

Inspection Report

Name of Service:	Rylands
Provider:	Rylands Nursing Home Limited
Date of Inspection:	16 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:	Rylands Nursing Home Limited
Responsible Individual/Responsible Person:	Mrs. Connie Hutchinson
Registered Manager:	Mrs. Valerie Rutherford
Service Profile – Rylands is a registered nursing home which provides nursing care for up to 45 patients. The home is situated over the ground floor and provides nursing care for people with a learning disability and general nursing care needs. There are communal bathrooms, a number of lounges and a large dining room. There is also access to outdoor space. There is a separate, registered residential care home which occupies part of the ground floor and the registered manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 16 June 2026, between 9.20 am to 4.10 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 15 November 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 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. Please refer to Section 3.2 for more details.

As a result of this inspection all of the previous areas for improvement were assessed as having been addressed by the provider and no new areas for improvement were identified. Details can be found in the main body of this report.

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. 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 spoken with were positive about their environment, the meals provided, the activities offered and the staff who cared for them. They told us that 'the staff couldn't do more for me and the home is spotless' and 'I am very happy here, there's lots of things to do'.

Patients told us that they have choice in how to spend their day. They said that they had a choice of meals. They also said that they can choose sit beside their friends at mealtimes and can retire to their room for a rest during the day as they wish.

Staff told us that they very happy working in the home and that they were supported by management. They also told us they had confidence that any concerns raised would be listened to actioned where appropriate.

Questionnaires returned from patients and visitors following the inspection, indicated a high level of satisfaction with the care received in the home. One visitor told us that 'staff are always smiling...always say hello and offer you a cup of tea every time you are in'.

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. Staff were observed to be responding to patients promptly and in a compassionate and kind manner.

Appropriate checks were made to ensure that staff maintained their registration with professional bodies such as The Nursing and Midwifery Council (NMC) and The Northern Ireland Social Care Council (NISCC).

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 knowledgeable of individual patients' needs, their daily routine, wishes and preferences.

All staff received a handover at the start of their shift. Staff told us that these were detailed and assisted them in carrying out their role to ensure safe patient care.

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 observed to use orientation techniques for patients who were displaying confusion and disorientation.

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 offered patient's choice in how and where they spent their day or how they wanted to engage socially with others. For example the activities therapist encouraged patients to attend the planned activity, and if they did not wish to, offered them an alternative activity such as reading the daily newspaper.

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 a sample of care records reviewed, reflected the patients' assessed needs and communication with other healthcare professions when needed.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, referrals were made to other healthcare professionals as needed such as the Trust's Specialist Falls Service.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

The dining experience was an opportunity for patients to socialise, music was playing, and the atmosphere was calm and unhurried. It was observed that patients were enjoying their meal and their dining experience. Patients requiring assistance received dignified care and a system was in place to ensure they receive a meal suitable for their needs.

The importance of engaging with patients was well understood by the manager and staff.

The home has activities therapists who work Monday to Friday. There was an activity plan on display which confirmed activities happened in the morning and afternoon. Activities included, 'knit and natter', music, church services and men's groups. Patients had input to the type of activities offered which was confirmed through minutes of resident meetings.

Observation of the planned activity after lunch, which was flower arranging, demonstrated that staff knew and understood patients' preferences and wishes and helped patients to participate in planned activities or to remain in their bedroom with their chosen activity such as reading, listening to music or waiting for their visitors to come.

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 patients' needs and included any advice or recommendations made by other healthcare professionals.

Patients care records were held confidentially.

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

Patients who have limited mobility may require assistance to change their position. Records evidenced that staff supported patients to reposition regularly and this was recorded appropriately.

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.

Review of records and observations confirmed that appropriate 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.

Fire safety measures were in place. The fire risk assessment was up to date with no outstanding actions required.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Valerie Rutherford has been the manager in this home since 24 March 2014.

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. It was clear from the records examined that the Management team had processes in place to monitor the quality of care and other services provided to patients.

Patients and their relatives spoken with said that they knew how to report any concerns and said they were confident that the manager would address their concerns.

A record of compliments was held, and included positive comments on the home and care in the home from the Northern Ireland Ambulance Service, GPs visiting patients and family members.

Reports of the provider's monthly monitoring visits were detailed. It was highlighted during inspection feedback to ensure that any actions to be taken by the Responsible person are signed off when completed, to ensure robust oversight.

There were no recorded complaints.

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 the person in charge, as part of the inspection process and can be found in the main body of the report.



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