The Regulation and Quality Improvement Authority

Inspection Report

17 November 2021

Laganvale Care Home

Type of service: Nursing Home
Address: 37 Laganvale Mews, Moira, BT67 0RE
Telephone number: 028 9261 9899

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: Ann's Care Homes Ltd **Responsible Individual:** Mrs Charmaine Hamilton	**Registered Manager:** Miss Edel Treanor **Date registered:** Acting Manager, not registered
Person in charge at the time of inspection: Miss Edel Treanor	**Number of registered places:** 72 The number includes: • a maximum of 36 patients in categories NH-I and NH-PH, and • a maximum of 36 patients in category NH-DE
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:** 51
Brief description of the accommodation/how the service operates: Laganvale Care Home is a registered nursing home which provides nursing care for up to 72 patients. The home is divided in two units. On the ground floor care is provided for patients who are living with dementia. On the first floor general nursing care is provided. Patients have access to communal lounges, dining rooms and garden space.	

2.0 Inspection summary

An unannounced inspection took place on 17 November 2021, between 10.10am and 4.30pm. The inspection was carried out by a pharmacist inspector and focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified since the last care inspection.

Review of medicines management found that patients were administered their medicines as prescribed. There were arrangements for auditing medicines and medicine records were well

maintained. Systems were in place to ensure that staff were trained and competent in medicines management. However, areas for improvement were identified in relation to the management of medicines on admission, record keeping for controlled drugs and thickening agents.

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. To complete the inspection the following were reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector also spoke with staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with three nurses, the deputy manager, the manager and the regional manager.

Staff were warm and friendly and it was evident from discussions that they knew the patients well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The staff members spoken with expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

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 feedback 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?

This is the first medicines management inspection in the home since the change of ownership.

The last inspection in the nursing home was undertaken on 3 November 2021 by a care inspector.

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 3 November 2021</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td>Area for improvement 1

Ref: Regulation 14 (2) (a)

Stated: First time</td><td>The registered person shall ensure that all chemicals are securely stored in accordance with COSHH legislation, to ensure that patients are protected from hazards to their health.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This area for improvement was in relation to canisters of air freshener in a day room.

Canisters of air freshener were not stored in the day room on the day of the inspection. Staff said that they were aware that all chemicals must be securely stored in accordance with COSHH legislation to ensure that patients are protected from hazards to their health.</td></tr>
<tr><th colspan="2">Action required to ensure compliance with Care Standards for Nursing Homes, April 2015</th><th>Validation of compliance summary</th></tr>
<tr><td>Area for improvement 1

Ref: Standard 4.1

Stated: First time</td><td>The registered person shall ensure an initial plan of care based on the pre-admission assessment and referral information is in place within 24 hours of admission.

The care plans should be further developed within five days of admission, reviewed and updated in response to the changing needs of the patient.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>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.</td></tr>
<tr><td>Area for improvement 2

Ref: Standard 4

Stated: First time</td><td>The registered person shall ensure supplementary care records are accurately and contemporaneously maintained to ensure:

• the type of mattress and correct setting is documented correctly on the patients</td><td>Carried forward to the next</td></tr>
</table>

	repositioning booklets • the fluid intake by patients is reconciled daily.	**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 will 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 and hospital appointments. The personal medication records reviewed at the inspection were accurate and up to date. In line with safe practice, a second nurse had verified and signed the personal medication records when they were written and updated to provide a check that they were accurate. Nurses were reminded that the date of writing should be recorded on the personal medication records.

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 and covert administration.

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 the management of distressed reactions was reviewed for two patients. Care plans directing the use of these medicines were available and staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain.

Directions for use were clearly recorded on the personal medication records and records of administration were accurately recorded. These medicines were used infrequently. Staff were aware that the reason for and outcome of all administrations should be recorded to facilitate review of effectiveness but this had not be recorded on all occasions. The manager agreed to discuss this finding with the nurses and to monitor as part of the medicine management audits.

The management of pain was discussed. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Two patients' records were reviewed; each patient had a pain management care plan and regular pain assessments were carried out by the nursing staff.

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 for four patients. Speech and language assessment reports and care plans were available. However, for one patient the care plan had not been updated followed a recent change in their prescription. Records of prescribing were available for three of the patients only and care assistants did not maintain records of administration. The management of thickening agents should be reviewed to ensure:

- care plans are updated in a timely manner
- records of prescribing are maintained
- records of administration by care assistants are maintained

An area for improvement was identified.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral tube. The management of medicines and nutrition via the enteral route was reviewed for one patient. 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. Nurses on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

A small number of patients have their medicines administered in food/drinks to assist administration. This had been authorised by the prescribers and care plans detailing how the patients like to take their medicines were in place.

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 the majority of medicines were available for administration when patients required them (see Section 5.2.4). 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. It was agreed that the storage of eye preparations would be reviewed to ensure that they are stored in accordance with infection prevention and control guidance.

Appropriate arrangements were in place for the 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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. The sample of these records reviewed had been accurately maintained. The records had been filed once completed, and were readily available for audit/review.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. In one of the treatment rooms, nurses were not recording the receipt, administration and disposal of controlled drugs in a bound controlled drug book. This is necessary to provide a clear audit trail. An area for improvement was identified.

Management and staff audited medicine administration on a regular basis within the home. Action plans to address any shortfalls had been implemented and addressed. The audits completed at the inspection indicated that the majority of medicines were administered as prescribed. It was agreed that the areas for improvement identified and discussed at this inspection would be included in the home's audit process.

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 four patients who had been recently admitted to the home was reviewed. The medicines prescribed had been confirmed with the GP practice and/or hospital discharge letters had been received for three of the patients only. Several medicines had been omitted for one patient for two days as they had been unavailable. In addition an error in the administration of one medicine for another patient was observed. The manager was requested to investigate these findings and submit incident report forms to RQIA.

The management of medicines on admission/readmission to the home should be reviewed to ensure that dosage regimes are confirmed in writing and medicines are available for administration. 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.

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 learning shared with staff in order to prevent a recurrence.

The audit system in place helps staff to identify medicine related incidents. The manager advised that the prescriber was aware of the non-administration of medicines detailed in Section 5.2.4 and that the non-reporting to RQIA had been an oversight. An incident report form describing the action taken to prevent a recurrence was received by RQIA following the inspection.

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 staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff.

There was evidence that staff 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.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to the management of medicines.

Although three areas for improvement in relation to medicines management were identified, the audits completed at the inspection indicated that patients were administered their medicines as prescribed.

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

7.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	3	2*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Edel Treanor, Acting 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:** From the date of the inspection	The registered person shall review the management of thickening agents to ensure: • care plans are updated in a timely manner • records of prescribing are maintained • records of administration by care assistants are maintained Ref: 5.2.1
	Response by registered person detailing the actions taken: All records reviewed and a thickening agent record added where applicable. Care plans for infrequent medications for use in distressed reaction situations have been discussed with RN's on recording the reason for administration and the outcome of the medication. This will continue to be monitored by Nurse on Duty and Home Manager.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that records for the receipt, administration and disposal of controlled drugs are maintained in a bound controlled drug record book. Ref: 5.2.3
	Response by registered person detailing the actions taken: A new and appropriate register to record the receipt, administration and disposal of contrrolled drugs was put insitu on the day of inspection.
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall review the management of medicines on admission to ensure that dosage regimes are confirmed in writing and medicines are available for administration. Ref: 5.2.2 & 5.2.4
	Response by registered person detailing the actions taken: All new residents newly admitted to the home will have a discharge summary/GP letter detailing prescribed medication. The Home Manager will ensure that all newly admitted residents are admitted with a minimum of two weeks supply of medication to ensure all medication is available for administation

Action required to ensure compliance with The Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 4.1 **Stated:** First time **To be completed by:** With immediate effect (3 November 2021)	The registered person shall ensure an initial plan of care based on the pre-admission assessment and referral information is in place within 24 hours of admission. The care plans should be further developed within five days of admission, reviewed and updated in response to the changing needs of the patient.
	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.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** With immediate effect (3 November 2021)	The registered person shall ensure supplementary care records are accurately and contemporaneously maintained to ensure: • the type of mattress and correct setting is documented correctly on the patients repositioning booklets • the fluid intake by patients is reconciled daily.
	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.

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