Inspection Report

13 October 2022

Parkmanor Oaks

Type of service: Nursing Home
Address: 6 Thornhill Road, Dunmurry, Belfast, BT17 9EJ
Telephone number: 028 9030 7700

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: Macklin Group **Responsible Individual:** Mr Brian Macklin	**Registered Manager:** Miss Claire Black **Date registered:** 14 April 2016
Person in charge at the time of inspection: Miss Claire Black	**Number of registered places:** 81 This number includes a maximum of 27 patients in category NH-DE to be accommodated on the first floor. There shall be a maximum of 2 named residents receiving residential care in category RC-I.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia	**Number of patients accommodated in the nursing home on the day of this inspection:** 80
Brief description of the accommodation/how the service operates: Parkmanor Oaks is a registered nursing home which provides nursing care for up to 81 patients. The home is divided into three units over three floors, each with its own living and dining areas.	

2.0 Inspection summary

An unannounced inspection took place on 13 October 2022, from 10.15am to 3.15pm. This was completed by two pharmacist inspectors and focused on medicines management within the home. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

The area for improvement identified at the last care inspection has been carried forward for review at the next care inspection.

Review of medicines management found that medicine records were well maintained and medicines were stored safely and securely. 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, two new areas for improvement were identified in relation to the management of medicines for distressed reactions and the management of medicines for new admissions. Details of the areas for improvement are included in the quality improvement plan.

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

Based on the inspection findings and discussions held, RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the management team.

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

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing 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 previous inspection findings, incidents and correspondence. The inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspectors spoke to staff and management about how they plan, deliver and monitor the management of medicines.

4.0 What people told us about the service

The inspectors met with nursing staff, the deputy manager and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well. 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.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no questionnaires had been received by RQIA.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

Areas for improvement from the last inspection on 28 February 2022		
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 27 **Stated:** First time	The registered person shall repair the damaged/discoloured areas in the shower/toilet rooms on three floors and repair the damage to the identified wall.	**Carried forward to the next inspection**
	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.	

5.2 Inspection findings

5.2.1 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 the GP, the 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 at the inspection were mostly accurate and up to date. Some of the personal medication records reviewed were not signed and checked by a second member of staff when they were written and updated to state that they were accurate. This was discussed with the manager for ongoing monitoring. It was identified that one personal medication record for a patient recently admitted to the home was not accurate and up to date (see section 5.2.4).

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

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 nurses on 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 nurses record the reason for 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 for four patients. Nurses knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain/infection. Directions for use were clearly recorded on the personal medication records; however care plans directing the use of these medicines did not specify the prescribed medication for some of the patients reviewed. The reason for and outcome of each administration was not consistently recorded. An area for improvement was identified.

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 and pain assessments were in place and reviewed regularly.

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 for five patients was reviewed. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside the recommended range.

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

Medicines 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.

The records inspected 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 medicines 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. Medicine refrigerators and controlled drugs cabinets were available for use as needed.

Satisfactory arrangements were in place for the safe disposal of medicines.

5.2.3 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 reviewed were found to have been fully and accurately completed. However, audits completed by the inspectors identified that the medicines administration record for a new admission was inaccurate (see section 5.2.4). The 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 were recorded in the controlled drug record books. 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 plans. Written consent and a care plan were in place when this practice occurred.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out including a monthly management audit which encompassed all aspects of medicines management. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. A small number of minor discrepancies were highlighted to the manager for ongoing close monitoring and review.

5.2.4 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.

The management of medicines for one patient recently admitted to the home from another nursing home was reviewed. An accurate list of prescribed medicines had not been obtained from the GP on admission and it could therefore not be determined if the resident was being administered all of their prescribed medicines. The patient's personal medication record had been completed inaccurately and errors were observed in the handwritten medicine administration records. Robust systems must be in place to ensure any medicines brought into the home by patients are reconciled with the up to date list provided by the GP and any discrepancies are resolved in a timely manner. An area for improvement was identified.

5.2.5 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.

5.2.6 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 they staff are competent in managing medicines and that they are supported.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	1	2*

* The total number of areas for improvement includes one that is carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Claire Black, Registered Manager and Ms Nicola Cork, Deputy 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 (4) **Stated:** First time **To be completed by:** Ongoing from the date of inspection (13 October 2022)	The registered person shall review the management of medicines for patients newly admitted to the home to ensure that an accurate list of medicines is obtained from the prescriber at or prior to admission and that personal medication records and medicines administration records are accurately completed. Ref: 5.2.1, 5.2.3 & 5.2.4
	Response by registered person detailing the actions taken: Admission checklist ammended to include hospital discharge letter or GP list of medications included & checked by staff nurse & management for each admission
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 27 **Stated:** First time **To be completed by:** 31 May 2022	The registered person shall repair the damaged/discoloured areas in the shower/toilet rooms on three floors and repair the damage to the identified wall.
	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: 5.1
Area for improvement 2 **Ref**: Standard 18 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (13 October 2022)	The registered person shall review the management of medicines prescribed for distressed reactions to ensure: • A care plan is in place for all patients prescribed these medicines. • The reason for and outcome of each administration is consistently recorded. • Medicines administration records are accurately completed. Ref: 5.2.1
	Response by registered person detailing the actions taken: Distressed reactions care plans audited. Distressed reactions charts put into medication files for nurses to record reason for administration & outcome each time medication is given

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