



The Regulation and
Quality Improvement
Authority

Inspection Report

Name of Service: Dunlarg Care Home
Provider: Healthcare Ireland No 2 Ltd
Date of Inspection: 8 April 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:	Healthcare Ireland No 2 Ltd
Responsible Individual:	Ms Amanda Mitchell
Registered Manager:	Mrs Nontobeko Nqwababa, not registered
<p>Service Profile: Dunlarg Care Home is a nursing home registered to provide nursing care for up to 50 patients. The home is divided into two units, The Keady Unit and The Armagh Unit. Bedrooms and communal rooms are located over one floor. Patients have access to dining and lounge areas within each unit.</p> <p>A residential care home is attached to the nursing home. The registered manager is responsible for both services.</p>	

2.0 Inspection summary

An unannounced inspection took place on 8 April 2025, from 10.30am to 2.30pm. The inspection was completed by two pharmacist inspectors and focused on medicines management within the home.

The findings of the medicines management inspection on 24 October 2024 evidenced that safe systems were not in place for some aspects of medicines management. Areas for improvement were identified in relation to the management of insulin, cold storage, personal medication records, controlled drugs storage, medicine audits and the management of medicines for distressed reactions. The management team were given a period of time to address the issues identified. This follow-up inspection was undertaken to evidence if the necessary improvements had been implemented and sustained.

Mostly 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. However, improvements were necessary in relation to the management of insulin.

Whilst areas for improvement were identified, there was evidence that patients were being administered their medicines as prescribed.

The areas for improvement in relation to cold storage, personal medication records, controlled drugs storage, medicine audits and the management of medicines for distressed reactions identified at the last medicines management inspection were assessed as met and no new areas for improvement were identified. The area for improvement in relation to the management of insulin was stated for a second time. Areas for improvement identified at the last care inspection were carried forward for review at the next inspection. Details 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 said they had worked hard to implement and sustain improvements identified at the last medicines management inspection and had received help and support from senior management to do so. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

RQIA did not receive any completed questionnaires or responses to the staff survey following the inspection.

3.3 Inspection findings

3.3.1 The management of insulin

All patients should have care plans which detail their specific care needs and how the care is to be delivered. Care plans were in place for the management of insulin. They contained sufficient detail to direct the required care.

Improvements were noted in the management of insulin, however two in use insulin pen devices did not have the date of opening recorded to facilitate audit and disposal on expiry. In addition, one was not individually labelled with the patient's name. An area for improvement was stated for a second time.

3.3.2 Cold storage of medicines

The medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located.

The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately.

Medicines which require cold storage must be stored between 2°C and 8°C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. Satisfactory arrangements were in place for medicines requiring cold storage.

3.3.3 Medicine records

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 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. A small number of minor discrepancies were highlighted for immediate corrective action and on-going vigilance.

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

3.3.4 The management of distressed reactions

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 the majority of administrations.

3.3.5 Controlled drugs

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.

3.3.6 Medicine Audit

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 the majority of medicines to facilitate audit and disposal at expiry.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

4.0 Quality Improvement Plan/Areas for Improvement

One area for improvement have been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	2*	1*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Nontobeko Nqwababa, Manager, as part of the inspection process. The timescale for completion commences 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 (4) Stated: Second time To be completed by: Immediate and ongoing (8 April 2025)	<p>The registered person shall review the management of insulin to ensure that records of prescribing and administration are clear and complete.</p> <p>Ref: 3.3.1</p> <p>Response by registered person detailing the actions taken: The date of opening recorded to facilitate audit and disposal on expiry on insulin pens has been discussed at a meeting with the nurses and supervision completed .The insulin pen not labelled had been sent to the home with the resident on discharge from Craigavon Hospital unlabelled. The resident was admitted to the home on a Friday evening and the nurses had contacted the GP to have a new insulin pen prescribed which would have been labelled by the providing pharmacy. The nurses have been advised that should this happen again they are to ensure a label is to be handwritten at home level - countersigned by two nurses and secured to the pen until a pharmacy label can be obtained.</p>
Area for improvement 2 Ref: Regulation 13 (1) (a)(b) Stated: Second time To be completed by: 31 August 2024	<p>The registered person shall review the management of challenging behaviours in the home to include the training of staff and the appropriate record keeping.</p> <p>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.</p> <p>Ref: 2.0</p>
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 21 Criteria (1) Stated: Second time To be completed by: 31 July 2024	<p>The registered person shall ensure that bowel management is recorded contemporaneously and that actions from any deficits identified are clearly recorded in the patient's daily evaluation records.</p> <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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