

Inspection Report

Name of Service: Brooklands Healthcare Kilkeel

Provider: Brooklands Healthcare Ltd

Date of Inspection: 23 June 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:	Brooklands Healthcare Ltd
Responsible Individual:	Ms Victoria Humphries
Registered Manager:	Miss Sharon Troughton
Service Profile – This home is a registered residential care home which provides health and social care for up to 10 residents. The home is split between a nine bedded unit in the main building for residents living with dementia and a single occupancy unit behind the main building registered for learning disability. Residents within each unit have access to dining and lounge areas. There is a separate registered nursing 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 23 June 2026 from 9.25am to 3.25pm 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 17 February 2026; 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 the service was well led.

Residents 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 all areas for improvement from the previous care inspection were assessed as having been addressed and no new areas for improvement were identified.

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 residents, 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

All residents were well presented in their appearance and were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. One told us, "It's lovely here; the staff are very nice"; another commented, "I like it here; really enjoy my breakfast".

A relative consulted responded positively in relation to the service provision. They told us, "The care is excellent; we are very happy. We can come and go as we please. We know the codes to get in or out. Staff always keep us up to date with anything going on and phone calls are answered when we ring. We can take them out when we want". We received no questionnaire responses from residents or relatives.

Staff told us that they were happy working in the home and enjoyed engaging with the residents. They felt that they worked well together and were supported by management to do so. There were no responses from the staff online survey.

3.3 Inspection findings

3.3.1 Staffing Arrangements

All appropriate recruitment safety checks had been verified prior to staff commencing in post.

Newly employed staff completed a structured induction at the commencement of their employment which included mandatory training. A robust system was in place to ensure that all staff were compliant with pre-determined mandatory training requirements.

Staff raised concerns regarding the staffing levels. This was discussed with the manager who confirmed that concerns had already been raised with the senior management team. Following the inspection, we received confirmation that the staffing levels had been increased. RQIA will continue to monitor staffing arrangements in the home at subsequent inspections.

Observation of the delivery of care evidenced that residents' needs were met by the two staff on duty and that staff responded to requests for assistance promptly in a caring and compassionate manner.

Minutes of recent staff meetings were available to all staff to aid in the communication within the home.

Checks were made to ensure care staff were registered with the Northern Ireland Social Care Council.

3.3.2 Quality of Life and Care Delivery

All 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 residents. It was clear through listening to and observing resident and staff interactions, that the staff knew their residents well.

Residents could choose where to spend their day. While some preferred to remain in the lounge, others preferred the privacy of their bedrooms. Staff were seen assisting residents with their preferences.

At times some residents 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 residents and to manage this aspect of care.

Care records were detailed for those residents who could, at times, display behaviours which could be challenging. The records identified the triggers for the behaviours to avoid and clearly laid out the actions to take in the event of behaviours escalating. Any incidences of challenging behaviour were recorded and reported to the appropriate persons.

Residents had good access to food and fluids throughout the day and night. Food was prepared freshly onsite. Residents were offered a choice of meals and alternatives provided where the resident did not like either choice. The menu offered a good variety of food and the food served appeared appetising and nutritious.

Activities were dependent on the residents' preferences. Staff were aware of each resident's hobbies and interests. Daily records were maintained of activity engagements which included arts and crafts, baking, music, bingo, movies, garden walks, hairdressing and nail therapy. Activities was on the agenda of a recent residents' meeting, as was, food provision, the environment and residents' satisfaction levels with the care and service provision in the home.

3.3.3 Management of Care Records

Residents' 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 the residents' needs. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate. Assessments and care plans were reviewed regularly to make sure that they remained relevant. Care records were stored securely.

Supplementary care records were maintained to evidence the care delivered to residents. The records included personal care delivery, food and fluid intake, repositioning, checks made on residents and continence care. All care records were audited to ensure accurate completion.

Care staff recorded daily evaluations of the care delivered to the residents.

3.3.4 Quality and Management of Residents' Environment

The main home was clean, tidy and warm providing the residents with a comfortable environment to live in. The single occupancy unit was well maintained and personalised for the resident. Residents had dining spaces and lounge areas to relax in. Residents could choose where to sit or where to go during the day. Staff were observed assisting residents with their choices.

Fire safety measures were in place to protect residents, visitors and staff 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. Staff confirmed that they had taken part in fire drills. A current fire risk assessment was in place and all actions identified had been completed.

Regular infection control audits were completed to monitor the environment and staffs' practices. All staff were observed to be bare below the elbow and washed their hands at the appropriate intervals. Personal protective equipment and hand hygiene facilities were readily available throughout the home and the unit.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Miss Sharon Troughton has been registered as manager of the home since 18 June 2020. Staff commented positively about the manager and described her as supportive and approachable.

In the absence of the manager there was a nominated shift lead person to provide guidance and leadership. The shift lead was clearly identified on the duty rota.

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 manager had a suite of audits to complete. Audit records included actions taken in response to findings and dates the actions were completed.

There was a low number of accidents attributed to the home. Accidents were reviewed monthly for patterns and trends in order to potentially prevent future falls from occurring.

The number of complaints to the home was low. There was a system in place to manage any complaints received. All compliments received, including emails and thank you cards were shared with staff.

Staff told us that they would have no issue in raising any concerns regarding residents' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Sharon Troughton, Registered Manager and Gabriela Ciurea, Regional Operations Manager, as part of the inspection process and can be found in the main body of the report.



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