

Inspection Report

Name of Service: Mount Lens Care Home

Provider: Beaumont Care Homes Limited

Date of Inspection: 25 November 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:	Ms Paulene Rogers
Service Profile – This home is a registered nursing home which provides nursing care for up to 31 patients living with dementia. Patients’ bedrooms, communal lounges and dining rooms are located over two floors in the home. Patients have access to an enclosed courtyard area and a number of seating areas at the front and the rear of the home.	

2.0 Inspection summary

An unannounced inspection took place on 25 November 2025 from 9.25 am to 3.25 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 determine if the home is delivering safe, effective and compassionate care and if the service is well led.

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 patients’ dignity and well-being and that staff were knowledgeable and well trained to deliver safe and effective care.

As a result of this inspection, the 12 previous areas for improvement were assessed as having been addressed by the provider. 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 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: "The staff are very good. They help you. The food is very good, I haven't starved yet!", "I get my visitors and I am happy here" and "The food is lovely. We always get a good choice. The staff helped me decorate the Christmas tree."

Staff offered choices to patients throughout the day, which included preferences for getting up and going to bed, 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 food is nicely served. The staff are kind. They offer me a cup of tea or coffee. They are very empathetic to me and my husband."

Staff spoken with said that Mount Lens 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. Comments from staff included, "We have seen a lot of improvements to the home. Families have commented saying they haven't seen it look so well." and "I love the home because it is homely and the staff are lovely."

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

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 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.

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.

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.

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 one to one, board games, jigsaws, art therapy, external entrainment, hairdresser and family visits.

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. However, person centred care plans were not in place for patients who required one to one care. Records reflecting the patient's likes and preferences were not available to the care staff providing one to one care. An area for improvement was identified.

Examination of activity records for patients who required one to one care identified that some improvement had been made in record keeping since the last care inspection. However, further work is required to evidence that all patients are provided with meaningful activities in keeping with their individual likes and preferences. An area for improvement identified at a care inspection on 7 May 2025 was stated for a second time.

3.3.4 Quality and Management of Patients' Environment

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

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.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Ms Paulene Rogers has been the Registered Manager in this home since 13 June 2025. It was positive to note that the manager was taking part in the 'My Home Life' leadership support programme, which is run by the University of Ulster and commissioned by the Department of Health.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. The manager or delegated staff members completed regular audits to quality assure care delivery and service provision within the home.

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. 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.

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	1	1*

*The total number of areas for improvement includes one that has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Paulene Rogers, 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 Nursing Homes Regulations (Northern Ireland) 2005	
<p>Area for improvement 1</p> <p>Ref: Regulation 16 (1)</p> <p>Stated: First time</p> <p>To be completed by: 25 November 2025</p>	<p>The registered person shall ensure detailed and person centred care plans are in place for those patients who require one to one care.</p> <p>Ref: 3.3.3</p>
	<p>Response by registered person detailing the actions taken: The Care plans for the two residents receiving 1:1 care have been reviewed, involving the individual resident, families and friends. To ensure the care plans are person centred and contain meaningful information in relation to what matters to the individual resident, their life history, experiences, preferences, likes & dislikes have been included, which focuses on abilities. To promote learning and development nurses will receive further coaching on writing and evaluating person centred care plans. As part of the care plan auditing processes 1-1 care plans will be reviewed and any areas for deficit addressed through time bound action plans The provider will review 1-1 care planning as part of the Regulation 29 visit and areas for improvement will be addressed through time bound action plan.</p>
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
<p>Area for improvement 1</p> <p>Ref: Standard 11</p> <p>Stated: Second time</p> <p>To be completed by: 25 November 2025</p>	<p>The registered person shall ensure that accurate care delivery records are retained for patients in receipt of one to one care. These records should be person centred and evidence that the activities delivered reflect the patient's individual likes and preferences.</p> <p>Ref: 2.0 and 3.3.3</p>
	<p>Response by registered person detailing the actions taken: The Staff providing 1-1 care will be familiar with the resident's life history, preferences, likes / dislikes including activities and social engagement. Staff providing 1-1 care will receive supervision on how to reflect person centred and meaningful records including outcomes of participation in activities and engagement and any changes to abilities and preferences The records will be reviewed as part of the manager's walk about audit and any areas for improvement will be addressed through a time bound action plan.</p>

	<p>The provider will review the 1-1 records as part of the regulatory visit and areas for improvement will be discussed with the manager and addressed via a time bound action plan.</p>
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