The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Lansdowne Care Home**

Provider: **Beaumont Care Homes Limited**

Date of Inspection: **6 October 2025**

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

1.0 Service information

Organisation:	Beaumont Care Homes Limited
Responsible Individual:	Mrs Ruth Burrows
Registered Manager:	Mr John Paul Chempakessery – not registered
Service Profile – This home is a registered nursing home which provides nursing care for up to 86 patients. The home is divided into three units over three floors. The Annabella unit on the ground floor provides care for people living with dementia. The Innisfayle and Cavehill units on the first floor and second floor provide general nursing care.	

2.0 Inspection summary

An unannounced inspection took place on 6 October 2025, from 9.30 am to 6.00 pm by two care inspectors.

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 14 January 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection identified concerns in regard to modified diet choices, the management of risks to patients, environmental deficits and the management of falls. Details were shared with the management team during the inspection and discussed again at a more detailed feedback meeting with the management team and the registered person on 20 October 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 at this meeting that the appropriate action had been taken with regards to the concerns identified.

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

As a result of this inspection, one area 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 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 who were able to share their opinions on life in the home said they were well looked after. Some patients had difficulty telling us about their care experiences. Patients who had communication difficulties looked relaxed in their environment and during interactions with staff. Patients spoken with said that they were happy with the care and services provided to them. Patients described the staff as "good" and "nice." One patient said, "I can't complain".

Staff spoken with said that Lansdowne Care Home was a good place to work. Staff said that they were satisfied with staffing levels, teamwork was good, the management team was approachable and they enjoyed working in the home.

Following the inspection, no patient, patient representative or staff questionnaires were received 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. Review of two recruitment records identified deficits; there was no evidence that

employment gaps had been explored or that a professional registration check was conducted prior to employment and on file, this was discussed with the manager and an area for improvement was identified.

Staff commented positively on the increased staffing levels and teamwork on the Cavehill unit. Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty in all three units. One patient and family comment regarding daily routines was discussed with the management team to address.

There was a system in place to monitor that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC).

3.3.2 Quality of Life and Care Delivery

Patients looked well cared for and were seen to enjoy warm and friendly interactions with the staff. Staff were observed to be chatty, friendly and polite to the patients at all times.

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 offered patients choice in how and where they spent their day or how they wanted to engage socially with others.

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

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. A review of repositioning records evidenced that particularly at night there was no evidence that on the records reviewed, that the patients had their position in bed altered to relieve pressure. Furthermore, some patients were not repositioned as prescribed in their care plans. An area for improvement was identified.

Examination of care records and discussion with the manager confirmed how the risk of falling and falls were managed and referrals were made to other healthcare professionals as needed. Review of records confirmed that staff took appropriate action in the event of a fall, for example, they commenced observations and sought medical assistance if required. However, it was observed that within the home, inconsistencies were apparent in the management of falls. The falls policy reviewed did not reflect best practice guidance and was noted to be out of date. In addition; staff were using different post fall documentation in each of the units, which was contributing to confusion. An area for improvement was identified.

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.

Observation of the lunchtime meal confirmed that enough staff were present to support patients with their meal and that the food served smelt and looked appetising. The dining experience was an opportunity for the patients to socialise and the atmosphere was calm, relaxed and unhurried. It was observed that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

Review of patient menu choice records evidenced that the patients correct consistency of food was recorded however; it was not always evident that those patients who were prescribed a modified diet were afforded a choice of meal at all times. An area for improvement was stated for the third time. Non-compliance with this repeated area for improvement was discussed at the meeting on 20 October 2025, the management team described the systems implemented since the inspection which included manager oversight of menu choice records to ensure patient choice is upheld and that those patients prescribed a modified diet have two menu choices at all times.

The importance of engaging with patients was well understood by the manager and staff. There was a range of activities provided for patients by activity staff. The planned activity schedule was displayed. The range of activities included social, community, cultural, religious, spiritual and creative events. Patients' needs were met through a range of individual and group activities. Activity records were maintained which included patient engagement with the activity sessions.

3.3.3 Management of Care Records

Patients' needs should be assessed at the time of their admission to the home. Following this initial assessment, care plans should be developed in a timely manner to direct staff on how to meet the patients' needs. A review of one identified new patient's care records evidenced that some of their care plans had not been developed or completed in a timely manner. An area for improvement was identified.

A sample of patient care records were reviewed and evidenced a number of deficits. For example, the care plans for patients who required continuous supervision and patients who had a diagnosis of dementia lacked detail in the ongoing management of this assessed need. Furthermore, a number of care records evidenced alterations or additions to the original text; these changes had not made in line with best practice guidance. Areas for improvement were identified.

Deficits were identified in regards to patient confidentiality, patient care records were observed unattended in a corridor and in a communal lounge. An area for improvement was identified.

3.3.4 Quality and Management of Patients' Environment

Review of the home's environment identified a number of environmental issues. Infection prevention and control deficits were identified where basins used to wash patients were observed stored on the floor, hoist slings were inappropriately stored, manual handling equipment and fall out mats required additional cleaning and bed rail protectors were cracked or ripped. An area for improvement was identified. In additional items of furniture were observed in need of repair or replacement. At the meeting on the 20 October 2025, the management team confirmed a number of new items of furniture have been procured.

Concerns were identified in regard to the management of risks to patients; shortfalls were identified in regard to the safe storage of toiletries within the Annabella unit. Staff belongings were observed in communal patient areas throughout the home and the hairdressing and boiler rooms were unlocked. Areas for improvement were identified.

Additional concerns were identified when a number of rooms were being used not in keeping with the homes current registration or statement of purpose. An area for improvement was identified. This was discussed at the meeting on 20 October 2025, the management team advised that staff are now using the dedicated staff rest area for their breaks, the bath in the identified bathroom has been fixed and the toilet has been cleared of staff lockers. The registered person advised that they plan to visit the home and review the identified bedroom to establish the best outcome.

Fire safety measures were in place to ensure patients, staff and visitors to the home were safe. However, following review of the fire risk assessment action plan after the inspection a number of actions had not been addressed within the timeframes identified by the fire risk assessor. An area for improvement was identified.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Mr John Paul Chempakessery has been the Manager in this home since 23 September 2025.

RQIA were concerned regarding the support systems in place for the new acting manager, it was observed that he was working a high number of hours and at the time of the inspection did not have any deputy manager in post to support him. This was discussed at the meeting on 20 October 2025 and the management team provided an update that a new deputy manager was to start soon and another manager will provide support two days a week for Mr Chempakessery.

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 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.

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	3	10*

*the total number of areas for improvement includes one standard that has been stated for a third 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) **Stated:** First time	The Registered Person shall ensure as far as reasonably practical that all parts of the home to which patients have access to are free from hazards to their safety. Ref: 3.3.4
To be completed by: 6 October 2025	**Response by registered person detailing the actions taken:** Following the inspection, to ensure areas are free from hazards, the following took place: • 13 lockable cabinets for bathrooms within Dementia unit were purchased and are in place. • The hairdressing room and the boiler room were locked immediately after identification at the Inspection. • Flash Meetings have been commenced daily. • Staff Meetings and HOD meetings were completed on 16.10.25. Discussion took place during these meetings about the safety concerns highlighted and the importance that all staff should ensure resident's safety is maintained at all times ensuring that the doors for the linen room, store rooms and boiler rooms are kept locked. • This area for improvement will be monitored through Walkabout Audits 5 times per week (Monday to Friday) completed by the Acting Home Manager and further monitored through the Regulation 29 Report. • An additional section will be added to the daily Walkabout specific to Lansdowne which will reference safety within the lived environment. This will ensure that there is the locking of doors to areas which might pose hazards to residents. • The Hairdressing room has been tidied and de-cluttered as of 16.10.25. Plan is in place for the refurbishment of Hairdressing room when Dementia unit corridor is completed. • On 07.10.25 - The staff lockers identified in section in Nursing unit toilet have been removed.

Area for improvement 2 **Ref:** Regulation 3 (1) (b) **Stated:** First time **To be completed by:** 6 November 2025	The Registered Person shall review the use of the identified rooms and if required submit a variation to RQIA to change their registered purpose. Ref: 3.3.4
	Response by registered person detailing the actions taken: Following the inspection, the following took place: • All inappropriate clutter and excess storage items have been removed from the identified room, contributing to a safer and more organised environment 7 (GF) • The identified Fridge was removed and disposed of as of 07.10.25. • Repair has been completed on the identified bath and is now ready for use – the room will continue to be used as a bathroom, as per its registered purpose • Room 81 is scheduled to be repurposed as a storage area. Due to its irregular shape and limited space, it is not suitable for accommodating residents who require moving and handling aids or specialised equipment. A variation will be submitted.
Area for improvement 3 **Ref:** Regulation 27 (4) (a) **Stated:** First time **To be completed by:** 6 October 2025	The Registered Person shall ensure the following in regard to fire safety arrangements: • the fire risk assessment is effectively maintained by the manager and evidences any actions taken in regard to the recommended actions required within the required timeframe. Ref: 3.3.4
	Response by registered person detailing the actions taken: • All actions required following the completion of the last fire safety inspection have now been addressed. • The Registered Manager going forward will ensure that there is additional oversight to ensure all fire risk assessment actions are monitored, assigned, and completed within the specified timeframe going forward.

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 12 **Stated:** Third time **To be completed by:** 7 October 2024	The registered person shall ensure a comprehensive review of the menu choice documentation is conducted to ensure the full name of patients is recorded and accurate menu options are recorded for those patients on a modified diet. Ref: 2.0 and 3.3.2
	Response by registered person detailing the actions taken: A Robust action plan has been implemented in relation to menu choice • Only one menu choice record will be printed by the nursing staff and given to the kitchen the night before. • Three will be printed on a Friday to cover the weekend and Monday. This will avoid kitchen staff having excess menu choice records with incorrect information. • Kitchen staff will bring the menu choices having been completed over the weekend to the Flash Meeting on a Monday, for review by the Home Manager or Clinical Lead Nurse. • The Home Manager or Clinical Lead Nurse will cross reference the menu choice with food and fluid charts completed over the weekend to ensure adequate nutritional options were made available for residents prescribed a modified diet. • The Home Manager will be mindful to investigate any evidence that all residents are being offered the same option, or that residents are not being given an appropriate option for Sunday's evening meal. • Once menu choice list completed by care staff, it will be handed over to the nurses to check and verify before handing over to kitchen staff • This will continue to be reviewed as part of the monthly monitoring visit.

Area for improvement 2 **Ref:** Standard 38.3 **Stated:** First time **To be completed by:** 6 October 2025	The Registered Person shall ensure that before staff commence working in the home that all gaps in employment are explored and the professional registration status of staff is checked and recorded. Ref: 3.3.1
	Response by registered person detailing the actions taken: • This error identified at time of inspection was resolved immediately. • A Separate file is now in use to keep all staff's professional registration status. • All mandatory records, recruitment checks, and documentation will be thoroughly reviewed and verified before any staff commence work • Compliance will be monitored as part of the monthly monitoring visit
Area for improvement 3 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 7 October 2025	The Registered Person shall ensure that where a patient requires repositioning; supplementary recording records should clearly evidence: • repositioning in accordance with the patients care plan • a change in the patient's position. Ref: 3.3.2
	Response by registered person detailing the actions taken: • Following inspection an Investigatory meeting was completed and sanctions were given as appropriate–Reflective discussion were completed with staff • During recent staff meeting the Registered Nurses were reminded of their professional obligation to ensure this have oversight of supplementary files. Compliance will be monitored by the Acting Manager through supplementary file audit • The Acting Manager will also check the evidence of the accurate completion of the supplementary chart during the completion of the walkabout Audit. • Compliance will be monitored as part of the monthly Reg 29 visit.

Area for improvement 4 **Ref:** Standard 22 **Stated:** First time **To be completed by:** 31 October 2025	The Registered Person shall ensure that the home's falls policy is reviewed and updated to clearly provide guidance for staff in Lansdowne Care Home on the appropriate documentation to utilise. Ref: 3.3.2
	Response by registered person detailing the actions taken: • The Beaumont Clinical Facilitator reviewed the Post Fall Management across Lansdowne Care Home on the 30.10.25. • A new post fall checklist has been given to all units and separate file has been introduced to keep only post fall documents • Beaumont neurological observation document in use for all post fall observation recording and restore 2 will be used for all other general deterioration observations. • The Clinical Facilitator attended the Heads of Department meeting held on 16.10.25 and gave staff copies of Post Fall protocol and GCS schedule. • The Acting Home Manager will monitor Post falls through the completion of the post fall audit, following every fall in the Home. • The Operations Manager will complete Post Falls Management Audits of 10% of the total number of falls per month. • Discussion took place during staff meeting on 16.10.25 and all staff nurses are aware about the falls policy
Area for improvement 5 **Ref:** Standard 4.1 **Stated:** First time **To be completed by:** 7 October 2025	The Registered Person shall ensure that a system is in place to monitor the completion of care records following a patient's admission to the home. Ref: 3.3.3
	Response by registered person detailing the actions taken: • It was discussed during a staff meeting held on 16.10.25, that a new admission governance audit is to be completed following any admission to ensure that all records had been completed within the required timescales.

	• During the staff meeting it was also reinforced to staff the requirement to complete all care plans and assessment within 5 days of admission and 2 days of re-admission. • The Acting Home Manager will check and verify the new admission governance audit on the 6th day following admission and on the 3rd day of any re-admission. • Compliance will be monitored as part of the monthly monitoring visit carried out by the Operations Manager
Area for improvement 6 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 7 October 2025	The Registered Person shall ensure detailed and patient centred care plans are in place for those availing of bespoke one to one care. Ref: 3.3.3
	Response by registered person detailing the actions taken: • The identified 1:1 care plan was rewritten on 07.10.25 • On the 15.10.25 the Beaumont Care Quality Manager reviewed all 1-1 care plans to ensure that they were written in a person-centred manner. • Compliance will be monitored during the completion on the monthly monitoring visit.
Area for improvement 7 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 27 October 2025	The Registered Person shall ensure detailed and patient centred care plans are in place for those patients living with a diagnosis of dementia. Ref: 3.3.3
	Response by registered person detailing the actions taken: • The identified Care files have been reviewed and person-centred care plans are in place for those residents living with a diagnosis of dementia • These care plans will be audited as part of the monthly auditing process and any actions identified will be addressed in a timely manner

Area for improvement 8 **Ref:** Standard 37 **Stated:** First time **To be completed by:** 7 October 2025	The Registered Person shall ensure that any alterations to records are made in line with professional standards and best practice guidance. Ref: 3.3.3
	Response by registered person detailing the actions taken: • We have strengthened our documentation process to ensure that any changes to records are completed strictly in accordance with professional standards and best- practice guidance. • Each resident is allocated with named nurses on all floors and they are responsible for periodic checking of files and ensure records are in line with professional standards and best practice guidance • Staff have been reminded of their responsibilities during staff meeting, and regular audits will be carried out to maintain accuracy, accountability, and compliance • This will continue to be reviewed as part of the Acting Manager's walkaround audit as well as the monthly monitoring visit.
Area for improvement 9 **Ref:** Standard 37 **Stated:** First time **To be completed by:** 7 October 2025	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 and that records are not accessible to visitors to the home. Ref: 3.3.3
	Response by registered person detailing the actions taken: • The historical Resident files and information identified on the day of the inspection were removed immediately and stored safely in a locked storage unit. • Flash Meetings have been commenced daily. • Staff Meetings and HOD meetings completed on 16.10.25 and outcome of the inspection was discussed. • This area for improvement will be monitored through Walkabout Audits 5 times a week (Monday to Friday) completed by the Acting Home Manager and the Regulation 29 Report.

	• The Walkabout Audit will have an additional section added relating specifically to GDPR and the management and oversight of same. • On the 16.10.25 during a staff meeting it was advised that nurses are to ensure that care staff are writing their own names on the handover they are given to avoid them being left lying about. • This will continue to be reviewed as part of the monthly monitoring visit
Area for improvement 10 **Ref:** Standard 46 **Stated:** First time **To be completed by:** 10 October 2025	The Registered Person shall ensure the infection prevention and control issues identified during this inspection are managed to minimise the risk of spread of infection. Ref: 3.3.4
	Response by registered person detailing the actions taken: • The Linen cupboard on ground floor will be fitted with an additional shelf to ensure that linen is not being stored on the ground. • The identified staff member noted to be wearing gel nails was dealt with through company policy. All staff have been reminded of the uniform policy. • A Walk round audit will be carried out by Acting Home Manager 5 times a week. An additional section has been added to check on the cleanliness and condition of clinical equipment with specific reference to footplates and bed rail protectors. • On 06.10.25 a Heads of Department meeting was held which highlighted the requirement to ensure that disinfectant wipes and spray is available within sluices to facilitate decontamination. This is particularly in relation to over bed tables and moving and handling equipment. • The Acting Home Manager will verify during daily walkabout the evidence of the nurse's oversight on the decontamination files • Night visits have been planned with areas of particular focus being decontamination records and repositioning charts.

	• Hooks within all bedrooms will be made available for the safe and clean storage of hoist slings. Staff to ensure that these are not left hanging in areas where they are in contact with soiled linen trolleys. • Linen storage and storage of slings will be reviewed as part of the Home Manager's daily walk round. • Storage of slings will be reviewed to ensure that slings are not being stored in open areas and those in use by specific residents are hung in their own bedrooms. When removed from any resident's bedroom these will be laundered and then stored in the linen store. • The identified unclean microwave was removed from first floor on the same day of inspection

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