The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Tennent Street Care Home**

Provider: **Beaumont Care Homes Limited**

Date of Inspection: **4 August 2026**

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/Responsible Person:	Mrs Ruth Burrows
Registered Manager:	Mrs Aleyamma George

Service Profile –

Tennent Street is a registered Nursing Home which provides nursing care for up to 44 patients.

The home is divided into three units over one floor; the Sandhurst Unit which provides care for past or present alcohol dependency, the Sandringham Unit which provides general nursing care and the Balmoral Unit which provides care for patients living with dementia.

There is a Residential Care Home which occupies the first floor of the home and the Registered Manager for this home manages both services.

2.0 Inspection summary

An unannounced inspection took place on 4 August 2026, from 9.05 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 assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 3 December 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. 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 eight areas 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 a future medicines management 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 spoken said that 'the staff are very good', 'I have nothing but good things to say' and 'the portions [of food] are good'.

One relative reported that they were happy with the care their loved on received.

It was noted that no relatives had attended the last relatives meeting held by the home manager. Assurances were provided that relatives' views were sought regularly; and that relatives give informal feedback or raise any concerns directly to the manager and that there is an, 'open door policy'.

Staff spoken with said that Tennent Street 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, “I am happy here. I have no concerns.’

Patients who were unable to communicate their views were observed to be comfortable with the staff providing care and in their surroundings.

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. This include management checks to ensure that staff were registered with their regulatory body.

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. Staff were observed to be responding promptly to calls for assistance from patients and in a caring and compassionate manner.

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 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. Staff were observed to be compassionate and caring in approach with one distressed patient and conversations with residents were polite and courteous.

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. During this inspection, patients could choose to attend a church service and 1-1 activities which was observed to be a ball game.

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.

Where a patient was at risk of falling, measures to reduce this risk were put in place.

For example, some residents had alarm mats and bed alarms to alert staff if they were attempting to mobilise unaided. Examination of care records 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. Staff checked to ensure that the meal was appropriate for those with a modified diet. Patients were observed to be enjoying their meal and staff were ensuring dignity was considered for those who require additional assistance. Menus were displayed in the dining rooms and reflected the meal served. The dining experience in the Dementia unit could be enhanced with a pictorial menu. This was highlighted to the manager for action.

The importance of engaging with patients was well understood by the manager and staff. Observation of the planned activity which was a church service 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 or waiting for their visitors to come. Other patients were observed to be spending time in the outside space or being assisted with hairstyling and makeup by care staff.

Life story work with patients and their families helped to increase staff knowledge of their patients' interests and enabled staff to engage in a more meaningful way with their patients throughout the day.

Staff understood that meaningful activity was not isolated to the planned social events or games. Arrangements were in place to meet patients' social, religious and spiritual needs within the home. There is an activities therapist for each unit. The weekly programme of social events was displayed on the noticeboard and in patients' rooms advising of future events.

Patients' needs were met through a range of individual and group activities such as singing, board games, arts and crafts, one to one reading or watching television. Patients had access to a daily newspaper. There were also additional special events from outside entertainment such as 'Elvis' and 'The Music Man'. Special events were also celebrated. A record for each resident is maintained and what activities they engaged in that 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.

Information pertaining to residents was noted to be visible at a nursing station, both on the computer system and paper records on the wall. This was discussed with the management team on the day of inspection. An area for improvement was identified.

Care records were largely well maintained and there was evidence of review and evaluation of care.

A sample of patient care plans for those who require one to one enhanced care, identified that nursing staff had not been regularly reviewing or updating care plans to ensure they reflected the patients' current care needs. Details were discussed with the management team and an area for improvement was identified for the second time.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were suitably furnished, warm and comfortable. Management advised that a refurbishment of the units is to take place to address scuffed paint work and general redecoration.

Review of records confirmed that environmental and safety checks were carried out, as required on a regular basis, to ensure the home was safe to live in, work in and visit. For example, fire safety checks and nurse call system checks.

There was evidence that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance. Staff were observed to be adhering to best hand hygiene practice and wearing PPE when appropriate.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Aleyamma George has been the manager since 3 November 2023.

Patients and staff commented positively about the manager and described them as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced 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.

Patients and their relatives said that they knew who to approach if they had a complaint and that the manager is approachable.

There was a record of compliments maintained and throughout the units were thank you cards displayed from residents and families thanking the staff for the care of their relative.

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*	4*

* the total number of areas for improvement includes one Regulation that has been stated for a second time; and three standards which are carried forward for review at a future medicines management inspection.

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 16.1 **Stated:** Second time	The registered person shall ensure detailed and person-centred care plans are in place for those patients who require one to one care and should be available to care staff providing this care. Ref: 3.3.3
To be completed by: 14 August 2026	**Response by registered person detailing the actions taken:** The care plan identified on the day of the inspection has been reviewed on 27th August 2026 and now includes the most current care directions to improve the Resident's well being through person centred care and effective intervention. Other Residents who are in receipt of 1-1 care, care plans have been reviewed on 27th August 2026 and have been updated in accordance with each resident's assessed and changing needs as required and at a minimum of a monthly review. Residents' progress notes are updated daily to reflect any changes in health status, presentation, behaviours, risks, or care requirements to ensure continuity of care and to reflect on the effectiveness of interventions. Effective communication systems are in place to ensure that all relevant information is shared promptly with registered nurses and care staff during shift handovers. For residents receiving 1:1 care, care staff are provided with clear information regarding care plans, identified risks, care interventions, and expected outcomes to ensure care is delivered consistently and in line with assessed needs. Registered Nurses undertake regular review of supplementary documentation, including 1:1 observation records and monitoring tools, to ensure care is being delivered in accordance with the resident's care plan and that any concerns are identified and addressed promptly. The Home Manager maintains oversight through walk-around audits and routine audits of care documentation to provide assurance that records are accurate, person-centred, and reflective of the care being delivered. This oversight supports timely review, accountability, and the continuous assessment of residents' wellbeing and changing needs. These are further checked during the monthly monitoring visit .
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 28	The registered person shall review the management of pain medication, ensuring that care plans are in place for each patient. Ref: 2.0

Stated: First time **To be completed by:** 21 October 2025 (Carried Forward)	**Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**
Area for improvement 2 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 21 October 2025	The registered person shall review the management of thickening agents, to ensure that records of prescribing and administration are accurately maintained. The recommended consistency level should be recorded on all records. Ref: 2.0
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 3 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 21 October 2025	The registered person shall review the process for reconciling controlled drugs at shift handover, to ensure that a physical count occurs on all occasions. Ref: 2.0
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for Improvement 4 **Ref:** Standard 37 **Stated:** First Time **To be completed by:** 4 August 2026	The registered person shall ensure that all patient records, and their personal details, are stored confidentially and in line with GDPR. This includes but is not limited to all electronic records and paper records. Ref: 3.3.3
	Response by registered person detailing the actions taken: Residents' care records maintained electronically are managed securely and in accordance with GDPR and data protection requirements. Access to electronic records is restricted to authorised personnel through secure login arrangements to ensure the confidentiality, integrity and availability of resident information. All paper-based records, supplementary documentation, monitoring booklets and other sensitive information are stored securely within a locked office environment when not in use. Appropriate measures are in place to ensure that resident information remains confidential and is only accessible to staff who require it to fulfil their role.

	Information governance requirements, record security, confidentiality, and the appropriate storage of records have been discussed with all staff and reinforced through team meetings, handovers, supervision sessions, and ongoing practice oversight. Staff have been reminded of their responsibilities regarding the safe handling, storage, and sharing of resident information. The Registered Manager maintains oversight through regular walk-rounds and routine checks of both electronic and paper records to provide assurance that documentation is appropriately maintained, securely stored, accurate, and up to date. Any identified issues are addressed promptly through supervision, feedback, and ongoing monitoring to ensure continued compliance with information governance requirements and the safe management of resident information. This is also checked as part of the monthly monitoring visit.

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