The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Parkmanor Oaks

Provider: Macklin Group

Date of Inspection: 31 March 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:	Macklin Group
Responsible Persons:	Mr Brian Macklin Mrs Mary Macklin
Registered Manager:	Miss Claire Black
Service Profile: Parkmanor Oaks is a nursing home registered to provide 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. The Catney unit on the first floor provides care for patients living with dementia. The Connolly and Clifford units provide general nursing care.	

2.0 Inspection summary

An unannounced inspection took place on 31 March 2025, from 10.00am to 4.10pm. The inspection was completed by two 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. The inspection also reviewed the areas for improvement identified at the last medicines management 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 refrigerator temperatures and the secure storage of medicines.

The areas for improvement in relation to distressed reactions and management of medicines during admission, identified at the last medicines management inspection, were assessed as met. New areas for improvement were identified in relation to refrigerator temperatures and the secure storage of medicines. Details, including the 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 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.

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 distressed reactions, pain, thickening agents and epilepsy were 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.

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. One personal medication record did not detail the dose of insulin to administer. Records evidenced the correct dose of insulin had been administered. This was discussed with the nurse in charge and updated immediately.

The management of warfarin was reviewed. Warfarin is a high risk medicine which requires regular blood testing. The dose of warfarin prescribed depends on the blood test result. Records evidenced warfarin had been administered as prescribed and care plans were in place. Obsolete records had not been cancelled and achieved. 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.

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 advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

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 most 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. One medicine was not available (see section 3.3.4).

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. However, medication trolleys were not secured to the wall and the keys were observed in each trolley. Medicines must be stored securely to prevent unauthorised access. An area for improvement was identified.

Temperatures of medicine storage areas were monitored and recorded to ensure that medicines stored at room temperature were stored appropriately.

Medicines which require cold storage must be stored between 2ºC and 8ºC 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. Review of refrigerator temperatures evidenced temperatures above 8ºC had regularly been recorded. This had not been escalated by staff and no corrective action had been taken. An area for improvement was identified.

Satisfactory arrangements were in place for the storage of controlled drugs.

Satisfactory arrangements were in place for 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. A small number of handwritten medication administration records did not have the month and year recorded. This was discussed with the nurse in charge and rectified immediately. 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. One entry in the controlled drug reconciliation record was missing a second signature. This was discussed with the manager for review and on-going monitoring.

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 and disposal at expiry.

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 the majority of medicines were administered as prescribed. One medication was out of stock, this was discussed with the nurse and assurance was provided that this medication was ordered and would be obtained later that day.

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.

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. The manager was in the process of reassessing competency for all staff. 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 Regulations.

	Regulations	Standards
Total number of Areas for Improvement	4*	1*

* the total number of areas for improvement includes three which were 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, 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:** 31 March 2025 (with immediate effect)	The registered person shall ensure that refrigerator temperatures are appropriately monitored and action taken if the temperature range is outside 2ºC-8ºC. Ref: 3.3.2
	Response by registered person detailing the actions taken: New thermometers got for fridges & temperaatrues monitored & recorded daily.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 31 March 2025 (with immediate effect)	The registered person shall ensure that medicine trolleys are stored securely to prevent unauthorised access. Ref: 3.3.2
	Response by registered person detailing the actions taken: New chains & lock got & all medication trollies secured to wall
Area for improvement 3 **Ref:** Regulation 27 (4) (d) **Stated:** First time **To be completed by:** 31 October 2024	The registered person shall ensure there is a robust system in place of regular periodic maintenance checks of fire doors.
	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 13 (4) (a) **Stated:** First time **To be completed by:** 3 October 2024	The Registered person shall ensure as far as reasonably practical that all parts of the home to which patients have access are free from hazards to their safety. This is in specific reference to the storage of food and fluids.
	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 23 **Stated:** First time **To be completed by:** 31 October 2024	The registered person shall ensure that where a patient has been assessed as requiring repositioning: • The frequency of repositioning recorded within charts is reflective of the recommended frequency within the care plan • Recordings are contemporaneous
	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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