The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Brooklands Healthcare Antrim**

Provider: **Brooklands Healthcare Ltd**

Date of Inspection: **3 April 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:	Brooklands Healthcare Limited
Responsible Individual:	Mr Jarlath Conway
Registered Manager:	Mrs Christine Alvarez – not registered

Service Profile –

This home is a registered nursing home which provides nursing care for up to 49 patients within the categories of dementia, elderly, physical disability and terminal illness. There are a range of communal areas throughout the home and patients have access to an enclosed garden.

There is a separate registered residential home which occupies the same building and the manager for this home manages both services.

2.0 Inspection summary

An unannounced inspection took place on 3 April 2025, from 9.30 am to 5.00 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 December 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 residents 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.

This inspection resulted in no areas for improvement being identified; one previous area for improvement from the inspection undertaken on 4 December 2024 was addressed by the provider and three areas for improvement, relating to the management of medicines have been carried forward for review at a future inspection. Full details 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 patient's, 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.

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 who were able to share their opinions on life in the home said or indicated that they were well looked after. Patients who were less able to share their views were observed to be at ease in the company of staff and to be content in their surroundings.

Patients told us that staff offered choices to them throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Relatives spoken with told us, they were satisfied with the care and services provided to their loved ones.

Following the inspection, one response was received from the patient/relative questionnaires that indicated they were generally satisfied with the services provided by Brooklands Antrim, comments made were shared with the manager for review and action as appropriate. There were no responses received from the staff questionnaires within the allocated timeframe.

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, minor gaps were noted in one staff member's record; this was discussed with the management for immediate review and action as appropriate.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

Bespoke care arrangements were in place for a number of patients and staff were observed supporting patients with their assessed care needs. The majority of patients who required bespoke care had individualised care plans in place and staff spoken with were knowledgeable about the patient's needs; inconsistencies were identified in one patient's record, this was discussed with the management for immediate review, who provided assurance that they were working with the Trust to ensure the needs of the patient was addressed.

Staff told us that the patients needs and wishes were important to them. Staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through observation of the interactions between the patients and staff that the staff knew the patients well.

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 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 were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

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.

The risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed.

Observation of the lunch time meal, review of records and discussion with patients, staff and the manager evidenced that there were robust systems in place to manage patients' nutrition and mealtime experience.

The weekly programme of social events was displayed on the noticeboard in the main entrance advising future events. Arrangements were in place to meet the patients social, religious and spiritual needs within the home. Activities for patients were provided which involved both group and one to one activities.

3.3.3 Management of Care Records

Patients' needs were assessed by a suitably qualified member of staff 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 in general were person centred and regularly reviewed to ensure they continued to meet the patients' needs, where inconsistencies were identified in one patient's record as discussed in section 3.3.1, this was discussed with the management for review and action as 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.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regulary monitored by the manager and records kept.

3.3.5 Quality of Management Systems

Mrs Christine Alvarez has been the Manager in this home since 4 February 2025.

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

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.

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	0	3*

* the total number of areas for improvement includes three which are carried forward for review at the next inspection.

This inspection resulted in no areas for improvement being identified.

Quality Improvement Plan	
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 January 2024)	The registered person shall ensure that a patient specific care plan is in place and that the reason for and the outcome of administration is recorded on every occasion when medication is prescribed/administered on a 'when required' basis for the management of distressed reactions. Ref: 5.1 & 5.2.6
	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:** From the date of inspection (30 January 2024)	The registered person shall ensure that medicine records are maintained to ensure a clear audit trail. This is stated with reference to entries on personal medication records and medicine administration records which must not be amended when there is a prescribed dosage change. Ref: 5.1 & 5.2.6
	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 28 **Stated:** First time **To be completed by:** From the date of inspection (30 January 2024)	The registered person shall ensure that care plans for the covert administration of medicines include current patient and medicine specific detail to direct staff as to how each medicine should be administered. Ref: 5.1 & 5.2.6 **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.**

Please ensure this document is completed in full and returned via the Web Portal

The Regulation and Quality Improvement Authority

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