The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Gillbrooke Nursing Home

Provider: Tierney Homes Ltd

Date of Inspection: 5 February 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:	Tierney Homes Ltd
Responsible Individual:	Mrs Maria Virgilita Tierney
Registered Manager:	Mrs Jennifer McCaffrey
Service Profile – This home is a registered nursing home which provides nursing care for up to 25 patients. Accommodation is over two floors, with communal sitting and dining area on the ground floor.	

2.0 Inspection summary

This unannounced inspection took place on 5 February 2026, from 9.15am to 1.30pm. A care inspector conducted the inspection.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the three areas for improvement identified by RQIA, during the last care inspection on 28 May 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The three previous areas of improvement were met. Two previous areas of improvement from the medicines management inspection, on 16 January 2025, were not reviewed on this occasion and carried forward to the next inspection.

There was safe, effective and compassionate care delivered in the home and the home was well led by the manager.

It was evident that staff promoted the dignity and well-being of patients.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

One area of improvement was identified during this inspection. This was in respect of putting in place adequate activity and social event provision for patients.

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 said that they felt content and well cared for in the home. They said that staff were kind and caring and they enjoyed the meals. One patient made the following comment; "They (the staff) look after me very well. Anything I want I just have to ask. The food is very good too. There is no problems here." Two patients raised negative views on the lack of activities in the home.

Patients who were unable to articulate their views were seen to be comfortable and at ease in their environment and interactions with staff.

Staff spoke positively about the provision of care, workload, teamwork, training and managerial support. Staff also said there was a nice atmosphere in the home and they would have no hesitation raising concerns with management, as necessary.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Observation of the delivery of care evidenced that patients' needs were largely met by the number and skills of the staff on duty. There was enough staff in the home to respond to the needs of the patients in a timely way. It was noted that there was a deficit in activity provision, both for group and individual activities. An area of improvement was made for this area of need to be reviewed and subsequently met.

Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the provision of training and supervision. Staff meetings were held on a regular and up-to-date basis, with records of same appropriately maintained.

A schedule of staff supervision and staff meetings were maintained on an up-to-date basis.

3.3.2 Quality of Life and Care Delivery

Staff had knowledge and understanding of each individual patient's needs.

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 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, such as bed rails and / or alarm mats. It was established that safe systems were in place to safeguard residents and to manage this aspect of care.

The lunchtime meal was appetising, wholesome and nicely presented. Staff assistance was organised and unhurried. Throughout this inspection, patients commented positively on the provision of meals, including choice.

Frailer patients were seen to be comfortable with needs attended to regularly by staff.

The genre of television channels and music played was in keeping with patients' age group and tastes. Two patients made negative comments about the general lack of activities, which they said lacked variety and were only facilitated for a brief period during the afternoons. An area of improvement was made with this regard.

3.3.3 Management of Care Records

Patients' care records were maintained safely and securely to ensure confidentiality.

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.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Care staff recorded regular evaluations about the delivery of care.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and fresh smelling throughout, with a programme of redecoration and refurbishment in place. Communal areas were suitably furnished and comfortable. Bathrooms and toilets were clean and hygienic.

The catering and laundry departments were tidy and well organised.

Cleaning chemicals were stored safely and securely.

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.

3.3.5 Quality of Management Systems

Mrs Jennifer McCaffrey is the registered manager of the home. Staff spoke positively about the managerial arrangements in the home, saying that they would readily feel comfortable about raising any issue of concern.

It was established that the manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to the patient's next of kin and their aligned named worker, and as appropriate to RQIA.

A comprehensive programme of quality assurance was in place and maintained by the manager on a regular and up-to-date basis.

The home was visited each month by a representative on behalf of the responsible individual to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail. These reports are available for review by patients, their representatives, the Trust and RQIA.

4.0 Quality Improvement Plan/Areas for Improvement

One area of improvement has been identified where action is required to ensure compliance with regulations and standards.

	Regulations	Standards
Total number of Areas for Improvement	1	2*

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

The one area of improvement and details of the Quality Improvement Plan was discussed with Mrs Jennifer McCaffrey, 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(1)(a) **Stated:** First time **To be completed by:** 5 March 2026	The registered person must put in place adequate activity provision for patients. Ref: 3.3.1 and 3.3.2
	Response by registered person detailing the actions taken: Activity Therapist returned from sick leave on reduced hours for a period of time. Two activity therapists in place at present 5 days a week to ensure there is adequate activities in place for patients in Gillbrooke.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 31 **Stated:** Second time **To be completed by:** With immediate effect 16 January 2025	The registered person shall ensure that controlled drugs, including those in Schedule 3 and Schedule 4 (Part 1) are denatured prior to disposal. 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 2 **Ref:** Standard 18 **Stated:** First time **To be completed by:** With immediate effect 16 January 2025	The registered person shall review that management of distressed reactions, to ensure that the reason for and outcome of the administration of 'when required' medicines is recorded 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.

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

The Regulation and Quality Improvement Authority

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