

Inspection Report

Name of Service: Brooklands Healthcare Londonderry

Provider: Brooklands Healthcare Limited

Date of Inspection: 9 October 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:	Ms Victoria Humphries – not registered
Registered Manager:	Miss Shauna Rooney
Service Profile:	
<p>This home is a registered nursing home with 45 beds providing general nursing care for patients over 65 years of age and up to 12 patients under 65 years of age with a physical disability. The home has four floors with patients' bedrooms located on each floor. Patients have access to lounges, dining rooms and outdoor spaces.</p>	

2.0 Inspection summary

An unannounced inspection took place on 9 October 2025 from 9.45 am to 7.00 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 found that care was delivered to patients in a compassionate manner and that the home was well led. It was evident that staff promoted the well-being of patients. One new area for improvement was identified in relation to the implementation of care plans for patients at risk of malnutrition.

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 it was positive to note that ten areas for improvement were assessed as having been addressed by the provider. Two areas for improvement have been stated for a second time. One area for improvement relating to medicines management will be reviewed at a future 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 told us they were happy living in the home, they felt well looked after and listened to by staff and management. Patient's comments included: "Very content here", "The staff are just great", "They (staff) are more than good to me", "This is a home from home" and "I feel safe here".

Staff spoke positively in terms of the provision of care in the home and their roles and duties. Staff spoken with advised that there was good teamwork and everyone is willing to help. Staff reported that the care provided in the home was good and the patients were well cared for. Staff told us that the manager was supportive and available for advice and guidance.

There was no response to the online survey or questionnaires within the timeframe provided.

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 observed that staff responded to requests for assistance promptly, in a caring and compassionate manner.

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

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 patients' needs, their daily routine, wishes and preferences.

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 patients choice in how and where they spent their day or how they wanted to engage socially with others.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly, and records were mostly well maintained.

Review of care records regarding wound care evidenced that wound care evaluation records were not consistently completed to evidence that the wound dressing had been changed. An area for improvement has been stated for a second time.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The dining experience was an opportunity for patients to socialise and the atmosphere was calm, relaxed and unhurried. A menu was on display within the dining room offering a choice of two meals and a meal time co-ordinator was allocated to oversee the correct delivery of meals.

Patients commented positively about the food provided within the home with comments such as: "The food is good here and plenty of choices", "The food is nice" and "The food is great and if you don't like something, they always make you something different".

The importance of engaging with patients was well understood by management and staff. A pictorial schedule of activities was on display within the home offering a range of individual and group activities such as bingo, baking, gardening, games and films. External activities were also arranged for patients to attend.

The activity co-ordinator was very enthusiastic in her role and was observed positively engaging with patients and encouraging them to participate in activities. Arts and crafts made by the patients for Halloween were displayed within the home.

Mass was available on the television in the morning followed by a movie and reminiscing with items from the past, took place in the afternoon. Patients commented positively regarding the activities provided within the home and were seen to be content and settled in their surroundings and in their interactions with staff. Comments included: "Plenty of things going on everyday", "I really enjoy the activities" and "The activity person is excellent".

Some patients were engaged in their own activities such as; watching TV, resting or chatting to staff and arrangements were in place to meet patients' social, religious and spiritual needs within the home.

3.3.3 Management of Care Records

Review of a sample of patients' care records evidenced that some care plans did not contain sufficient details and were not fully reflective of the patient's current needs. Details were discussed with the management team and an area for improvement has been stated for a second time.

Nutritional risk assessments were carried out monthly using the Malnutrition Universal Screening Tool (MUST) to monitor patients' weight loss and weight gain. Review of a sample of these records evidenced that patients at risk of malnutrition did not have a care plan in place to direct the relevant care. An area for improvement was identified.

Daily progress records were kept of how each patient spent their day and the care and support provided by staff. Care records were held confidentially.

3.3.4 Quality and Management of Patients' Environment

The home was clean, neat and tidy and patients' bedrooms were personalised with items important to the patient. There was evidence that refurbishment works had been completed since the last care inspection and the painting of bedrooms was taking place during the inspection. The manager confirmed that further refurbishment works were on the homes agenda including ongoing painting throughout the home, the replacement of identified floor coverings and bedroom furniture.

Corridors and fire exits were clear from clutter and obstruction. A fire risk assessment (FRA) had been completed on the 3 June 2025. A number of actions were required following this assessment and these were signed by management as completed.

There was evidence that systems and processes were in place to manage infection prevention and control, with regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Miss Shauna Rooney has been the Manager in this home since 22 July 2021.

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

Review of the records of accidents and incidents which had occurred in the home found that two had not been reported to RQIA. This was discussed with the manager who had them submitted retrospectively.

A record of complaints was held within the home. Review of a sample of complaints evidenced that these were appropriately addressed.

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 home was visited each month by a representative of the responsible person to consult with patients, their relatives and staff and to examine all areas of the running of the home. Reports of these visits were available within the home.

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*	2*

* The total number of areas for improvement includes one regulation and one standard that have been stated for the second time and one regulation carried forward for review at the next 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 13 (4) Stated: Second time To be completed by: With immediate effect (21 January 2025)	The registered person shall ensure safe systems are in place for the management of insulin. Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0
Area for improvement 2 Ref: Regulation 16 (2) (a) Stated: Second time	The registered person shall ensure that care plans are kept up to date to ensure they are reflective of the patients' needs. Ref 2.0 and 3.3.3

<p>To be completed by: 9 October 2025</p>	<p>Response by registered person detailing the actions taken: The frequency of care plan auditing has been increased with a care plan review schedule implemented. Newly admitted patients have their care plans audited as a priority to ensure all relevant care plans are in place and are personalised to their individual needs.</p>
<p>Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)</p>	
<p>Area for improvement 1</p> <p>Ref: Standard 23</p> <p>Stated: Second time</p> <p>To be completed by: 9 October 2025</p>	<p>The registered person shall ensure that wound care evaluation records are completed following wound care.</p> <p>Ref: 2.0 and 3.3.2</p> <p>Response by registered person detailing the actions taken: Wound tracking audits have been updated to reflect items discussed at inspection. Supervision has been completed with nursing staff reinforcing the requirement to complete wound care evaluation records thoroughly ensuring they provide a comprehensive reflection of the wounds current condition and care provided.</p>
<p>Area for improvement 2</p> <p>Ref: Standard 12.3</p> <p>Stated: First time</p> <p>To be completed by: 9 October 2025</p>	<p>The registered person shall ensure that patients who have been identified at risk of malnutrition, have a care plan in place to direct the necessary care.</p> <p>Ref: 3.3.3</p> <p>Response by registered person detailing the actions taken: MUST assessments continue to be utilised on a monthly basis with audit templates updated to ensure that where appropriate a care plan has been implemented for any patients identified as being at risk of malnutrition.</p>

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