

Inspection Report

Name of Service:	Mount Lens Care Home
Provider:	Beaumont Care Homes Limited
Date of Inspection:	23 June 2026

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 23 June 2026 from 9.35 am to 5.05 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 patient's dignity and well-being and that staff were knowledgeable and well trained to deliver safe and effective care.

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 food is not bad and the staff are decent", "The staff are very good and friendly", "I am very happy here. They (the staff) paint my nails for me" and "The staff are very good and kind to me. The food is quite good, I can't complain."

Relatives commented positively about the overall provision of care within the home. Comments from relatives included, "The staff are lovely and willing" and "The care is excellent. I have no concerns at all."

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, "The teamwork is so good and the staff will support you."

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

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.

Staff said that they were satisfied that the number and skill mix of staff on duty met the needs of the patients. Patients raised no concerns in relation to the staffing arrangements.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty and that staff responded to requests for assistance promptly in a caring and compassionate manner.

Checks were made to ensure nurses maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

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 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 important information about 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.

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 may need support with meals ranging from simple encouragement to full assistance from staff. Concerns were identified in relation to the supervision of patients requiring assistance at mealtimes. 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.

Management and staff understood the importance of engaging with patients. Patients were encouraged to participate in their own activities such as watching TV, reading, resting or chatting to staff and visitors. Arrangements were also in place to meet patients' social, religious and spiritual needs. An activity planner displayed highlighted events such as one to one activities, board games, jigsaws, reading, movie afternoon and art therapy. A monthly newsletter highlighting recent activities was available in the foyer of the home and plans were in place to have a petting farm visit. Some patients and relatives spoken with advised that they would like to see more interactive activities with greater choice.

Activity records reviewed confirmed gaps in record keeping of up to two months. Other records reviewed were repetitive, not person centred and lacking in sufficient detail. There was no evidence that registered nursing staff had oversight of these records. There is a need for improvement in regard to the system in place for evidencing delivery of meaningful and patient centred activities. Areas for improvement were identified.

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.

Review of a selection of care records evidenced that care plans were in place to meet patients assessed needs in a timely manner.

Nursing staff recorded regular evaluations about the delivery of care. Examination of a selection of care records confirmed that some entries were illegible. Other daily evaluation records over a 24-hour period evidenced that some of these entries had been completed as early as four hours into the 12 hour shift on some occasions and no further entries had been made to reflect on the care delivered. To ensure that daily evaluations of care are meaningful and all care records are legible, areas for improvement were identified.

3.3.4 Quality and Management of Patients' Environment

The home was clean and tidy. Bedrooms and communal areas were suitably furnished, warm and comfortable. For example, patients' bedrooms were personalised with items important to the patient. There was evidence of ongoing maintenance works to the home. Review on monthly monitoring reports confirmed that some planned improvements had not been completed for up to one year. This was escalated to the Responsible Individual who acknowledged the challenges in completing some of these planned works. They provided assurances regarding maintenance provision to the home and committed to reviewing the refurbishment and estates plans to address the areas identified.

Fire safety measures were in place to protect patients, visitors and staff in the home. The manager confirmed there were no outstanding actions following the most recent fire risk assessment.

A small number of shortfalls in individual staff practice with infection prevention and control (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. 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.

A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly at the time. However, at least three notifiable events had not been submitted to RQIA as required. The manager agreed to notify RQIA retrospectively. An area for improvement was identified.

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.

A review of a sample of audits evidenced that improvements were required regarding the audit process to ensure it was effective in identifying shortfalls and driving the required improvements; particularly in relation to oversight of wounds and care records. An area for improvement was identified.

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	2	4

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	
Area for improvement 1 Ref: Regulation 30 (1) (d) (f) Stated: First time To be completed by: 23 June 2026	The registered person shall give notice to RQIA without delay of the occurrence of any notifiable incident. All relevant notifications should be submitted retrospectively. Ref: 3.3.5
	Response by registered person detailing the actions taken: All notifiable incidents have been reviewed and retrospective notifications have been submitted where required. The Home Manager will ensure that notifications will be completed, including for notifiable incidents where GP advice was sought, even if no injuries occurred. The Deputy Manager will complete required notifications in Home Manager's absence. A monitoring and oversight template has been implemented to ensure that all relevant notifications are submitted timely. The Provider will review those notifications required have been submitted to RQIA timely as part of the Regulation 29 visit. Any deficits will be addressed with the Home Manager at the time of the visit.
Area for improvement 2 Ref: Regulation 10 (1) Stated: First time To be completed by: 23 June 2026	The registered person shall review the home's current governance systems to ensure that they are effective in identifying concerns and in driving the necessary improvements. Ref: 3.3.5
	Response by registered person detailing the actions taken: The Home's current governance systems have been reviewed. The audit purpose and process has been reiterated with qualified staff, including care plans and that all new wounds are to be documented and recorded appropriately; short term care plans are to be implemented and that escalation to allied health professionals is utilised where necessary. The Home Manager will audit all wound care plans and documentation relating to wound management to ensure wound management is maintained effectively. Any areas identified for improvement will be addressed through a time bound action plan. The Provider will review the governance systems as part of the Regulation 29 visit.

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 11 Stated: First time To be completed by: 23 June 2026	The registered person shall ensure that a comprehensive and person centred record of the activities delivered is retained. Ref: 3.3.2
	Response by registered person detailing the actions taken: A comprehensive and person-centred record of activities delivered within the Home is being maintained on file by the PALs. Records are supported with photographs which capture individuals engaged in a variety of activities. The Home Manager will review the records and provide feedback of the entries during discussions with the PALs, which are minuted. Compliance will be monitored through the completion of the weekly audits and as part of the Home Manager's Walkabout Audit. Supervision will take place with the PAL's and also with the nurses to support development. The Provider will review the recording of activities to ensure information is comprehensive and person centred, as part of the Regulation 29 visit.
Area for improvement 2 Ref: Standard 4.9 Stated: First time To be completed by: 23 June 2026	The registered person shall ensure that activity care plan evaluations evidence oversight by registered nursing staff of activities delivered. Ref: 3.3.2
	Response by registered person detailing the actions taken: A meeting was held with the Nurses on the 24/06/2026 to discuss the meaningful evaluation of activity care plans. Further supervision/discussion was again held on the 05/08/2026. Moving forward, further meetings will be held regularly with the nurses to review Activity Care Plan evaluations to identify examples of good practice to share and also to identify any areas that require improvement, which will be addressed through a timebound action plan. Staff huddles will be held as necessary to discuss any changes to resident's wellbeing in addition to Flash Meetings already taking place, which will include activities. Further training and supervision will be provided if required to improve the quality of oversight by the registered staff. We have also introduced a system where the Nurses will liaise with the PAL's regarding input of activities by directing her to specific activities/residents. The Provider will review activity care plan evaluations as part of the Regulation 29 visit. Any area for improvement will be addressed through a timebound action plan.

Area for improvement 3 Ref: Standard 4 Stated: First time To be completed by: 23 June 2026	The registered person shall ensure that all care record entries are legible. Ref: 3.3.3 Response by registered person detailing the actions taken: During the meeting with Nurses on the 24/06/2026 and on the 05/08/2026 the nurses were reminded that they are professionally accountable to ensure that all record keeping is legible in keeping with the NMC Code. It was discussed that the nurse in charge on each shift will spot check care record entries to ensure that entries are legible and if the entries are not legible supervision/training will be provided. Legibility of record keeping will be reviewed as part of the Home Manager's walkabout audit and any areas identified for improvement will be addressed with the individual member of staff, in keeping with Company policy and procedure. As part of the Regulation 29 Visit the Provider will review the legibility of record keeping and actions for address will be provided for the Home Manager to follow up. The Company is currently considering the use of electronic care planning systems which may be an advantage in the elimination of handwriting legibility issues.
Area for improvement 4 Ref: Standard 4 Stated: First time To be completed by: 23 June 2026	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: Following the inspection, meetings were held with the nursing team on 24/06/2026 and 05/08/2026 to reinforce best practice in the evaluation and recording of daily care, ensuring that documentation is completed in a timely, meaningful, and person-centred manner during each shift. Individual supervision sessions have also been conducted, during which nurses were reminded of the requirement to cross-reference relevant care plans when completing progress notes and evaluations. This is to ensure that care delivery is accurately assessed and documented against the identified needs, goals, and interventions of each resident. To support ongoing improvement and monitoring, a sample of daily progress notes will be reviewed through the Manager Walkabout Audit process, with findings and learning points shared with nursing staff to address any identified gaps in practice. In addition, the Provider will review the quality and effectiveness of daily care evaluations as part of the Regulation 29 visit. Any areas requiring further improvement will be incorporated into a time-bound action plan, with clear responsibilities and review dates to ensure sustained compliance and continuous quality improvement.

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