The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Camphill Community Glencraig

Provider: Camphill Community Glencraig

Date of Inspection: 22, 23 & 29 January 2026

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:	Camphill Community Glencraig
Responsible Individual:	Dr Elizabeth Mitchell
Registered Manager:	Mrs Ellen Majella McVeigh
Service Profile – This home is a registered Residential Care Home which provides health and social care for up to 54 residents living with a learning disability. Many of the residents have complex learning disabilities and may present with behaviours which challenge. The residential home is made up of 12 houses of various size and occupancy across a large site. The home is managed by a board of Trustees from Camphill Community and beds are commissioned by a number of trusts on a regional basis.	

2.0 Inspection summary

An unannounced inspection took place on 22 January 2026 from 9.40am to 4.30pm, and on the 23 January 2026 from 10.00am to 4.00pm by two care inspectors. A further unannounced inspection took place on 28 January 2026, from 10.00am to 3.00pm by two pharmacist inspectors and focused on medicines management within the home.

The medicines management 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 well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. However, improvements were necessary in relation to medicines requiring cold storage and monitoring the temperature of medicine storage areas.

Whilst areas for improvement were identified, there was evidence that residents were being administered their medicines as prescribed. The area for improvement in relation to medicine audits identified at the last medicines management inspection was assessed as met.

The care 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 5 & 6 February 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 residents and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of residents and that staff were knowledgeable and well trained to deliver safe and effective care.

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

While we found care to be delivered in a safe and compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery.

As a result of this combined inspection nine areas for improvement were assessed as having been addressed by the provider. One area for improvement has been stated for a second time, and one area for improvement will be reviewed 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 resident's, 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. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

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

Staff advised that they were familiar with how each resident liked to take their medicines. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

Residents told us that they were happy living in the houses. Some residents were involved in helping in the grounds or in day opportunities. There was a range of activities for residents provided or facilitated by staff during the inspection.

Residents unable to clearly verbally express their thoughts appeared relaxed and indicated through body language or non-verbal communication, such as smiling or giving the thumbs up.

Staff spoke of the strong sense of community working within the homes, the positive support from management, the training and staffing levels. Staff were proud of the ethos of the community

0ne returned questionnaire from a resident indicated high degrees of satisfaction with the care and services offered in the home. Comments included, "The care is the best! I like it that staff taught me to share things with friends."

Following the inspection, no additional feedback or comments were provided by staff or relatives.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of residents. There was evidence of robust systems in place to manage staffing.

Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels.

It was noted that there was enough staff in the home to respond to the needs of the residents in a timely way; and to provide residents with a choice on how they wished to spend their day.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the residents. Staff were knowledgeable of individual residents' needs, their daily routine wishes and preferences.

Staff were observed to be prompt in recognising residents' needs and any early signs of distress or illness, including those residents who had difficulty in making their wishes or feelings

known. Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs.

Staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly. Staff were also observed offering resident choice in how and where they spent their day or how they wanted to engage socially with others.

At times, some residents 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 residents and to manage this aspect of care.

Examination of care records and discussion with the manager confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

The dining experience was observed in some of the houses. It was an opportunity for residents to socialise, and the atmosphere was calm, relaxed and unhurried. It was observed that residents were enjoying their meal and their dining experience, in some houses staff and residents ate their meal together. It was observed that staff had made an effort to ensure residents were comfortable, had a pleasant experience and had a meal that they enjoyed.

Arrangements were in place to meet residents' social, religious and spiritual needs within the home. Residents' needs were met through a range of individual and group activities such helping in the large grounds, day opportunities, religious services, outings and musical activities. There was a wide range of themed activity's respecting the seasons of the year and events.

3.3.3 Management of Care Records

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

Residents care records were held confidentially.

Care records were person centred, well maintained and updated to ensure they continued to meet the residents' needs. Care staff recorded regular evaluations about the delivery of care. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate. It was discussed with the manager for a more regular review date to be recorded in the care plans, with a staff member's signature. The manager agreed to review this. This will be reviewed at a subsequent inspection.

3.3.4 Quality and Management of Residents' Environment

The home was clean, tidy and well maintained. Different houses had resident's artwork on display. Residents' bedrooms were personalised with items important to the resident. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

In two identified houses, four volunteer staff were found to be living in four staff bedrooms. RQIA received assurance from the manager on the 2 February 2026 that these staff had moved out to alternative accommodation. An area for improvement was identified.

Significant progress has been made by management in the fitting of a call bell system to each of the houses. This process has not yet finished. An area for improvement was carried over for review at a subsequent inspection.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance, however several staff were not were not bare below the elbow. An area for improvement was stated for a second time.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Ellen McVeigh has been the manager in this home since 28 June 2021

Staff commented positively about the manager and the management team and described them as supportive, approachable and able to provide guidance.

It was clear from the records examined that the manager team had processes in place to monitor the quality of care and other services provided to residents.

3.3.6 Medicines management

Residents in residential care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times residents' 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.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. 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 the personal medication records when they

were written and updated to confirm that they were accurate. The manager agreed to implement a process where these checks are verified by a signature rather than typed initials.

Copies of residents' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

All residents 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, thickening agents and epilepsy 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.

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the resident'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 residents 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 resident could be easily located. However, temperatures of medicine storage areas were not monitored and recorded to ensure that medicines were stored appropriately. An area for improvement was identified.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. In three houses the maximum and minimum temperatures were had been recorded outside the recommended range for a number of weeks and the thermometer was not being reset. In addition, in one house only the current temperature was being monitored. The manager agreed that staff would receive training on how to effectively monitor the medicine refrigerator temperatures. An area for improvement was identified.

Satisfactory arrangements were in place for the safe disposal of medicines.

It is important to have a clear record of which medicines have been administered to residents 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 the controlled drug record book. There were no controlled drugs

requiring safe custody, however, one liquid controlled drug was stored in the controlled drug cabinet as per the home's standard operating procedures. The manager agreed to review the maintenance of the running balance for this medicine.

Occasionally, residents 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 resident'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.

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.

There had been no recent admissions/readmissions to the home. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the resident's medicines and this was shared with the GP and community pharmacist.

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.

To ensure that residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that 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.
As detailed above staff should receive training on monitoring and recording the medicine refrigerator temperature.

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	1	4*

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

Areas for improvement and details of the Quality Improvement Plan were discussed the management team 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 3 (1)(b);(3)(a)(b) **Stated:** First time **To be completed by:** 23 January 2026	The Registered Person shall ensure that the home works within its statement of purpose at all times. This is stated in relation to the housing of non-residents in registered premises. Ref: 3.3.4
	Response by registered person detailing the actions taken: The statement of purpose clearly states that co workers live and work alongside residents. However, RQIA requested that all co workers vacate the two registered houses identified during the inspection. This action has been completed.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (Dec 2022)	
Area for improvement 1 **Ref:** Standard 35.7 **Stated:** Second time **To be completed by:** 1 June 2026	The registered person shall ensure that all staff employed in the home adheres to the guidance provided by the Northern Ireland Regional Infection Prevention and Control Manual (PHA) Specifically that staff are bare below the elbow. Ref: 2.0 & 3.3.4
	Response by registered person detailing the actions taken: Managers will continue to provide guidance and training in IPC and reinforce this standard.
Area for improvement 2 **Ref:** Standard E8 **Stated:** First time **To be completed by:** 1 May 2026	The registered person shall review the houses and ensure that call points accessible to residents are provided in every room that is used by residents. Ref 2.0 & 3.3.4
	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.
Area for improvement 3 **Ref:** Standard 32 **Stated:** First time **To be completed by:**	The registered person shall ensure that the temperature of the medicine storage areas is monitored and recorded to ensure that medicines are stored appropriately, as per the manufacturers' instructions. Ref: 3.3.6

Immediate and ongoing (28 January 2026)	**Response by registered person detailing the actions taken:** Thermometers and recording sheets are in place. All staff have been provided with guidance to manage this appropriately.
Area for improvement 4 **Ref:** Standard 32 **Stated:** First time **To be completed by:** Immediate and ongoing (28 January 2026)	The registered person shall ensure that the medicine refrigerator temperature is monitored and recorded as detailed in the report and that staff take appropriate action when the temperature recorded is outside the recommended range. Ref: 3.3.6
	Response by registered person detailing the actions taken: Thermometers and recording sheets are in place. All staff have been provided with guidance to manage this appropriately.

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

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