The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Cherryvalley Care Home

Provider: Beaumont Care Homes Ltd

Date of Inspection: 14 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 Ltd
Responsible Individual:	Mrs Ruth Burrows
Registered Manager:	Mrs Erminia Suciu, not registered
Service Profile: Cherryvalley Care Home is a nursing home registered to provide general nursing care for up to 46 patients, including patients with a terminal illness, patients living with a physical disability other than sensory impairment, over and under the age of 65 years. Patients' bedrooms are located over the ground and first floors. There are communal lounges, a dining room, and garden space.	

2.0 Inspection summary

An unannounced inspection took place on 14 October 2025, from 10.15am to 4.30pm. 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 inspection also reviewed the areas 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.

The outcome of this inspection indicated that robust arrangements were not in place for some aspects of medicines management. Areas for improvement were identified in relation to: record keeping, management of changes to medication, management of thickening agents, management of insulin, audit and management of medicines on admission. Whilst areas for improvement were identified, there was evidence that the majority of medicines were administered as prescribed.

Following the inspection, the findings were discussed with the senior pharmacist inspector in RQIA. . It was decided that the home would be given a period of time to implement the necessary improvements. A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained. Failure to implement and sustain the improvements may lead to enforcement action.

The areas for improvement in relation to the timing of medicines administration and medicines ordering process identified at the last medicines management inspection were assessed as met. Details of the inspection findings, including new areas for improvement identified and areas for improvement carried forwards for review at the next inspection, 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 where applicable, 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.

No completed questionnaires or responses to the staff survey were received 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 sample of personal medication records reviewed were not up to date with the most recent prescription and some were incomplete. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff did not use these records as part of the administration of medicines process. An area for improvement was identified.

The management of changes to prescribed medicines was reviewed. For one patient who had recent changes to their medication regime, the personal medication record had not been accurately updated with details of the new medication or discontinued medicines. Copies of the new prescriptions were not available for reconciliation. The medication administration record indicated that the new medicines were being administered in accordance with the prescriber's directions. An area for improvement was identified.

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 and pain 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.

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. For one patient reviewed records

of prescribing and administration which included the recommended consistency level were not maintained. An area for improvement was identified.

Although care plans were in place when patients required insulin to manage their diabetes, they did not contain sufficient detail to direct staff if the patient's blood sugar was outside of the recommended range. Details of the patient's prescribed insulin regime were not included in the care plan, and for one patient insulin was not recorded on their personal medication record. An area for improvement was identified.

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. A patient specific care plan was in place where warfarin was prescribed. However, obsolete warfarin dosage directions had not been archived. This could lead to the administration of an incorrect dose. This was highlighted to the manager and for correction and ongoing monitoring.

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.

In the ground floor treatment room the worktop around the sink area had become water damaged. The door to the ground floor treatment room was lockable however the threshold strip was catching the bottom of the door making it difficult to open and close. These issues were discussed with the manager who advised that remedial work is planned in the coming weeks.

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. Most of the records were found to have been accurately completed. As detailed in Section 3.3.1, records of administration of thickener for one patient had not been maintained. 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 the controlled drug record book. There were mostly satisfactory arrangements in place for the management of controlled drugs. Staff were reminded of the need to bring the running balance to zero when controlled drugs have been denatured and disposed of.

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.

The audits completed by management and staff had not identified the issues identified at this inspection. The manager should implement a robust audit system which covers all aspects of the management and administration of medicines including those identified. Any shortfalls identified should be detailed in an action plan and addressed. An area for improvement was identified.

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.

The audits completed at the inspection indicated that the medicines had been administered as prescribed and written confirmation of prescribed medicines had been obtained on admission. However the personal medication record had not been written accurately. For one patient three medicines had not been transcribed and medicine formulations were not recorded. , An area for improvement was identified.

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 audit trails completed at the inspection indicated that medicines had been administered as prescribed. However, as detailed in Section 3.3.3, the manager should implement a robust audit system which covers all aspects of the management and administration of medicines.

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 they 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 and Standards.

	Regulations	Standards
Total number of Areas for Improvement	4*	5*

* 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 Erminia Suciu, Manager, and Mrs Ruth Burrowes, Responsible Individual, 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:** 16 October 2025	The registered person shall ensure that personal medication records are accurate and up to date with the most recent prescription. Ref: 3.3.1& 3.3.4
	Response by registered person detailing the actions taken: Copies of each residents' medical prescriptions have been requested from Boots Pharmacy and all personal medication Kardex's have been rewritten in accordance with the prescriptions, these have been checked and signed by 2 trained staff. Monthly Medication Audits are being completed on each floor. Spot checks will be completed during Home walkaround and during Reg 29 visits by Operations Manager to ensure compliance is maintained.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 16 October 2025	The registered person shall ensure that safe systems are in place for the management of medication changes. Ref: 3.3.1
	Response by registered person detailing the actions taken: Boots Pharmacy have been contacted to request that copies of all medication prescriptions are forwarded to the Home when changes have been made to individual residents prescribed medications going forward. Home Manager will be made aware of all changes in residents' medication via the 24-Hour Shift Report and Handover sheet. Spot checks will be completed by Home Manager and by Operations Manager during Reg 29 visit.
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 16 October 2025	The registered person shall ensure that safe systems are in place for managing medicines on admission. Ref 3.3.1 & 3.3.4
	Response by registered person detailing the actions taken: All resident's medication records have been reviewed to ensure accuracy of records. The Home Manager will complete spot checks after new residents are admitted to the Home to ensure medication records are completed accurately. Spot checks will be completed by Operations Manager during Reg 29 visits.

Area for improvement 4 **Ref:** Regulation 30 **Stated:** First time **To be completed:** 27 February 2025	The registered person shall ensure that RQIA is made aware of any notifiable event without delay. **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 29 **Stated:** First time **To be completed by:** 16 October 2025	The registered person shall ensure that records of prescribing and administration of thickening agents are accurately maintained and include the recommended consistency level. Ref: 3.3.1 **Response by registered person detailing the actions taken:** There are currently 3 residents who are prescribed thickening agents in the Home. All records of prescribing of thickening agents have been reviewed to ensure they are accurate. Home Manager will be made aware of all changes in residents fluid IDDSI level via the 24-Hour Shift Report. Spot checks will be completed by Home Manager and by Operations Manager during Reg 29 visit to ensure accuracy of records.
Area for improvement 2 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 16 October 2025	The registered person shall ensure that care plans for the management of diabetes contain sufficient detail to direct the required care. Ref: 3.3.1 **Response by registered person detailing the actions taken:** All care plans for the management of diabetes have been reviewed to ensure they contain details of actions to be taken when a resident's blood sugars are outside the recommended range and the residents current prescribed insulin regime. The Home Manager will be made aware of all changes in residents insulin regime via the 24-Hour Shift Report. Spot checks will be completed by Home Manager to ensure medication records and care plans have been amended accordingly. Home Manager will complete spot checks after new residents with a diagnosis of diabetes are admitted to ensure care plans contain relevant information. Spot checks will be completed by Operations Manager during Reg 29 visits.

Area for improvement 3 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 16 October 2025	The registered person shall implement a robust audit tool which covers all aspects of medicines management. Ref 3.3.3 & 3.3.5
	Response by registered person detailing the actions taken: Monthly Medication Audits are now completed on each floor by Home Manager and Deputy Manager/Sister. The Home Manager will spot check audits completed by other staff to ensure accuracy. Action plans will be developed where required which will be reviewed and signed off when addressed. Medication Audits will be reviewed by Operations Manager during Reg 29 visits.
Area for improvement 4 **Ref:** Standard 21.5 **Stated:** Second time **To be completed by:** 27 February 2025	The registered person shall ensure that oral care is provided in line with best practice and that the rationale for any variation from best practice is clearly documented.
	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 4.9 **Stated:** First time **To be completed by:** 27 February 2025	The registered person shall ensure that supplementary care records, specifically, repositioning records are completed in a comprehensive, accurate and contemporaneous manner in accordance with legislative and best practice guidance.
	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

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews