



The Regulation and  
Quality Improvement  
Authority

# Inspection Report

**Name of Service:** Nazareth House Care Village  
**Provider:** Nazareth Care Ireland  
**Date of Inspection:** 29 July 2025

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

## 1.0 Service information

<b>Organisation/Registered Provider:</b>	Nazareth Care Ireland
<b>Responsible Individual:</b>	Mr John Thornton
<b>Registered Manager:</b>	Mrs Carmel Blaney
<p><b>Service Profile:</b>  Nazareth House Care Village is a nursing home registered to provide nursing care for up to 60 patients. The home provides general nursing care, care to patients living with a physical disability and to patients who are terminally ill. The home is divided into four streets. Within each street patients have access to communal lounges and dining rooms. Patients also have access to extensive communal gardens.</p> <p>There is a separately registered residential care home which occupies the same site/building; managed by a different registered manager.</p>	

## 2.0 Inspection summary

An unannounced inspection took place on 29 July 2025, from 9.50am to 3.15pm. The inspection was completed by pharmacist inspectors 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 were carried forward for review at the next inspection.

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, improvement was necessary in relation to the management of insulin.

Whilst one new area for improvement was identified, patients were being administered their medicines as prescribed.

The area for improvement in relation to the administration of medicines, identified at the last care inspection, was assessed as met. Details of the inspection findings, including areas for improvement carried forward for review at the next inspection and the new area for improvement identified, can be found in the main body of this report and 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. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

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

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, insulin, warfarin, antibiotics and anaphylaxis 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. (See also section 3.3.2).

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 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 on most

occasions. Staff were reminded that this record should be completed on every occasion and that administration should be recorded on every occasion on medication administration records as well as in the record of controlled drug reconciliation.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

The management of thickening agents was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained. Two personal medication records needed to be updated to reflect the current prescription, this was addressed immediately. The patients were receiving the correct prescribed consistency.

### **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. Management agreed to follow up one medicine that was unavailable and inform the prescriber if necessary.

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. 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 and the storage of controlled drugs.

Mostly satisfactory arrangements were in place for the safe disposal of medicines. However, insulin pen devices were not always labelled with the patient's name and the date of opening and one had not been removed from use immediately, once expired. The manufacturer's instructions on use and storage must be adhered to. An area for improvement was identified.

### **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. A couple of missed signatures were brought to the attention of the manager for ongoing monitoring. Records were filed once completed and were readily retrievable for audit/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.

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. A small amount of expired medicines was removed from stock for disposal.

### **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 incident which had been reported to RQIA since the last inspection was discussed. 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 medicines were being administered as prescribed.

### 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 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. Medicines management policies and procedures were in place.

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

An area for improvement has been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	4*	4*

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

The new area for improvement and details of the Quality Improvement Plan were discussed with Mrs Carmel Blaney, Registered Manager, and the Deputy Manager as part of the inspection process. The timescales for completion commence from the date of inspection.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005</b>	
<p><b>Area for improvement 1</b></p> <p><b>Ref:</b> Regulation 13 (4)</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 29 July 2025</p>	<p>The registered person shall review the management of insulin to ensure that insulin pen devices are labelled with the patient's name and the date of opening and are removed from use immediately, once expired.</p> <p>Ref: 3.3.2</p> <hr/> <p><b>Response by registered person detailing the actions taken:</b> Insulin Pens are now labelled with the residents name and the date of opening upon first use. Expired pens are removed immediately. Compliance will be assured via our robust training and auditing systems.</p>
<p><b>Area for improvement 2</b></p> <p><b>Ref:</b> Regulation 21 (1) (b) Schedule 2</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 10 June 2025</p>	<p>The registered person shall ensure that all pre-employment checks are completed before any staff commence working in the home and evidence retained of managerial oversight of all such records.</p> <hr/> <p><b>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.</b></p> <p>Ref: 2.0</p>
<p><b>Area for improvement 3</b></p> <p><b>Ref:</b> Regulation 14 (2) (a) (c)</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 10 June 2025</p>	<p>The registered person shall ensure that all areas of the home to which patients have access are free from hazards to their safety.</p> <hr/> <p><b>Action required to ensure compliance with this regulation was however not fully reviewed as part of this inspection and this is carried forward to the next inspection.</b></p> <p>Ref: 2.0</p>
<p><b>Area for improvement 4</b></p> <p><b>Ref:</b> Regulation 10 (1)</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 10 June 2025</p>	<p>The registered person shall ensure that there is a robust system of governance in place, that it is effective and proactive in identifying shortfalls and driving improvements through clear action planning.</p> <hr/> <p><b>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.</b></p> <p>Ref: 2.0</p>

<b>Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022</b>	
<b>Area for improvement 1</b> <b>Ref:</b> Standard 4 <b>Stated:</b> First time <b>To be completed by:</b> 10 June 2025	The registered person shall ensure that accurate records are maintained for all patients who are on a modified diet.
	<b>Action required to ensure compliance with this standard was not fully reviewed as part of this inspection and this is carried forward to the next inspection.</b>  Ref: 2.0
<b>Area for improvement 2</b> <b>Ref:</b> Standard 37.4 <b>Stated:</b> First time <b>To be completed by:</b> 10 June 2025	The registered person shall ensure that patients' fluid intake over a 24-hour period is reviewed by a registered nurse where appropriate and accurate records are maintained.
	<b>Action required to ensure compliance with this standard was not fully reviewed as part of this inspection and this is carried forward to the next inspection.</b>  Ref: 2.0
<b>Area for improvement 3</b> <b>Ref:</b> Standard 21.1 <b>Stated:</b> First time <b>To be completed by:</b> 10 June 2025	The registered person shall ensure that patients receiving wound care have an individualised care plan for each wound.
	<b>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.</b>  Ref: 2.0
<b>Area for improvement 4</b> <b>Ref:</b> Standard 46 <b>Stated:</b> First time <b>To be completed by:</b> 10 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 and storage of patient equipment.  <b>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.</b>  Ref: 2.0

*\*Please ensure this document is completed in full and returned via the Web Portal\**



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