The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Abbeylands Care Home – Seapark Unit

Provider: Beaumont Care Homes Limited

Date of Inspection: 22 May 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:	Mr Leslie Stephens

Service Profile –

This home is a registered residential care home which provides health and social care for up to 37 residents. The home is divided over two floors, with communal lounges, bathrooms and dining rooms on each floor.

The home provides care for residents requiring general residential care and residents living with mental health disorders excluding learning disability or dementia.

There is also a registered nursing home located within the same building for which the manager also has operational responsibility and oversight.

2.0 Inspection summary

An unannounced inspection took place on 22 May 2025, between 9.30 am and 6.45 pm by a care inspector.

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 16 April 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection found that, effective and compassionate care was delivered to residents. Details and examples of the inspection findings can be found in the main body of the report.

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

Residents said that living in the home was a good experience.
While we found care to be delivered in a compassionate manner, improvements were required to ensure the maintenance, décor and cleanliness of some areas of the home; and to the

management of potential hazards to health and safety of residents and to the oversight of care records. Details were shared with the management team during the inspection. Further details were shared with the manager and the registered individual (RI) during an enhanced feedback meeting on 4 June 2025. The management team discussed the actions that had been taken since the inspection and the further planned actions. RQIA were assured with the evidence provided following the inspection; that the appropriate action had been taken with regards to the concerns identified.

As a result of this inspection four areas for improvement were assessed as having been addressed by the provider. Other areas for improvement have either been stated again or 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.

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

Residents described staff as "very good" and "great". Residents spoken with said that they were happy living in the home. Comments included, "I don't have to worry about anything, I would not want to leave here" and "I like it here, I am well settled."

Staff told us that they enjoyed working in the home and that the resident's care was very important to them. One staff member said, "we all work well together, we support each other."

A recent compliment to the home thanked staff for "the love, care and attention."

Three replies were received from the online survey following the inspection. All the respondents expressed dissatisfaction with aspects of care delivery and the leadership within the home; these comments were shared with the senior management team for action as required.

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 systems in place to manage staffing. One new member of staff confirmed that they had received a robust induction.

Audits with regards to staff registration with the Northern Ireland Social Care Council (NISCC) were not robust. RQIA identified that three staff names, although registered with NISCC were missing from the checklist provided. An area for improvement was stated for a second time.

There was evidence that staff had received their formal appraisal; however, there was limited evidence that all staff had received individual, formal supervision within the required timeframe. An area for improvement was identified.

Residents said that there was enough staff on duty to help them. 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. Observation of the delivery of care evidenced that residents' needs were met by the number and skills of the staff on duty.

Discussion with staff and a review of the domestic duty rota raised concerns regarding domestic staffing levels. This was discussed with the management team and assurances were provided that staffing levels would be reviewed. The management team also confirmed that posts had been advertised for the domestic role within the home.

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.

It was observed that 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.

Where a resident was at risk of falling, measures to minimise this risk of falls should be put in place. Examination of records showed inconsistencies in post fall observations. An area for improvement was identified.

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. Inconsistencies were noted in residents care records in regards to the International Dysphagia Diet Standardisation Initiative (IDDSI) levels. An area for improvement was identified.

The dining experience was an opportunity for residents to socialise, the atmosphere was calm, relaxed and unhurried. It was observed that residents were enjoying their meal and their dining experience.

One resident told us, “the food is very good, you get an option.”

The importance of engaging with residents was well understood by the manager and staff.

Residents’ commented positively on the provision of activities in the home, one resident told us, “The activities are good, the girl will ask us what we like and what we don’t like.”

A review of records confirmed that residents participated in regular residents’ meetings which provided an opportunity for them to comment on aspects of the running of the home. For example, planning activities and menu choices.

Arrangements were in place to meet residents’ social, religious and spiritual needs within the home. The weekly programme of social events was displayed on the noticeboard advising of future 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.

It was noted that care records had been left unattended in both of the lounges in the home; this was discussed with the management team for immediate action. An area for improvement was identified.

Care records were person centred, care staff recorded regular evaluations about the delivery of care. However, there was limited evidence of resident involvement in the planning of their own care. An area for improvement was stated for a second time.

3.3.4 Quality and Management of Residents’ Environment

Environmental issues were observed throughout the home. The overall environment was worn, with several identified areas in need of repair or redecoration. For example, the carpet in the upstairs lounge was worn and in need of replacing, handrails throughout the home needed attention and sealant around the sinks in a number of bedrooms also needed to be replaced. An area for improvement was identified.

Some areas of the home were found to be in need of a deeper clean. For example, the sluice room sinks and cupboard required a deep clean, doors throughout the needed washed, the activity room was unlocked and untidy; equipment in one bedroom was also found to be unclean and poorly maintained. An area for improvement was identified.

Improvement was required to the management of potential hazards to residents' health and safety. The domestic cleaning trolley was left unattended and disinfectant spray was found in an unlocked cupboard. In addition to this denture cleaning tablets where found in a number of bedrooms and a box of un-prescribed medication was found in the downstairs lounge. Two areas for improvement were identified.

Fire safety measures were in place to ensure residents, staff and visitors to the home were safe. Actions from the latest fire risk assessment were completed in a timely manner. However, it was noted that some fire doors were propped open, this was discussed with the management team during the inspection for immediate action and an area for improvement was identified.

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 a change in the management of the home since the last inspection. Mr Leslie Stephens has been the manager in this home since April 2024.

Residents and staff commented positively about the manager and described him as supportive, approachable and able 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. However, these audits were not always robust; for example, the manager did not evidence oversight of weight loss audits and the last choking audit was completed in July 2024. In addition to this many of the findings from this inspection had not been picked up during the managers' audits. An area for improvement was identified

Residents and their relatives said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

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	8*	4*

* the total number of areas for improvement includes two that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with 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 21 (1) (b) Schedule 2 (5) **Stated:** Second time **To be completed by:** 22 May 2025	The registered person shall ensure that the NISCC audit is kept up to date, includes all relevant staff and accurately reflects their registration status. Ref: 3.3.1
	Response by registered person detailing the actions taken: All staff on the day of the inspection were registered with NISCC. Staff who may be allocated to work in both Abbeylands and Seapark are now on a combined NISCC log. Monthly NISCC checks are completed by the Manager and staff reminded of the next fee date as this arises. The log is is checked as part of the Regulation 29 visit carried out by the Operations Manager.
Area for improvement 2 **Ref:** Regulation 19 (1) (b) **Stated:** First Time **To be completed by:** 22 May2025	The registered person shall ensure that confidential information relating to residents is safely secured. Ref: 3.3.3
	Response by registered person detailing the actions taken: The safe storage of supplementary charts was discussed during recent staff meeting. All supplementary charts are to be stored in the offices, and staff have been reminded to return charts after recording. Compliance will be monitored as part of the walkaround and during the Regulation 29 visit
Area for improvement 3 **Ref:** Regulation 27 (2) **Stated:** First time **To be completed by:** 23 July 2025	The registered person shall ensure that there is a time bound refurbishment plan outlining the planned refurbishments to the home; including those areas discussed as part of the inspection. This should include projected timeframes for the works to take place. Ref 3.3.4

	Response by registered person detailing the actions taken: A timebound environmental action plan has been submitted to RQIA, this will be overseen and reviewed by the Home Manager. This includes additional resources required from the Regional Painter. The plan will be reviewed by the Operations Manager for progress and compliance.
Area for improvement 4 **Ref:** Regulation 27 (2) (d) **Stated:** First time **To be completed by:** 22 May 2025	The registered person shall ensure that all parts of the home are kept clean. Ref: 3.3.4
	Response by registered person detailing the actions taken: The deficits in cleaning that were identified on the day of the inspection were immediately addressed. The need for the attention to detail was discussed during the Domestic staff meeting held on 9th June 2025. IPC training took place on 12th June 2025. Cleaning records are in place for all required areas and this will be spot checked by the Manager on a weekly basis. The required improvement will be monitored as part of the daily walkaround and during the Regulation 29 visit .
Area for improvement 5 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** 22 May 2025	The registered person shall ensure that residents to not have access to substances hazardous to their health such as the domestic cleaning trolley and denture cleaning tablets. Ref: 3.3.4
	Response by registered person detailing the actions taken: Staff have been advised through staff meetings and ongoing supervision, that domestic trolleys are not be left unattended, or chemicals stored in resident accessible areas. All doors that store chemicals are now locked. COSHH training took place on 12th June 2025. Steradent is now locked in the treatment room and provided to residents who require this. Compliance will be monitored as part of the walkaround and during the completion of the Regulation 29 visit.
Area for improvement 6 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** 22 May 2025	The registered person shall ensure that medicines are stored securely. Ref 3.3.4
	Response by registered person detailing the actions taken: The Home was unable to identify the source of the unnamed medication, found on the day of the visit. All staff have been reminded about the safe storage of medication during the staff meeting held on 9th June 2025. Staff have been advised to be vigilant regarding any non-prescribed medication being brought into the Home. Any identified issues will be reported and investigated appropriately. The walkaround has been updated to

	ensure spot checks are taking place to identify and address any concerns. Compliance will be monitored during the Regulation 29 visits.
Area for improvement 7 **Ref:** Regulation 27 (4) (a) **Stated:** First time **To be completed by:** 22 May 2025	The registered person shall ensure that fire safety precautions are in place to protect residents, staff and visitors. This area for improvement is in relation to the propping open of fire doors. Ref: 3.3.4
	Response by registered person detailing the actions taken: All staff have been advised at the staff meeting held on 9th June 2025, that it is unacceptable that any fire door was to be propped open, due to a significant breach of fire safety policy and procedures. Fire doors will be checked as part of the walkaround audit and during the completion of the Regulation 29 audit.
Area for improvement 8 **Ref:** Regulation 10 (1) **Stated:** First time **To be completed by:** 22 May 2025	The registered person shall ensure that a robust governance system is implemented and maintained to promote and assure the quality of services in the home. Ref: 3.3.5
	Response by registered person detailing the actions taken: There is a system of governance audits in place, alongside a monthly planner. Additional training and support have been provided to the Home in relation to, action planning and appropriate timebound review. This will be monitored as part of the Regulation 29 visits.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022) (Version 1:2)	
Area for improvement 1 **Ref:** Standard 6.6 **Stated:** Second time **To be completed by:** 30 June 2025	The registered person shall ensure that there is evidence of resident involvement in the care planning process where appropriate. Ref: 3.3.3
	Response by registered person detailing the actions taken: An audit on the completion of the care plan agreement form has taken place for each resident. All residents now have a care plan agreement form in place, which reflects their involvement and where necessary, the Next of Kins involvement, if they are deemed to lack capacity. All new admissions will be checked via the care plan auditing process and monitored during the Regulation 29 visit.

Area for improvement 2 **Ref:** Standard 24.2 **Stated:** First time **To be completed by:** 30 June 2025	The registered person shall ensure that all staff have recorded individual, formal supervision no less than every six months. Ref: 3.3.1
	Response by registered person detailing the actions taken: An annual supervision planner is in place and the majority of staff have now had at least one supervision completed within the last 6 months. The supervision planner has been discussed with the Deputy Manager to ensure all staff have at least 2 supervisions per year as per Policy. Compliance will be monitored as part of the Regulation 29 visit.
Area for improvement 3 **Ref:** Standard 8 **Stated:** First time **To be completed by:** 22 May 2025	The registered person shall ensure that all records are kept up to date, legible and accurate. This area for improvement relates to post fall observation records. Ref: 3.3.2
	Response by registered person detailing the actions taken: The management of falls and post falls documentation was discussed during the staff meeting held on 9th June 2025. Further supervision has been completed with the relevant staff. A falls governance audit is to be completed by the Home Manager after each fall. Where required, an action plan will be generated, addressed and reviewed. Compliance will be monitored as part of the Regulations 29 visit by the Operations Manager.
Area for improvement 4 **Ref:** Standard 8 **Stated:** First time **To be completed by:** 22 May 2025	The registered person shall ensure that all records are kept up to date, legible and accurate. This area for improvement relates to Dysphagia Diet Standardisation Initiative (IDDSI) levels. Ref: 3.3.2
	Response by registered person detailing the actions taken: The Dysphagia records for the identified resident was addressed on the day of the inspection. The menu choice sheet and all nutritional documentation has been reviewed for anyone on a modified diet to ensure all documents correlate. This will be reviewed by the Home Manager as part of the walkaround and through care plan auditing, as well as the completion of the 6 monthly resident at risk of choking audits. The compliance with this will be reviewed as part of the Regulation 29 visit completed by the Operation's Manager.

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