

Inspection Report

Name of Service: Oak Tree Manor Nursing Home

Provider: Healthcare Ireland (Belfast) Limited

Date of Inspection: 21 April 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:	Healthcare Ireland (Belfast) Limited
Responsible Individual:	Ms Amanda Mitchell
Registered Manager:	Miss Veronica Sousa
Service Profile: Oak Tree Manor Nursing Home is a nursing home registered to provide nursing care for up to 25 patients living with dementia. The home is situated on the first floor of the building. This home shares the same building as Oak Tree Manor Residential Home. The registered manager is responsible for both services.	

2.0 Inspection summary

An unannounced inspection took place on 21 April 2026, from 10.30am to 3.10pm. 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. The inspection also reviewed the area for improvement identified at the last medicines management inspection. The areas for improvement identified at the last care inspection 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, improvements were necessary in relation to the management of obsolete personal medication records, the management of warfarin and facilitating a clear audit trail for medicines administered 'when required'.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, patients were being administered their medicines as prescribed.

The area for improvement identified at the last medicines management inspection, in relation to records of medicines administered for distressed reactions, was assessed as met. Three new areas for improvement were identified. Details, including new areas for improvement identified and areas for improvement carried forward for review at the next inspection, 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.

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 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.

Obsolete personal medication records had not always been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly. An area for improvement was identified.

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 that 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 distressed reactions, pain, thickening agents and warfarin was reviewed.

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.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans were in place and reviewed regularly. One care plan needed to be updated to reflect the current prescription, it was agreed this would be completed following the inspection.

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 which included the recommended consistency level were maintained.

The management of warfarin was reviewed. Warfarin is a high-risk medicine that requires regular blood testing. The dose of warfarin prescribed depends on the blood test result. Blood results and dosage regimes were obtained by telephone, if results are not obtained in writing; they should be confirmed by two nurses in line with the home's own policy. Although warfarin administration records were in place, running balances were not maintained and the date of opening was not always recorded in order to facilitate a clear audit trail and identify discrepancies promptly. An area for improvement was identified.

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 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. 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. Records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Controlled drugs are medicines that are subject to strict legal controls and legislation. They commonly include strong painkillers. 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.

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 action plans had been implemented and addressed. The date of opening was recorded on the majority of medicines to facilitate audit and disposal at expiry. However, arrangements in place to audit the management of medicines should be reviewed. The running balance of medicines used on a 'when required' basis, should be recorded in line with the home's own policy and documentation. An area for improvement was identified.

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 reported to RQIA since the last inspection was discussed. There was evidence that the incident 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, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with the nurses on duty and the manager for on-going 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 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.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. 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

Areas for improvement have been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	4*	5*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Veronica Sousa, Registered Manager, and the regional 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 13 (1) (b) Stated: Third time To be completed by: 11 November 2025	The registered person shall ensure that patients who are identified as being at risk of choking are appropriately assisted at mealtimes in keeping with their assessed needs and plan of care.
	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 21 (1) (b) Schedule 2 Stated: Second time To be completed by: 11 November 2025	The registered person shall ensure that checks relating to proof of a person's identity; including a recent photograph, are completed before any staff commence working in the home and evidence retained of managerial oversight of all such records. This includes arrangements for temporary/agency staff employed to work in the home.
	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 10 (1) Stated: Second time To be completed by: 11 November 2025	The registered person shall ensure that there is a robust environmental audit in place, that it is effective and proactive in identifying shortfalls and driving improvements through clear action planning.
	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 19 (2) and 3 (b) Stated: First time To be completed by: 11 November 2025	The registered person shall ensure that patient menu choice records are effectively maintained and are available for inspection at all times.
	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 29 Stated: First time To be completed by: 21 April 2026	The registered person shall ensure that obsolete personal medication records are cancelled and archived promptly. Ref: 3.3.1
	Response by registered person detailing the actions taken: Obsolete personal medication records are cancelled and archived. All nurses have been reminded of their responsibility to ensure this is completed when introducing a new record. This will be monitored by Registered Manager within the internal governance systems and by Senior Management during Reg 29 visits.
Area for improvement 2 Ref: Standard 28 Stated: First time To be completed by: 21 April 2026	The registered person shall review the management of warfarin as detailed in the report. Ref: 3.3.1
	Response by registered person detailing the actions taken: Supervision has been completed with all nurses regarding management of warfarin medication, its administration and recording date of opening the medication and running balance. The receiving of INR results and resulting prescribed daily dosage and administration of warfarin is being completed by 2 staff. The running balance will be recorded on the Warfarin medication administration sheet. The Registered Manager is monitoring compliance within internal governance systems. Senior management will also monitor compliance within Reg 29 visits
Area for improvement 3 Ref: Standard 28 Stated: First time To be completed by: 21 April 2026	The registered person shall ensure review arrangements in place to audit the management of medicines. This is in reference to the audit of medicines used on a 'when required' basis, in line with the home's own policy. Ref: 3.3.3
	Response by registered person detailing the actions taken: Supervision has been completed with all nurses regarding requirement to record running balance for all "as required" medications after administration including liquid medications. The Registered Manager is monitoring compliance within internal governance systems. Senior Manager will also monitor compliance within Reg 29 visits

Area for improvement 4 Ref: Standard 39.1 Stated: Second time To be completed by: 11 November 2025	The registered person shall ensure that all staff newly appointed, including agency staff, complete a structured orientation and induction programme in a timely manner and that accurate records are retained for inspection. Records should evidence managerial oversight of all staff inductions. 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 5 Ref: Standard 11 Stated: First time To be completed by: 11 November 2025	The registered person shall ensure that a contemporaneous record of activities delivered is retained. Care plan evaluations should evidence oversight of these records by registered nursing 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

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