The Regulation and Quality Improvement Authority

Inspection Report

6 February 2024

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: Ann's Care Homes Limited **Responsible Individual:** Mrs Charmaine Hamilton	**Registered Manager:** Ms Mayvelyn Talag **Date registered:** 27 July 2023
Person in charge at the time of inspection: Ms Mayvelyn Talag	**Number of registered places:** 72 This 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:** 69
Brief description of the accommodation/how the service operates: Laganvale Care Home is a nursing home registered to provide nursing care for up to 72 patients. The home is divided into two units over two floors. The unit downstairs provides care for patients living with dementia and the first floor provides general nursing care. Patients have access to communal lounges, dining rooms and a garden space.	

2.0 Inspection summary

An unannounced medicines management inspection took place on 6 February 2024 from 10.00am to 2.30pm. This was completed by two pharmacist inspectors and focused on medicines management. 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.

Four areas for improvement identified at the last care inspection were not examined and will be followed up at the next inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. The majority of medicine records and the 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. One new area for improvement was identified in relation to records and care plans for emergency medicine prescribed for the management of seizures.

Whilst one area for improvement was identified, 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 regarding the management of medicines.

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, staff training and the auditing systems used to ensure the safe management of medicines. Discussions were held 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 inspectors met with three nurses, the deputy manager, the manager and the regional peripatetic manager.

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 for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, one positive response from a staff member 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 3 and 4 October 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	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	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area of improvement was met. See section 5.2.1.	
Area for Improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area of improvement was met. See section 5.2.3.	
Area for Improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area of improvement was met. See section 5.2.4.	

Area for Improvement 4 **Ref:** Regulation 32 (h) **Stated:** First time	The registered person shall review the use of the identified rooms and if necessary submit a variation to registration to RQIA.	**Carried forward to the next inspection**
	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.	
Area for Improvement 5 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that all notifiable events, including accidents and incidents, are reported to RQIA in a timely manner.	**Carried forward to the next inspection**
	Notifications regarding medicines incidents had been reported appropriately, however, action required to ensure compliance with this regulation was not fully reviewed as part of this inspection and this is carried forward to the next inspection.	
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 37.4 **Stated:** First time	The registered person shall ensure that the handover record is routinely reviewed and updated to ensure it is reflective of the patients' current needs.	**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.	
Area for improvement 2 **Ref:** Standard 37 **Stated:** First time	The registered person shall ensure that a clear, time bound management plan for the transferring of records from a paper base to the electronic platform is developed.	**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 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 state 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.

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 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 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 care plans directing the use of these medicines were in place. Nurses knew how to recognise a change in a patient's behaviour and were aware of the factors that this change may be associated with. Nurses were reminded that records should include the reason for and outcome of each administration.

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. 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 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.

Care plans were also in place, for example, when patients required insulin to manage their diabetes; including sufficient detail to direct staff if the patient's blood sugar was too low or too high and when patients were prescribed warfarin. However, for several patients prescribed rescue medicines for seizures, these were not recorded on the personal medication record and a patient specific care plan/epilepsy management plan to direct their use was not in place. An area for improvement was identified.

5.2.2 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.

The records inspected showed that medicines were available for administration when patients required them.

The medicine storage areas were observed to be locked to prevent any unauthorised access when not in use. They were tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicines storage areas was monitored and recorded. Medicine refrigerators and controlled drugs cabinets were available for use as needed. Although current and minimum temperatures were satisfactory, the medicines refrigerator in the downstairs unit was indicating high maximum temperatures that were unexplained. The manager agreed to take further appropriate action immediately.

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 and these were found to have been accurately completed. The records were filed once completed. Nurses were reminded that handwritten medicine administration records should always include the start date, as is the expected practice within the home.

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 plans. Consent was recorded and care plans were in place when this practice occurred.

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

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

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.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

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. 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. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Competency was assessed following induction and then annually. Policies and procedure documents were in place.

6.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with the Care Standards for Nursing Homes, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	2*	3*

* The total number of areas for improvement includes four that have been carried forward for review at the next inspection.

The new area for improvement and details of the Quality Improvement Plan were discussed with Ms Mayvelyn Talag, Registered Manager, as part of the inspection process. The timescale for completion commences 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 32 (h) **Stated:** First time **To be completed by:** Immediate and ongoing (4 October 2023)	The registered person shall review the use of the identified rooms and if necessary submit a variation to registration to RQIA. **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: 5.1
Area for improvement 2 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** Immediate and ongoing (4 October 2023)	The registered person shall ensure that all notifiable events, including accidents and incidents, are reported to RQIA in a timely manner. **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: 5.1
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 37.4 **Stated:** First time **To be completed by:** Immediate and ongoing (4 October 2023)	The registered person shall ensure that the handover record is routinely reviewed and updated to ensure it is reflective of the patients' current needs. **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 37 **Stated:** First time **To be completed by:** Immediate and ongoing (4 October 2023)	The registered person shall ensure that a clear, time bound management plan for the transferring of records from a paper base to the electronic platform is developed. **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 3 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 13 February 2024	The registered person shall ensure that when patients are prescribed rescue medicines for seizures, these are recorded on the personal medication record and a patient specific care plan/epilepsy management plan to direct their use is in place. Ref: 5.2.1
	Response by registered person detailing the actions taken: Residents who have been prescribed rescue medication for seizures are now recorded on their prescription sheets, medication administration sheets and an individual care plan is in place. This will be reviewed with their respective GPs when necessary and records and care plans updated accordingly.

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

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care