 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. 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 management of medicines. Medicines were stored securely. Medicine records and most 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, improvements were necessary in relation to the management of pain, the management of thickening agents and the controlled drug reconciliation process conducted at each shift handover.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, patients were being administered their medicines as prescribed. Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, and new areas 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

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 and medicines were administered in accordance with individual patient preference. Staff also said that they prioritised patients who required pain relief and time-critical medicines during each medicine round.

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 distressed reactions 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.

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 not in place for two patients prescribed controlled drug pain medication. Care plans must be in place and reviewed regularly. An area for improvement was identified.

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.

However, one personal medication record did not include the recommended consistency level. The records of administration reviewed, did not include the recommended consistency level. Records of prescribing and administration, including the recommended consistency level must be maintained. 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. One insulin pen device was labelled to denote ownership but did not have the date of opening recorded to facilitate audit and disposal at expiry. This was discussed with the manager for immediate corrective action and on-going vigilance.

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, 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 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.

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. Review of records of receipt, administration and disposal of controlled drugs indicated that they had been administered as prescribed and the balances remaining in stock were correct. However, a review of the records of reconciliation carried out by two members of staff at each handover indicated that two balances had been recorded incorrectly for several days.

This suggests that staff did not perform a physical count of the stock each time. This was discussed with staff and the manager for immediate corrective action. An area for improvement was identified.

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. With the exception of insulin (see section 3.3.1), 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 the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with the manager for on-going monitoring.

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 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 Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	5*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Aleyamma George, 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 Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 21 October 2025	The registered person shall review the management of pain medication, ensuring that care plans are in place for each patient. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Registered Person has now reviewed the management of pain medication and can confirm that care plans are in place for those residents that require medication for the management of pain. The care plans reflect that the prescribed medications are administered as per advice from the GP and are administered in accordance with the medication administration policy/guidelines. The prescribed analgesia/ controlled drugs patches are administered by x 2 Registered Nurses. All documentations will be contemporaneously completed as per care plan. Any PRN/ as required analgesia including controlled drugs will be administered as prescribed and the effect of the the medication administered monitored and documented. There are audits in place to monitor. Registered Nurse supervisions and reflective learning have been completed. Compliance will be monitored by the Registered Manager as part of the monthly care plan audit process, ensuring ongoing compliance and continuous improvement in practice.
Area for improvement 2 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 21 October 2025	The registered person shall review the management of thickening agents, to ensure that records of prescribing and administration are accurately maintained. The recommended consistency level should be recorded on all records. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Registered Manager has now reviewed the management of thickening agents and can confirm that: • Staff have been reminded to record the prescribed consistency level of fluids at the point of administration, ensuring accurate documentation and safe practice. • Care plans are in place for the use of thickening agents. • The prescription is documented in the Central prescription chart, with the required level of modification/consistency also recorded in the MARR sheet and supplementary booklets. Compliance will be monitored as part of the internal auditing process and via the monthly completion of the reg 29 audit.

Area for improvement 3 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 21 October 2025	The registered person shall review the process for reconciling controlled drugs at shift handover, to ensure that a physical count occurs on all occasions. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Registered Manager can confirm that the controlled drugs are checked by 2 registered nurses at shift change, hand over times as well as the medication administration times. The physical count/ balance stock check counts are documented in the records as per guidelines with the medication management policy. The Registered Manager has conducted reflective learning / supervision with the Registered Nurses. The Registered Home Manager will continue to monitor compliance through walkaround audits, ensuring ongoing oversight and adherence to policy.
Area for improvement 4 **Ref:** Standard 44 **Stated:** First time **To be completed by:** 31 March 2025	The Registered Person shall ensure the nursing home remains well maintained and suitable for its stated purpose. This includes; a pipe in a shower room, the doors, doorframes, furniture and the outside courtyard.
	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 5 **Ref:** Standard 44.1 **Stated:** First time **To be completed by:** 10 March 2025	The Registered Person shall ensure the home is kept clean. This includes an unclean kitchenette, fire exit, furniture, a bathroom, brass door plates and hoist slings hanging on the floor.
	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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