

Inspection Report

Name of Service: Collegeland Nursing Home

Provider: Roughan Care Ltd

Date of Inspection: 30 August 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:	Roughan Care Ltd
Responsible Individual:	Mr Patrick Anthony McAvoy
Registered Manager:	Mrs Kathleen McBride
Service Profile – This home is a registered nursing home which provides general nursing care for up to 34 patients; eight of which could be admitted for dementia care management. Patients have access to communal living and dining areas and a garden. Bedrooms and communal rooms are all on the same level. The grounds surrounding the home are well maintained.	

2.0 Inspection summary

An unannounced inspection took place on 30 August 2025 from 9.30am to 5.00pm 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 29 October 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to patients and the service was well led. However, areas for improvement were identified in relation to hand hygiene, notifications to RQIA and with the condition of bedrail bumpers.

As a result of this inspection one area for improvement from the previous care inspection was assessed as having been addressed by the provider and the second, in relation to medicines management, was stated for the second time. Full details, including the 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.

Patients spoke positively when describing their experiences of living in the home. Refer to Section 3.2 for more details.

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 told us that they were happy living in the home and that they were treated well by staff who were caring and supportive. One patient said, "This is a nice place and the food is very good. Staff are very kind". Another told us, "I like it here. The staff are very good". Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

We received six questionnaire responses from relatives. They indicated that they were very satisfied with the care provision in the home and one commented, "High quality of care and patients' needs always come first at Collegelands. Staff are so attentive and caring and also provide emotional support to family". A second wrote about excellent care provision and how all staff go above and beyond to help.

Staff told us that they were happy working in the home and enjoyed engaging with the patients. They felt that they worked well together and were supported by management to do so. There was no 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 robust systems in place to manage staffing.

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.

Regular staff meetings with management were held to enhance the communication in the home and allow staff to share their views.

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. A relative commented, "The staff make time for (xxx) and (xxx) needs are met at all times. There is a good line of communication between Collegelands and myself".

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. Patients spoke fondly on their interactions with staff.

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.

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 patients 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.

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. Wound care was audited to ensure that the correct actions were being taken and the correct records maintained.

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.

The management of distressed reactions was not consistently recorded within patients' care records. This was discussed with the manager and an area for improvement in this regard was stated for the second time.

Continence management was assessed on admission and care plans were in place to guide staff in this area of care and to identify any continence aids required to meet the patients' needs. Bowel management had been recorded well.

Patients had good access to food and fluids throughout the day and night. Patients had met with the cook to discuss menu planning. The menu was varied and offered patients a choice of meals. Meal choices were also offered to those patients who required to have their meals modified to meet their nutritional requirements. Patients were safely positioned for their meals and the mealtimes were well supervised. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs. Food was only served when the patients were ready to eat their meal. Food served appeared appetising and nutritious. Records of food and fluid intake had been recorded well. Patients' weights were closely monitored to identify any unplanned weight loss and act accordingly. However, some staff were observed going between different patients, when assisting them with their meals, without taking the opportunity for hand hygiene. This was discussed with the manager and identified as an area for improvement.

Patients confirmed that activities were conducted in the home with several commenting that they enjoyed the crafts the best. Each patient had an activities care plan highlighting their interests and hobbies. Individual records of activity engagements were maintained. Activities were conducted on a group and on a one to one basis. There was intergenerational work planned with the local primary school and staff confirmed that entertainers regularly came to the home to entertain the patients. The activity provision was audited to ensure that it was meaningful and relatives spoke positively of the activities. There was a recent fun day in which relatives were invited to attend with their loved ones.

There had been a recent relatives' meeting and minutes were available for review. Topics discussed included complaints, compliments, laundry, activities, communication and fire safety. It was also good to note that relatives had been invited to attend an Eating, Drinking and Swallowing awareness session hosted in the home.

Multiple examples of compassionate care delivery were observed during the inspection between staff and patients. A patient told us, "I am very happy here. The staff are very good. I can make my own choices here in what I do and where I go". A relative told us, "This is one of the best homes I have ever been in. The staff connect with the patients and couldn't do enough for them". A questionnaire respondent wrote, 'I am able to leave my mother here in the knowledge that she is being looked after and above all kept safe'.

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 the patients' needs. 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. Risk assessments and care plans were reviewed regularly to ensure that they remained up to date. Care records were stored securely.

Supplementary care records were maintained to evidence care delivery in areas, such as, personal care delivery, food/fluid intake, continence management and records were kept of any checks staff made on patients.

Nurses completed daily progress notes to monitor and evaluate the care delivered to the patients in their care.

3.3.4 Quality and Management of Patients' Environment Control

Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. Although, several bed rail bumpers were observed to be in a state of disrepair rendering them unable to be effectively cleaned. This was discussed with the manager and identified as an area for improvement. There were no malodours in the home.

Corridors and fire exits were clear of clutter and obstruction should the need to evacuate occur and fire extinguishers were easily accessible. Staff had attended fire training and fire safety checks were regularly conducted. The responsible individual confirmed that all actions required from the most recent fire risk assessment had been completed.

Monthly infection control and environmental audits were completed to monitor the environment and staffs' practices. The manager confirmed that, in addition to this, they conducted a daily walk around the home to monitor the environment and practices. Personal protective equipment was readily available throughout the home.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Kathleen McBride has been the registered manager of the home since 8 August 2022. Staff commented positively about the manager and described her as supportive and approachable.

In the absence of the manager there was a nominated nurse-in-charge (NIC) to provide guidance and leadership. The NIC was clearly identified on the duty rota.

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.

A review of accidents in the home found that three recent accidents, where medical advice had been sought, were not reported to RQIA. This was discussed with the manager and identified as an area for improvement.

The number of complaints to the home was low. There was a robust system in place to manage any complaints received. Compliments received were logged and shared with staff.

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. Patients and their 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	3*

*The total number of areas for improvement includes one that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Kathleen McBride, 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 Stated: First time To be completed by: With immediate effect (30 August 2025)	<p>The registered person shall ensure that notifiable events are notified to RQIA in a timely manner.</p> <p>Ref: 3.3.5</p> <p>Response by registered person detailing the actions taken: Manager has discussed reportable incidents with RQIA inspector and clarified that all incidents which require advice from GP must be reported. incidents have been reported retrospectively from last inspection until this inspection as requested. Manager will continue to report all notifiable incidents in a timely manner and will seek advice from RQIA inspector if needed</p>
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 18 Stated: Second time To be completed by: From the date of inspection (30 August 2025)	<p>The registered person shall ensure that care plans are in place with sufficient detail to direct care when medicines are prescribed for the management of distressed reactions. The reason for and outcome of administration should be recorded.</p> <p>Ref: 2.0 and 3.3.2</p> <p>Response by registered person detailing the actions taken: Careplans were in place on day of inspection . Clinical supervision has taken place with all nurses and they have been reminded of their roles and responsibilities in recording reason for administration and outcome of administration. These records will be monitored as part of the audit process</p>
Area for improvement 2 Ref: Standard 46 Criteria (11) Stated: First time To be completed by: With immediate effect (30 August 2025)	<p>The registered person shall ensure that staff engage in hand hygiene after assisting a patient at mealtimes and before going to another patient.</p> <p>Ref: 3.3.2</p> <p>Response by registered person detailing the actions taken: additional hand sanitisors have been placed in the dining room beside PPE. Handwashing poster also displayed in dining room. Staff have all been reminded of their roles and responsibilities in relation to infection control. This will continue to be monitored during the monthly mealtimes audit</p>

<p>Area for improvement 3</p> <p>Ref: Standard 46 Criteria (2)</p> <p>Stated: First time</p> <p>To be completed by: 30 September 2025</p>	<p>The registered person shall ensure that bedrail bumpers in use are maintained in a good state of repair and can be easily cleaned.</p> <p>Ref: 3.3.4</p>
	<p>Response by registered person detailing the actions taken: Bedrail Bumpers which were identified at time of inspection have been replaced. Audit completed of all Bedrail Bumpers and ongoing plans for replacement of bedrail bumpers identified in Audit</p>

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The Regulation and Quality Improvement Authority

James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA



Tel: 028 9536 1111



Email: info@rqia.org.uk



Web: www.rqia.org.uk



Twitter: @RQIANews