Inspection Report

Name of Service: Beverly Lodge

Provider: Ashdon Care Limited

Date of Inspection: 11 November 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:	Ashdon Care Limited
Responsible Individual:	Mrs Lesley Catherine Megarity
Registered Manager:	Miss Kerris Cintra Jack
Service Profile: This is a registered nursing home which provides care for patients living with dementia. The home can occupy up to 45 patients. Patient bedrooms are located on ground floor level. Patients have access to a range of communal areas, including lounges, dining rooms, and a patio and garden area.	

2.0 Inspection summary

An unannounced inspection took place on 11 November 2025 from 10 am to 1.45 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 17 September 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 safe, effective and compassionate care was delivered to patients 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 patients and that staff were knowledgeable and well trained to deliver safe and effective care.

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.

As a result of this inspection all of the previous areas for improvement were assessed as having been addressed by the provider and no new areas for improvement were identified. Details can be found in the main body of this report.

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 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. 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 spoken with said that they liked living in Beverly Lodge. They told us that they were well looked after and described staff "friendly" and "very nice."

Due to the nature of dementia, some patients were unable to express their views verbally. However, these patients looked comfortable and relaxed in their surroundings and indicated through non-verbal cues such as smiling, that they were content.

Relatives spoken with described care delivery as very good and spoke positively about staff. One relative complimented staff on how they dealt with "difficult" situations. Relatives said that they were kept informed about changes in their loved one's needs, and said that patients always looked well cared for.

No completed questionnaires were received following the inspection.

A visiting professional to the home at the time of the inspection commented positively about care records. The professional told us that they found daily care records to be detailed and relevant, and that staff were good at recognising and recording fluctuating changes in patients' mobility.

Staff spoken with said that they were happy working in the home and that they felt supported in their roles through regular training and good communication between management and staff.

No staff survey responses were received following the inspection.

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. There was evidence of robust systems in place to manage staffing.

It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way; and to provide patients with a choice on how they wished to spend their day. For example, staff were seen to assist patients who wished to walk around the home and staff responded to requests for assistance in a warm and polite manner.

Observation of the delivery of care, review of documents and discussions with relatives, staff and the manager, evidenced that the number and skill mix of staff met patients' needs.

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 patients. 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. For example, staff did not restrict patients' access around the communal areas of the home and assisted patients who wished to walk around but required some level of support.

It was observed that 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.

Patients and relatives were encouraged to share their views about the home through regular meetings. This was an opportunity to relatives and patients to hear about the running of the home and to share their thoughts and suggestions.

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.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs.

Examination of care records and discussion with staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. For example, patients were referred to the Trust's Specialist Falls Service, their GP, or for physiotherapy.

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

It was observed during the serving of the lunchtime meal that staff were well organised and communicated well with each other. For example, a mealtime coordinator was allocated in each dining room and staff conducted a safety pause prior to serving meals to ensure that patients received the correct meal and modifications where required.

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

The importance of engaging with patients was well understood by the manager and staff. During the inspection, staff were seen to play games with patients and in the afternoon a singer was booked to entertain everyone. Patients and visitors to the home also enjoyed seeing the Christmas decorations being put up.

The home had two full-time activity coordinators employed and a weekly programme of events was displayed on notice boards around the home.

Patients' needs were met through a range of individual and group activities such as bowling, gardening, games, sewing, knitting, puzzles, hand massage and exercise sessions. Discussion with the activity coordinator confirmed that there was flexibility within the weekly programme to change events based on what patients wanted to do on any particular day.

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.

Patients care records were held confidentially.

Care records 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. There was evidence that patients and/or relatives, where possible, were involved in care planning, or the details of care plans were shared with relatives, if this was appropriate.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. A number of minor deficits relating to one bed frame and a piece of flooring was brought to the attention of the manager to address.

Patients' bedrooms were clean and personalised with items of importance or interest to the patient. Communal toilets and bathrooms were clean and accessible.

Communal lounges were well furnished and there were homely touches throughout the home such as flowers, pictures, and soft furnishings.

Fire safety measures were in place. For example, fire exits were free from obstruction and fire-extinguishing equipment was accessible. Staff were trained in fire safety and records evidenced that staff participated in practice fire drills as part of their training.

The most recent fire risk assessment was conducted on 9 October 2025. The written report from the assessor was not yet available at the time of inspection; however, the manager was able to confirm that no recommendations had been made.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Miss Kerris Jack had been the manager since August 2023 and was registered with RQIA on 1 July 2024.

The nurse in charge of the home in the absence of the manager was displayed at reception and highlighted in the staff duty rota.

Staff commented positively about the manager, saying that she was available to them for support and guidance when needed and that they would feel confident in reporting concerns to her.

Relatives said that they knew how to raise concerns and it was observed during the inspection that the manager had an open door policy and relatives were seen to approach the manager with ease.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

A representative of the provider visited the home each month to monitor the care and services provided. Written reports from these visits were available for review and evidenced consultation with patients, relatives and staff, and resulted in action plans to continually drive improvements in the home.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Miss Kerris Jack, Manager, as part of the inspection process and can be found in the main body of the report.

The Regulation and Quality Improvement Authority

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