The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Parkview House

Provider: Apex Housing Association

Date of Inspection: 10 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:	Apex Housing Association
Responsible Individual:	Ms Sheena McCallion
Registered Manager:	Mrs Marion Davina McAllister
Service Profile: Parkview House is a registered nursing home which provides nursing care for up to 27 patients. Accommodation is on a ground floor level with shared lounge and dining facilities. Patients also have access to an enclosed courtyard garden.	

2.0 Inspection summary

An unannounced inspection took place on 10 July 2025, from 10.35am to 4.15pm. 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 area for improvement identified at the last care inspection was carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. The majority of medicine records and medicine related care plans were well maintained. There were 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 specialist medicines, cleaning of inhaler spacer devices and the medicine administration process.

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.

Details of the inspection findings, including the area for improvement carried forward for review at the next inspection, and new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

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.

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. One personal medication record did not have one prescribed specialist medication listed. This was highlighted to staff for immediate corrective action and on-going vigilance. There was evidence that the medicine 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.

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 records 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. Review of records of administration indicated that these medicines were used infrequently. The manager and staff were reminded that the outcome of each administration should be recorded.

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 had not been updated with the most recent prescribed dose of pain medication. The correct dose was being administered. This was discussed for corrective action and ongoing vigilance.

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. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained and included the recommended consistency level; the consistency level was accurately recorded on all the records.

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 of the recommended range. Two care plans needed the dose of insulin updated and one in-use insulin pen had no date of opening. This was discussed with the manager for immediate corrective action and on-going monitoring.

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.

Up to date regimens detailing the prescribed nutritional supplement and recommended fluid intake were in place. Records of administration of the nutritional supplement and water were maintained. Staff advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

The management of 'red list' (specialist) medicines was reviewed. The medication was not listed on the personal medication record, however administration records indicated that it had been administered as prescribed. A care plan which included details of procedures for monitoring, ordering and administration was not in place. 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 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, 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 audit/review.

It is important that nurses follow safe medication administration processes to ensure that medicines are administered to the right patient at the right time and the appropriate records are maintained. This includes administering medicines to each patient directly from their dispensed supply and signing the record of administration immediately after the medicine has been administered to the specific patient. Failure to follow this process may mean that medicines are administered to the wrong patient in error and records of administration are not accurately maintained. Afternoon medicines were observed being prepared for five patients at the same time and records of administration were signed prior to administration. This practice is unsafe and increases the likelihood of a medication error. Nurses must follow safe processes for the administration of medicines. This was brought to the attention of the nurse and the manager to address urgently. An area for improvement was identified.

A number of spacer devices needed to be cleaned or replaced. In addition, only one of the devices was labelled to denote ownership. This was discussed with the nurses during the inspection who agreed to clean the devices before the next medicine round and label each device to denote ownership. An area for improvement was identified.

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 was in place when this practice occurred however care plans were not in place. This was discussed with the manager and assurance was provided that care plans would be put in place.

Management and staff audited the administration of medicines on a regular basis within the home. The date of opening was recorded on medicines to facilitate audit and disposal at expiry. While regular medicines audits were conducted, review of recently completed audits found that some aspects of medicines management were not included in the audit process. A more robust audit system which covers all aspects of the management of medicines should be implemented. The RQIA inspection tool audit was shared with the manager of the home after the inspection.

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.

There had been no recent admissions/readmissions to the home. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the patient's medicines and this was shared with the GP and community pharmacist.

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, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with 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 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.

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.

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

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

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

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Marion Davina McAllister, Registered 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:** 17 July 2025	The registered person shall review the management of 'red list' medications to ensure that they are listed on the personal medication records and care plans contain sufficient detail to direct care including details of monitoring, ordering and administration. Ref: 3.3.1
	Response by registered person detailing the actions taken: This action has been completed for the one medication currently in use within the home. The relevant care plan has been updated to include all necessary information, including details of the prescribing consultant, administration guidance, and monitoring requirements - ensuring staff are fully informed and supported in delivering safe and effective care. The update has been shared with all staff nurses as part of a training initiative. It will be prioritised within our ongoing medication management improvements, with oversight provided by the Housing and Care Services Manager. Progress will be monitored through monthly Quality Monitoring visits, and any additional training or support will be provided to ensure full compliance.

Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure medicines are prepared immediately prior to their administration for each patient and records of administration signed immediately afterwards. Ref: 3.3.3
To be completed by: 10 July 2025	**Response by registered person detailing the actions taken**: All staff have been reminded that medications must be prepared immediately prior to administration for each individual, and that records of administration must be signed without delay following administration. This practice will be reinforced through ongoing supervision by the senior nurse, Registered Person and the H&CSM through monthly Quality Monitoring visits.

Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 45 **Stated:** First time **To be completed by:** 10 July 2025	The registered person shall ensure inhaler spacer devices are cleaned or replaced in line with current best practice and standards. Ref: 3.3.2
	Response by registered person detailing the actions taken: Staff have been reminded of the requirement to ensure these devices are either cleaned or replaced at appropriate intervals, as outlined in relevant clinical guidance. They have been incorporated into routine cleaning scedule and monitored on a regular basis by the registered person.
Area for improvement 2 **Ref:** Standard 23.4 **Stated:** First time **To be completed by:** 29 June 2025	The registered person shall ensure all nursing and care staff receive training in the management of falls.
	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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