

Inspection Report

Name of Service: Strathearn Court Care Home

Provider: Beaumont Care Homes Limited

Date of Inspection: 3 July 2025 & 7 July 2025

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

1.0 Service information

Registered Provider:	Beaumont Care Homes Limited
Responsible Individual:	Mrs Ruth Burrows
Registered Manager:	Mr John Cherian
Service Profile: This home is a registered nursing home which provides general nursing care for up to 55 patients under and over 65 years of age, with a physical disability or who are terminally ill. Patients' bedrooms, communal lounges and dining rooms are located over two floors in the home. Patients have access to an enclosed courtyard garden.	

2.0 Inspection summary

An unannounced inspection took place on 3 July 2025, from 10.00 am to 3.15 pm by pharmacy inspectors and on 7 July 2025, from 10.15 am to 6.30 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 21 June 2024 and medicines management inspection on 28 November 2022; 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 and compassionate care was delivered to patients. Details and examples of the inspection findings can be found in the main body of the report.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details. It was evident from discussions with patients and relatives that staff promoted their dignity and well-being and that staff were knowledgeable and well trained to deliver safe and effective care.

Review of medicines management found that 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 patients were administered their medicines as prescribed. The medicines related areas for improvement identified at the last inspection were assessed as met. No new areas for improvement in relation to medicines management were identified.

While we found care to be delivered in a compassionate manner, a number of areas for improvements were identified to ensure the effectiveness and oversight of certain aspects of care delivery, including; recruitment, evaluations of care and the home environment.

As a result of this inspection 10 areas for improvement were assessed as having been addressed by the provider. One area for improvement has been stated again and 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 patient'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

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "There is a friendly atmosphere in the home; the staff are approachable", "The staff take good care of me. I like the food", "I am well cared for" and "It is very clean here and the staff are very good."

Patients told us that staff offered choices to them throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options and where and how they wished to spend their time.

Relatives commented positively about the overall provision of care within the home. Comments included: "The staff are very helpful and kind" and "It's great here, the staff are very friendly."

Staff spoken with said that Strathearn Court Care Home was a good place to work and said the teamwork was very good. Staff commented positively about the manager and described them as supportive and approachable. One staff member said, "The teamwork is very good, we all work together."

We did not receive any questionnaire responses from patients or their visitors or any responses from the staff online survey within the timescale specified.

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 patients.

While there was evidence of systems in place to manage most aspects of staffing; discussion with the manager and review of a selection of recruitment records evidenced that all pre-employment checks had not been completed, as part of the recruitment process, prior to each staff member commencing in post. An area for improvement first stated following an inspection on 26 June 2024 is now stated for a second time.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they were satisfied with the staffing levels. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

3.3.2 Quality of Life and Care Delivery

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

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

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about their patients, especially changes to care, that they needed to assist them in their caring roles.

At times some patients 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 patients and to manage this aspect of care. A restrictive practice register was monitored and reviewed monthly.

Patients may require special attention to their skin care. For example, some patients may need assistance to change their position in bed or get pressure relief when sitting for long periods of time. These patients were assisted by staff to change their position regularly and records maintained.

Where a patient was at risk of falling, measures to reduce this risk were put in place. In addition, falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented.

Patients had good access to food and fluids throughout the day and night. Nutritional risk assessments were completed monthly to monitor for weight loss or weight gain. Nutritional care plans were in line with the recommendations of the speech and language therapists and/or the dieticians. Patients were safely positioned for their meals and the mealtimes were well supervised. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Observation of the lunchtime meal, review of records and discussion with patients, staff and the manager indicated that there were systems in place to manage patients' nutrition.

The food served looked appetising and nutritious. Patients told us they enjoyed the meal and the food was good. Some patient's commented negatively regarding the quality of the food and the choices available although they confirmed that improvements had been noticed recently. Discussion with the manager confirmed he was aware of this and actively monitoring improvements with patients and catering staff.

The importance of engaging with patients was well understood by management and staff and patients were encouraged to participate in their own activities such as watching TV, reading, resting or chatting to staff. Arrangements were also in place to meet patients' social, religious and spiritual needs. An activity planner displayed highlighted events such as movie days, arts and crafts, quizzes, McDonald's coffee morning and external entertainment/singers.

Patients spoken with told us they enjoyed living in the home and that staff were friendly.

3.3.3 Management of Care Records

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

Care records, for the most part, were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs.

Nursing staff recorded regular evaluations about the delivery of care. Review of a selection of daily evaluation records over a 24-hour period evidenced that some of these entries had been completed as early as three hours into the 12 hour shift on some occasions and no further entries had been made to reflect on the care delivered. To ensure daily evaluations of care are person-centred, an area for improvement was identified.

3.3.4 Quality and Management of Patients' Environment

The home was clean and tidy. For example, patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

It was observed that some areas in the home required repair or decoration. Assurances were provided by the manager that an ongoing refurbishment plan was in place. One area of concern included stained/worn carpets throughout the home. The above observations were discussed with the manager and an area for improvement was identified.

There was evidence that systems and processes were in place to manage infection prevention and control (IPC) which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

A small number of shortfalls in individual staff practice with IPC practices were discussed with the manager who agreed to monitor this through their audit processes and arrange additional training and supervisions if required.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mr John Cherian has been the Manager in this home since 16 October 2020.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place.

There was a system in place to manage any complaints received.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further.

Patients and their relatives spoken with said that if they had any concerns, they knew who to report them to and said they were confident that the manager or person in charge would address their concerns.

3.3.6 Medicines Management

Monitoring and review of medicines management

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 majority of 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 number of minor discrepancies were highlighted to nurses 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.

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.

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. For the majority of administrations, records included the reason for and outcome of each administration. The manager advised that he would discuss the need to record the reason for and outcome of administration on all occasions with nurses and monitor through the audit process.

The manager advised that warfarin had not been prescribed for any patients in the home for quite some time. He said that following the last medicines management inspection robust systems were put in place to ensure the safe management of warfarin: current warfarin dosage directions and the date of next scheduled blood tests is recorded for all patients and if warfarin dosage directions are received via telephone from the GP surgery they are checked and verified by a second member of staff when transcribed to ensure accuracy. Due to these assurances the area for improvement in relation to warfarin identified at the last medicines management inspection was assessed as met.

Supply, storage and disposal

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 at or below 25°C.

Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

Medicines awaiting collection for disposal in the treatment rooms were not in a locked cupboard. The manager was reminded that medicines awaiting collection for disposal should be stored securely to prevent unauthorised access and collected in a timely manner.

Medicines administration

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. The records inspected 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 pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

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. The audits completed at the inspection indicated that medicines were being administered as prescribed.

Transfer of medicines

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, including records of medicines received into the home, had been accurately completed and there was evidence that medicines were administered as prescribed.

Management of medicines 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.

Medicine management training

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 their 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.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

Records of staff training in relation to medicines management, thickening agents, epilepsy awareness, and the administration of nutrition and medicines via the enteral route were available.

It was agreed that the findings of this inspection would be discussed with staff to facilitate ongoing improvement.

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	0	3*

*The total number of areas for improvement includes one that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr John Cherian, 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 38.3 Stated: Second time To be completed by: 7 July 2025	The registered person shall ensure that the appropriate pre-employment checks are made before making an offer of employment. Ref: 2.0 and 3.3.1 Response by registered person detailing the actions taken: The pre-employment checks gaps identified at the Inspection have now been addressed. The registered person will review all new starters to ensure that all pre-employment checks are completed and evidenced in line with RQIA and legal requirements before making an offer of employment. The Home Manager's governance of this area for improvement will be monitored through the completion of the monthly Regulation 29 Report.
Area for improvement 2 Ref: Standard 4 Stated: First time To be completed by: 7 July 2025	The registered person shall ensure that nursing staff evaluate care in a meaningful manner and at an appropriate time. Ref: 3.3.3 Response by registered person detailing the actions taken: Supervisions pertaining to the recording of meaningful evaluations will be taken forward with all RN staff. The registered person will ensure that all nursing staff carry out meaningful care evaluations with sufficient detail and that all entries are made at an appropriate time reflecting the interventions provided through the completion of Walkabout Audit

	and the monthly care plan audit. This area for improvement will be monitored through the completion of the monthly Regulation 29 Report.
<p>Area for improvement 3</p> <p>Ref: Standard 43</p> <p>Stated: First time</p> <p>To be completed by: 7 October 2025</p>	<p>The registered person shall ensure the environmental deficits relating to floor coverings are addressed without delay.</p> <p>Ref: 3.3.4</p> <p>Response by registered person detailing the actions taken: A review of floor coverings will be conducted and be kept under review going forward. The registered person will ensure that environmental deficits identified in relation to floor coverings will have quotes and costs gathered and presented for capex approval.</p> <p>This area for improvement will be monitored through the completion of the monthly Regulation 29 Report. .</p>

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



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