The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Balmoral View Care Home

Provider: Beaumont Care Homes Limited

Date of Inspection: 14 May 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:	Beaumont Care Homes Limited
Responsible Individual:	Mrs Ruth Burrows
Registered Manager:	Ms Adeshola Adejuyigbe, not registered
Service Profile: Balmoral View Care Home is a nursing home registered to provide nursing care for up to 39 patients within the categories of dementia, elderly, physical disability, mental health and terminal illness. Patients bedrooms are located over two floors. There are a range of communal areas throughout the home and patients have access to an enclosed garden**.**	

2.0 Inspection summary

An unannounced inspection took place on 14 May 2026, from 10.15am 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 safe management of medicines. Medicines were stored securely. The majority of 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 area for improvement was identified in relation to controlled drug records and one area for improvement in relation to pre preparing medicines was stated for a second time.

Whilst areas for improvement were identified, there was evidence that patients were being administered their medicines as prescribed.

The areas for improvement in relation to personal medication records and the management of medicines for new admissions identified at the last medicines management inspection were assessed as met. Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, the new area for improvement and the area for improvement stated for a second time, 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. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

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. One minor discrepancies was highlighted for immediate corrective action and on-going vigilance. Obsolete personal medication records had been cancelled and archived.

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 pain, thickening agents and insulin 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. One in use insulin pen device did not have the date of opening recorded. This was highlighted to the manager for immediate action and ongoing monitoring.

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. 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. On a small number of occasions, the outcome was recorded as "monitor" and the manager agreed to address this immediately with staff and monitor closely.

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.

It is important that staff follow safe medication administration processes to ensure that medicines are administered to the right patient at the right time. This includes administering medicines directly from their dispensed supply and signing the record of administration immediately after the medicine has been administered to the specific patient. Failure to follow this process may mean that medicines are administered to the wrong patient in error. On one unit the medicines for one patient for their next administration had been pre prepared. This practice is unsafe. This was brought to the attention of staff and the manager to address urgently. Staff must follow safe systems for the administration of medicines. An area for improvement was stated for a second time.

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. Review of the controlled drug record book evidenced that when controlled drugs were disposed of or transferred out of the home, the balance had not always been brought to zero and signed as witnessed by two

nurses. It was acknowledged that records for the disposal of controlled drugs had been recorded in the disposal book. An area for improvement was identified. The manager was asked to investigate one controlled drug discrepancy in relation to controlled drugs transferred out of the home. Following the investigation a notification was submitted to RQIA on 27 May 2026.

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. The date of opening was recorded on the majority of medicines to facilitate audit and disposal at expiry (see section 3.3.1).

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 medicines were being administered as prescribed.

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.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent.

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	2*	8*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Adeshola Adejuyigbe, 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 Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** Second time **To be completed by:** 14 May 2026	The registered person shall ensure that medicines are prepared immediately prior to administration for each patient and the record of administration signed immediately after. Ref: 2.0 & 3.3.3 **Response by registered person detailing the actions taken:** The issue identified on the day of inspection was dealt with immediately and internal processes commenced. Discussion has taken place with all staff who administrator medication and reminding them of their accountability to the safe administration of medication. To ensure compliance the Home Manager will complete spot checks during medication rounds. This also will be quality assured during visits carried out by Operations Manager/Regional Support Manager during Reg 29 visits.
Area for improvement 2 **Ref:** Regulation 14 (2)(a) **Stated:** First time **To be completed by:** 10 March 2026	The registered person shall ensure that the rooms housing boilers are maintained locked. **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:** 14 May 2026	The registered person shall ensure that when controlled drugs are disposed of or transferred out of the home, this is recorded in the controlled drug record book, the balance is brought to zero and the record is signed by two trained members of staff. Ref: 3.3.3 **Response by registered person detailing the actions taken:** Staff who administer medication have completed refresher medication training and medication competencies have also been renewed. How To Guide on Management of Controlled Drugs has been issued to all above staff. The Home Manager will audit Controlled Drug Register randomly to ensure records are accurate. Spot checks will be completed by Operations Manager/Regional Support Manager during Reg 29 visits.

Area for improvement 2 **Ref:** Standard 44 **Stated:** First time **To be completed by:** 10 March 2026	The registered person shall ensure that an environmental action plan is submitted with timescales for completion of all planned and ongoing works.
	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 3 **Ref:** Standard 44 **Stated:** First time **To be completed by:** 10 March 2026	The registered person shall ensure that the home is maintained to an acceptable level of cleanliness. This refers to the dining room on the ground 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
Area for improvement 4 **Ref:** Standard 9 **Stated:** First time **To be completed by:** 10 March 2026	The registered person shall ensure that patients are offered choice and supported and encouraged by staff to have a varied and daily routine.
	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 11 **Stated:** First time **To be completed by:** 10 March 2026	The registered person shall review the activity provision for patients in the Coleman unit to ensure patients are offered the opportunity to participate in planned activities.
	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 6 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 10 March 2026	The registered person shall ensure that care records are person centred and reflective of patients preferences and choice with regard to their care delivery.
	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 7 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 10 March 2026	The registered person shall ensure that supplementary care records are completed to accurately reflect the care delivered.
	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 8 **Ref:** Standard 37 **Stated:** First time **To be completed by:** 10 March 2026	The registered person shall ensure that any record in the home which details patient information is securely stored in accordance with The General Data Protection Regulation (GDPR) 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

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