The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Comber Care Home**

Provider: **Beaumont Care Homes Limited**

Date of Inspection: **10 December 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:	Mrs Michelle MacMillan
Service Profile: This is a registered nursing home, which provides care for up to 72 patients under and over 65 years of age with a physical disability, needs relating to old age, or terminal illness. Patient accommodation is divided over ground floor and first floor levels. There is a range of communal areas throughout the home and patients have access to a garden.	

2.0 Inspection summary

An unannounced inspection took place on 10 December 2025, from 09.30 am to 4.30 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 4 March 2025; 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. There was some mixed feedback in relation to the food provided in the home and this is discussed further in sections 3.2 and 3.3.2 of this report.

Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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 were overall very content living in Comber Care Home. Patients described staff as, "excellent", "nice", "brilliant", "lovely…always nice to me", and "friendly…always around when I need them."

Patients confirmed that they are free to choose how and where they spend their time in the home. For example, one patient said that they like to spend time in a smaller lounge because they enjoyed company but in the smaller room, while another patient said that they prefer their own company and spend a lot of time in the privacy of their bedroom.

Some patients said that the food was "fine" and that they got a choice of at least two options at each mealtimes. However, a significant number of patients told us that they were not satisfied with the provision of meals. Patients' issues with the food included; the quality or taste of the food, the temperature of the food when served, and the menu choices. Some patients felt that the dessert options were repetitive and lacked flavour. Patient comments were discussed with the manager and relevant records were reviewed. This is discussed further in section 3.3.2 of this report.

Relatives spoken with said that they were very satisfied with the care and services provided in the home. Relatives described the care as "excellent" and "good", and told us that staff were "wonderful." One relative said that staff not only knew their loved one well, but also knew the family as a whole and were welcoming to family when visiting. This relative talked about the "small touches" such as staff making cups of tea or checking in on family when they were visiting a sick loved one.

Relatives told us that the home was always clean when they visited and that the home updated them with any changes in their loves one's needs. Relatives said that their loved ones looked cared for and were encouraged to join in with activities or social events.

Relatives said that they had confidence that any concerns raised would be managed appropriately by the home and one relative said that a previous complaint was taken seriously and addressed promptly and professionally by the management team.

No questionnaires were received following the inspection.

Staff spoken with said that they were happy working in Comber Care Home and that they felt supported by the manager and through training to do their jobs well.

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.

Patients 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.

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, it was observed that a patient, who initially wanted to attend a group activity in the morning, changed their mind during the activity and staff assisted the patient to return to their preferred location.

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 patients' 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, when a patient changed their mind about an activity, staff respectfully accommodated the patient's request to leave without question.

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.

Discussion with patients and relatives, and review of records evidenced that patients were encouraged to share their experiences of life in the home and were given opportunities to give suggestions about the running of the home. For example, through patient and relative meetings.

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 nurses 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 general practitioner (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.

Observation of the serving of lunch and discussion with staff confirmed that staff conducted a safety pause prior to any meals or drinks being served to ensure good communication across the team about changes in patients' needs and to ensure patients received the correct meal.

The dining experience was an opportunity for patients to socialise, music was playing, and the atmosphere was calm, relaxed and unhurried.

As previously discussed in this report, a number of patients felt that improvements were needed in relation to the food. Patient comments included, "food is sometimes cold", "the desserts are sometimes not what I ask for", "not nice", and "no flavour." Some patients said that the food could be repetitive and feedback from staff corroborated this view.

Review of records evidenced that a three-week menu was in place and was being followed by the catering team. Discussion with patients confirmed that if they did not like the two main choices at each mealtime, they could ask for an alternative. Review of patient meeting records also evidenced that the manager and head chef had met with individual patients to try to improve patient experience with food.

Discussion with the manager evidenced that she was well aware of the mixed views about food in the home and was attempting to address this. RQIA were satisfied at the time that action was being taken by the manager to resolve patient concerns. It was agreed that the feedback provided by patients during the inspection would be managed through the home's complaint process for the purpose of record keeping and evidence of actions taken. This will be reviewed again at the next care inspection.

The importance of engaging with patients was well understood by the manager and staff. Observation of the planned activity of Christmas decoration making in the morning confirmed that staff knew and understood patients' preferences and wishes and helped patients to participate in planned activities or to remain in their bedroom with their chosen activity such as reading, listening to music, enjoying collectable items, or waiting for their visitors to come.

An entertainer who sang Christmas songs visited the home in the afternoon. A large number of patients, staff and visitors attended the event and participated in the singing. There was a warm atmosphere throughout the home.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home. The weekly programme of social events was displayed on noticeboards advising future events and activities.

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. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

3.3.4 Quality and Management of Patients' Environment

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

An identified communal bathroom was being used as a storeroom. The provider did submit a variation application to RQIA in September 2022 to repurpose this room into a store. This variation application remains under review and an RQIA estates inspector has been liaising with the provider on a number of related matters. The application has not yet been fully approved by RQIA. This will be reviewed again at the next inspection.

Fire safety measures were in place. Fire doors and exits were free from obstruction and fire-extinguishing equipment was accessible. Staff were trained in fire safety and participated in fire drills. The most recent fire risk assessment was carried out on 16 January 2025 and the provider had addressed any recommendations made.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Michelle MacMillan has been manager in the home since 20 April 2020 and has been registered with RQIA since 23 June 2021.

The manager confirmed that they felt supported in their role by Beaumont Care Homes senior management team.

Patients, relatives and staff spoke positively about the manager. Patients and relatives said they knew who the manager was and that they were assured that the home was well led. Staff said that they could approach the manager with any concerns or queries and that she was available for support and/or guidance.

We reviewed records of accidents and incidents that occurred in the home. Accidents and incidents were managed appropriately.

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 management team 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 record of compliments received about the home was maintained and shared with staff. A recent card addressed to the manager read, “You run and excellent care home, your staff are excellent, everyone I met was nice and also professional.”

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 Mrs Michelle MacMillan, 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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