The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Brooklands Healthcare Kilkeel

Provider: Brooklands Healthcare Limited

Date of Inspection: 16 December 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 Sharon Troughton

Service Profile –
This home is a registered nursing home which provides nursing care for up to 48 persons. Patients' bedrooms are located over two floors. Patients with dementia are cared for on the ground and first floor and patients requiring general nursing care are cared for in a separate unit on the first floor. Patients have access to communal dining and lounge areas within each unit and all patients have access to a garden area.

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

2.0 Inspection summary

An unannounced inspection took place on 16 December 2025 from 10.00am to 5.15pm 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 6 May 2025; 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.

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

As a result of this inspection the areas for improvement from the previous care inspection were assessed as having been addressed and one new area for improvement was identified. Details can be found in the main body of the 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 that they were happy living in the home and that they were treated well by staff who were caring and supportive. Patients' comments included, "It's just great here. The staff are very good and we can make our own choices in what we do". Another commented, "I am very happy with the care; staff are very nice". Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. We received no questionnaire responses from patients.

Relatives consulted were positive in their feedback on care provision. One told us, "All staff are excellent. There is excellent, diligent care provision given here". We received one questionnaire response from a relative who described the carers as kind and showing respect and dignity. The respondent also identified their concern with the reduction of staffing levels at night. The concern was shared with the manager for their review and action as appropriate.

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. From May 2025, there was a reconfiguration of the categories of care and the staffing levels had been amended appropriately to facilitate this change. Staff told us that they were satisfied that the number and skill mix of staff on duty met the needs of the patients. Almost 98% of staff were compliant with mandatory training requirements. Newly employed staff had been recruited safely and inducted effectively into their roles. There was evidence of robust systems in place to manage staffing.

Staff confirmed that they had attended recent staff meetings to aid in the communication within the home.

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.

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.

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 about the 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 patients' needs, especially changes to care.

Patients who required special attention with skin care were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs. Where a patient had more than one wound, each wound was managed and evaluated separately and wound care records included body maps and photographs. This was discussed with the manager and identified as an area for improvement.

Care plans were developed to identify how to meet each patient's continence and personal care needs. Supplementary records were completed to evidence the care given to patients. Staff were aware of the actions to take should a patient repeatedly decline assistance with personal care.

Patients had good access to food and fluids throughout the day and night. Patients were safely positioned for their meals and the mealtimes were appropriately supervised. Staff communicated well to ensure that every patient received their meals in accordance with their assessed needs. Food was only served when the patients were ready to eat their meal. The meals served appeared appetising and nutritious. Some patients described the food as 'just ok'. Their comments were shared with the manager for their review and actions as appropriate. Staff were aware of the actions to take to prevent dehydration.

Plans were in place to celebrate the Christmas period. The home was decorated for Christmas and Christmas parties, movies and church services had been arranged. Many patients had their own Christmas trees in their rooms. Carol singers and outside entertainers had been organised to come to the home. Additional activities, such as, winter crafts, bun decorating and hot chocolate chats were planned. Christmas music was playing in the home. The preparation for Christmas and the variety of activities planned was commended. A recent residents' meeting included discussions on activities, food provision and comfort in the home.

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 reflective of patient need. Care records were stored securely.

Supplementary care records were maintained to evidence care delivery. The supplementary records were audited on a weekly basis within each unit to ensure that they have been appropriately completed.

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 them. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. There were no malodours in the home.

Externally the home was well maintained. There was a central enclosed garden area with a fountain.

Fire safety measures were in place to protect patients, visitors and staff. 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.

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 a change in the management of the home since the last inspection. The responsible individual for the Registered Provider is now Ms Victoria Humphries who is in the process of registering with RQIA. Miss Sharon Troughton remains as Registered Manager. 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. The manager had a suite of weekly and monthly audits to complete. Accidents in the home were reviewed monthly for patterns and trends in an effort to prevent future accidents from occurring.

The number of complaints to the home was low. There was a robust system in place to manage any complaints received. All 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 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.

	Regulations	Standards
Total number of Areas for Improvement	1	0

The area for improvement and details of the Quality Improvement Plan were discussed with Miss Sharon Troughton, 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 13 (4) (b) (c) **Stated:** First time **To be completed by:** With immediate effect (16 December 2025)	The registered person shall ensure that topical preparations are administered as prescribed and that there is written evidence of administration or rationale for not administering. Ref: 3.3.2
	Response by registered person detailing the actions taken: The registered person will ensure topical preparations will be administered in accordance with provided prescription. Clear written evidence will be maintained for each administration , on occasions where a topical administration is not administered a clear rationale will be documented. The registered person will ensure compliance through auditing, daily walkabout checks and provide staff with guidance through supervision.

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

The Regulation and Quality Improvement Authority

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