The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Parkanaur College

Provider: Thomas Doran Parkanaur Trust

Date of Inspection: 4 August 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:	Thomas Doran Parkanaur Trust
Responsible Individual:	Ms Maureen Elizabeth Crawford
Registered Manager:	Mr Waldemar Mietlicki

Service Profile
Parkanaur College is a residential care home registered to provide health and social care for up to 24 residents and is located within Parkanaur Manor House. The home is registered to provide care for residents with a range of needs including learning disability, mental health conditions and physical disability.

There are single and shared bedrooms and residents have access to communal lounges, dining room and external gardens.

There is a supported living service within the same building and the registered manager is responsible for both services.

2.0 Inspection summary

An unannounced inspection took place on 4 August 2026, from 10.15am 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.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. However, improvements were necessary in relation to care plans for medicines prescribed for use “when required” for the management of distressed reactions, care plans for the management of insulin, care plans for the management of pain and the management of medicine refrigerator temperatures.

Whilst areas for improvement were identified, there was evidence that residents were being administered their medicines as prescribed.

The area for improvement in relation to obtaining a current medication list on admission for new residents, identified at the last medicines management inspection, was assessed as met. The area for improvement identified at the last care inspection was carried forward for review at the next inspection.

Residents were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the residents well.

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 residents, 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 residents 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 resident 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?

Residents in residential care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times residents' 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.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. 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 to staff for immediate corrective action and ongoing vigilance.

Copies of residents' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

All residents 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 and insulin was reviewed. The audits completed indicated that medicines were administered as prescribed.

Residents 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 resident's distress and if the prescribed medicine is effective for the resident.

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. Staff knew how to recognise a change in a resident'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. However, care plans were not in place. An area for improvement was identified.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required. However, care plans were not in place. An area for improvement was identified.

A care plan was in place for one resident that required insulin to manage their diabetes. There was sufficient detail to direct staff if the resident's blood sugar was outside of the recommended range. However, a care plan was not in place for a second resident that required insulin to manage their diabetes. 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 resident'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 residents 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 resident 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 the storage of controlled drugs and the safe disposal of medicines.

Medicines which require cold storage must be stored between 2°C and 8°C 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. Although current temperatures were satisfactory, minimum temperatures were recorded as outside of the recommended range and had not been escalated for further action. This does not provide evidence that the temperature is maintained within the required range at all times. 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 residents to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. The records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Controlled drugs are medicines 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.

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 residents 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 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.

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 residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents 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	0*	5*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Waldemar Mietlicki, 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 Care Standards for Residential Homes, December 2022	
Area for improvement 1 **Ref:** Standard 6 **Stated:** First time	The registered person shall ensure that care plans are in place to direct care when residents are prescribed medicines “when required” to manage distressed reactions. Ref: 3.3.1
To be completed by: 4 August 2026	**Response by registered person detailing the actions taken:** Care plans have been put in place for all residents prescribed medication on a 'when required' basis for the management of distressed reactions. The care plans provide information to staff on when the medication should be administered, the alternative approaches to try first, and the need to record the reason for and outcome of each administration.
Area for improvement 2 **Ref:** Standard 6 **Stated:** First time	The registered person shall ensure care plans are in place where residents require medicines to manage pain. Ref: 3.31
To be completed by: 4 August 2026	**Response by registered person detailing the actions taken:** Care plans have been put in place for all residents who require medicines to manage pain. Each plan describes how the resident expresses pain and the medication prescribed.
Area for improvement 3 **Ref:** Standard 6 **Stated:** First time	The registered person shall review the management of insulin to ensure that care plans are resident centred and contain the necessary detail to direct the required care. Ref: 3.3.1
To be completed by: 4 August 2026	**Response by registered person detailing the actions taken:** Care plans have been put in place for the identified residents who require insulin. Care plans are resident centred and contain the details that care staff need to provide support and care effectively, including target blood glucose ranges, action to take if readings are outside those ranges, and when to seek medical advice. Information from other professionals e.g the diabetes nurse specialist / GP, has been included.
Area for improvement 4 **Ref:** Standard 32 **Stated:** First time	The registered person shall ensure that medicine refrigerator temperatures are monitored and managed appropriately to maintain temperatures within the recommended range. Ref: 3.3.2

To be completed by: 4 August 2026	**Response by registered person detailing the actions taken:** Medicines refrigerator temperatures (current, minimum and maximum) are recorded daily, which also includes resetting the thermometer. Staff have been briefed on the action to take if a reading is outside the range of 2°C to 8°C, including reporting it to the senior on duty and seeking advice from the pharmacist on the affected medicines. Senior Support Workers check the temperature records, and any out-of-range readings and the action taken are recorded.
Area for improvement 5 **Ref:** Standard 6.6 **Stated:** First time **To be completed by:** 1 March 2026	The registered person shall ensure that the identified residents care plans are fully reflective of their current needs in relation to the level of care and support required to maintain a safe environment. If risks are identified these must be clearly recorded and managed through a robust risk assessment and kept under regular review with multi-disciplinary involvement.
	Action required to ensure compliance this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.

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

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