

Inspection Report

Name of Service: Oakridge Care Home

Provider: Spa Nursing Homes Ltd

Date of Inspection: 17 July 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:	Spa Nursing Homes Ltd
Responsible Individual:	Mr Christopher Phillip Arnold
Registered Manager:	Mrs Irene Nazareth, not registered
<p>Service Profile: Oakridge Care Home is a nursing home registered to provide nursing care for up to 58 patients. The home is divided into three units over two floors. The Tollymore unit on the ground floor provides general nursing care and the Murlough and Tyrella units on the first floor provide care for patients living with dementia.</p> <p>There is a residential care home in the same building. The manager is responsible for both services.</p>	

2.0 Inspection summary

An unannounced inspection took place on 17 July 2025, from 10.00am to 4.00pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. One area for improvement identified at the last care inspection was reviewed. The remaining areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

The findings of the care inspection on 23 June 2025, resulted in an enforcement notice in relation to the delivery of care, the management team's systems to monitor the quality of care, staff knowledge of safeguarding and implementation of this procedure, recording keeping and maintenance of the environment. This was not reviewed during this medicines management inspection and will be reviewed at a planned enforcement monitoring inspection.

Review of medicines management found that satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed.

The area for improvement in relation to the secure storage of medicines identified at the last care inspection was assessed as met and no new areas for improvement were identified.

Details of the areas for improvement carried forward for review at the next inspection can be found in the quality improvement plan (QIP) (Section 4.0).

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients well.

RQIA would like to thank the staff for their assistance throughout the inspection.

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 service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection, information held by RQIA about this home was reviewed. This included areas for improvement identified at previous inspections, 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.

3.2 What people told us about the service and their quality of life

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each patient liked to take their medicines and medicines were administered in accordance with individual patient preference. Staff also said that they prioritised patients who required pain relief and time-critical medicines during each medicine round.

No completed questionnaires or responses to the staff survey were received following the inspection.

3.3 Inspection findings

3.3.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments.

The majority of personal medication records reviewed were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. One personal medication record needed the strength of one medication updated. This was discussed with the nurse in charge for immediate corrective action. The correct dose had been administered as prescribed.

Copies of patients' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets etc.

The management of pain, thickening agents and epilepsy was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Directions for use were clearly recorded on the personal medication record and patient-centred care plans were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors.

Records of administration included the reason for and outcome of each administration. Two care plans needed updated with the details of the name and dose of the prescribed medication and one care plan needed to be put into place. This was discussed with the manager for immediate action.

3.3.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

Records reviewed showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicine storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. A review of stock levels indicated an excess supply of medicines for a small number of patients and three expired medicines were observed. These were removed from the cupboard for immediate disposal by the nurse in charge. Stock management was discussed with the manager and assurance was provided that an action plan had been prepared to review and improve stock management within the home.

Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage, the storage of controlled drugs and the safe disposal of medicines.

3.3.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. Most of the records were found to have been accurately completed. Records were filed once completed and were readily retrievable for review.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plan. Written consent and care plans were in place when this practice occurred.

One care plan was needed for the crushing of medicines. This was discussed with the manager for immediate action.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits had been discussed with staff and addressed. The date of opening was recorded on medicines to facilitate audit and disposal at expiry.

3.3.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

A review of records indicated that satisfactory arrangements were in place to manage medicines at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

3.3.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, minor audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail the manager for ongoing monitoring.

3.3.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that their staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

4.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	4*	6*

* the total number of areas for improvement includes 10 which were carried forward for review at the next inspection.

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Mrs Irene Nazareth, Manager, and the Regional Support Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 14 (2) (a) (c) Stated: Second time To be completed by: 23 June 2025	The registered person shall ensure all areas of the home to which patients have access are free from hazards to their safety. Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0
Area for improvement 2 Ref: Regulation 27 (4) (a) Stated: Second time To be completed by: 31 July 2025	The registered person shall ensure recommendations made in the fire risk assessment are addressed in the recommended timeframe. Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0
Area for improvement 3 Ref: Regulation 30 (1) (d) (f) Stated: Second time To be completed by: 23 June 2025	The registered person shall give notice to RQIA without delay of the occurrence of any notifiable incident. All relevant notifications should be submitted retrospectively. Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0
Area for improvement 4 Ref: Regulation 27 (3) (b) Stated: First time To be completed by: 23 June 2025	The registered person shall ensure that all fire doors in the home are not propped open. Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0

Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 1 Ref: Standard 39.9 Stated: Second time To be completed by: 23 July 2025	The registered person shall ensure that mandatory training requirements are met to enable staff to meet the needs of patients safely and effectively.
	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. Ref: 2.0
Area for improvement 2 Ref: Standard 46.2 Stated: Second time To be completed by: 23 June 2025	The registered person shall ensure that the environment in the home is managed to minimise the risk and spread of infection. This area for improvement specifically related to the cleaning of environment and patient equipment within the home.
	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. Ref: 2.0
Area for improvement 3 Ref: Standard 12 Stated: First time To be completed by: 23 June 2025	The registered person shall ensure that when a care record in relation to patient dietary requirements has been commenced or reviewed that this is shared with the kitchen staff.
	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. Ref: 2.0
Area for improvement 4 Ref: Standard 12 Stated: First time To be completed by: 23 June 2025	The registered person shall ensure that where a patient is disorientated to time, that there is evidence of sufficient effort made to encourage good nutrition between planned meal times.
	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. Ref: 2.0

<p>Area for improvement 5</p> <p>Ref: Standard 4.9</p> <p>Stated: First time</p> <p>To be completed by: 23 June 2025</p>	<p>The registered person shall ensure that supplementary care records related to patient checks are accurately maintained in accordance with the care plan are completed contemporaneously.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>
<p>Area for improvement 6</p> <p>Ref: Standard 4.9</p> <p>Stated: First time</p> <p>To be completed by: 23 June 2025</p>	<p>The registered person shall ensure that supplementary care records are accurately maintained and are completed by the staff member(s) delivering the care.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>



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