

Inspection Report

Name of Service:	Collegeland Nursing Home
Provider:	Roughan Care Ltd
Date of Inspection:	29 July 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:	Roughan Care Ltd
Responsible Individual:	Mr Patrick Anthony McAvoy
Registered Manager:	Mrs Kathleen McBride
Service Profile: This home is a registered nursing home which provides general nursing care for up to 34 patients; eight of which could be admitted for dementia care management. Patients have access to communal living and dining areas and a garden. Bedrooms and communal rooms are all on the same level. The grounds surrounding the home are well maintained.	

2.0 Inspection summary

An unannounced inspection took place on 29 July 2026 from 9.15 am to 3 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 30 August 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. 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 three areas for improvement were assessed as having been addressed by the provider. Other areas for improvement have either been stated again or will be reviewed at the next 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 spoken with said that they were happy with the care and services they receive in the home. They described staff as pleasant and caring and available when they needed assistance.

Patients who were unable to voice their opinions indicated through non-verbal cues such as smiling or giving a thumbs up, that they were content living in Collegeland Nursing Home.

Relatives spoken with said that they were very happy with the care that their loved ones received. They described the care as "excellent" and told us that their loved ones were "comfortable and content."

Relatives were complimentary about staff, saying "They are like family", and "Everyone is so friendly." Relatives also confirmed that they knew who the manager was and said "Kathleen is so good" and "It's a well run home, we are kept informed."

Other relatives commented, "They couldn't do enough for us...they are so good...so hospitable, if I ate all that they offer me when visiting I couldn't move."

Relatives also confirmed that the visiting arrangements were working well.

Following the inspection RQIA received six questionnaires completed by relatives. All respondents indicated that they were satisfied that the care provided was safe, effective, delivered with compassion, and the service was well led.

Questionnaire comments about the care included; “Care is exceptional”, “Excellent”, “We are happy with the care”, “Our (loved one) has received the best care possible”, “Thoroughly excellent service...our (loved one) looks healthy and well...skin is immaculate and they are well settled”, and “Everything is five star experience.”

Relatives said that staff were “Always close at hand”, deliver care “with a smile”, and “Always attentive and so caring.”

About other services provided, relatives said, “Everyone is so good and nothing is overlooked”, “The bedroom is lovely and the food is enjoyable”, and “Food is cooked to a very high standard and presented beautifully...clothes are always returned from the laundry clean, ironed, and well folded.”

A visiting professional to the home said, “Care is excellent...my client is so content and happy and told me ‘this place is something else’.”

Staff told us that they were happy working in the home and that they were satisfied with the staffing levels. Staff described good teamwork and said the manager was good and approachable. Staff said that they were provided with adequate training to do their job safely.

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.

The staff duty rota was reviewed and evidenced stable staffing levels, the manager’s hours and capacity worked, and highlighted the nurse in charge of the home for each day and night. Review of records and discussions with staff evidenced that staff were provided with annual appraisals, supervision sessions at least every six months, and any nurse taking charge of the home had a competency and capability assessment in place to ensure they held the required skills and information in the absence of the manager.

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.

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.

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 patient choice 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 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 care records accurately reflected the patients' assessed needs.

Examination of care records and discussion with staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. For example, patients were referred to the Trust's Specialist Falls Service, their GP, or for physiotherapy.

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.

Observation of the lunch time meal, review of records and discussion with patients, staff and the manager indicated that there were robust systems in place to manage patients' nutrition and mealtime experience.

The importance of engaging with patients was well understood by the manager and staff. Observation of the planned activity of games in the lounge before lunch and baking in the dining room after lunch, confirmed 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.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home.

The home had dedicated activity therapist who planned a weekly programme of activities. This weekly programme of events was displayed on the noticeboard for patients, relatives and staff to see future events.

Patients' needs were met through a range of individual and group activities such as bingo, board games, arts and crafts or hand massage, hairdressing, one to one reading or listening to music.

Activities for patients were provided which involved both group and one to one activities. Birthdays and annual holidays were celebrated.

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.

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. A number of bedrail bumpers had been replaced with new and a previously identified area for improvement was assessed as met.

Communal lounges were clean and accessible to patients. The majority of furnishings throughout the home were in good condition. However, it was noted that a number of chairs in the dining room were badly worn and the surfaces could not be effectively cleaned. This was brought to the attention of the manager who confirmed that the identified chairs were being replaced. This will be reviewed at the next inspection.

Communal toilets and bathrooms were clean. However there were a number of inappropriately stored items such as urinal bottles and jugs for clinical use on the floor. This is poor infection prevention and control practice. An area for improvement was identified.

Staff were observed to carry out hand hygiene at appropriate times and a previously identified area for improvement was assessed as met. The manager conducted regular audits of hand hygiene practices and the use of personal protective equipment (PPE)

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Kathleen McBride has been the registered manager in this home since 8 August 2022. The manager confirmed that they were supported in their role by the provider.

The manager had completed the My Home Life programme led by the Ulster University in partnership with Age NI.

Patients, relatives, and staff commented positively about the manager. One comment from staff said, "Kathleen is very approachable and she knows what is happening with the patients...she is a present manager."

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

Review of records pertaining to accidents and incidents that occurred in the home evidenced appropriate reporting by the home to relevant persons, including RQIA when required. A previously identified area for improvement was assessed as met.

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.

There was a records of compliments made about the home evident through various cards, messages and gifts.

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	0	2*

* The total number of areas for improvement includes one that has been carried forward for review at the next medicines management inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Kathleen McBride, 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 Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 18 Stated: Second time To be completed by: From the date of inspection (30 August 2025)	The registered person shall ensure that care plans are in place with sufficient detail to direct care when medicines are prescribed for the management of distressed reactions. The reason for and outcome of administration should be recorded. Ref: 2.0 and 3.3.2
	Response by registered person detailing the actions taken: care plans continue to be audited for the management of distressed reactions. Medication audits continue to ensure reason for and outcome of administration is recorded
Area for improvement 2 Ref: Standard 46 Stated: First time To be completed by: 29 July 2026	The registered person shall ensure that staff adhere to best practice in relation to infection prevention and control. This is with specific reference to inappropriate storage in communal bathrooms/toilets. Ref: 3.3.4
	Response by registered person detailing the actions taken: All staff have been reminded of their roles and responsibilities in relation to infection prevention and control. The registered Manager has increased checks to be completed on communal bathrooms to ensure no inappropriate items are stored. The registered manager will continue to complete environmental audits to ensure compliance

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