Inspection Report

20 & 25 October 2022

Louisville

Type of service: Nursing Home (NH)
Address: Glen Road, Belfast, BT11 8BU
Telephone number: 028 9061 2018

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: Mr Barry Murphy **Responsible Individual:** Mr Barry Murphy	**Registered Manager:** Mrs Geetha Rajappan **Date registered:** 5 August 2015
Person in charge at the time of inspection: Mrs Geetha Rajappan	**Number of registered places:** 48
Categories of care: Nursing Home (NH) PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years TI – Terminally ill I – Old age not falling within any other category.	**Number of patients accommodated in the nursing home on the day of this inspection:** 41 – 20 October 2022 41 – 25 October 2022
Brief description of the accommodation/how the service operates: Louisville is a registered Nursing Home which provides nursing care for up to 48 patients. Communal lounges and a dining room are located on the ground floor with patients bedrooms located on the ground and first floors.	

2.0 Inspection summary

An unannounced inspection took place on 20 October 2022 from 9.30am to 5.00pm and 25 October 2022 from 10.20am to 3.40pm. The inspection was completed by care and pharmacy inspectors.

The inspection focused on care delivery and medicines management. The inspection assessed progress with the areas for improvement identified in the home since the last care inspection to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The first day of the inspection focused on care provision to patients and managerial oversight of the day to day operation of the home. Areas for improvement are detailed in Section 6.0 in the Quality Improvement Plan.

The second day focused on medicines management. Review of medicines management found that patients were being administered their medicines as prescribed. There were arrangements

for auditing medicines and medicine records were well maintained. Arrangements were in place to ensure that staff were trained and competent in medicines management. One area for improvement in relation to care planning and record keeping for distressed reactions 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 in relation to care and medicines management.

The findings of this report will provide the management with the necessary information to further enhance the quality of care and services in Louisville.

RQIA would like to thank the patients, staff and management 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 the home was 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 the care aspect of the inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, and a range of information about the service was reviewed to help us plan the inspection.

To prepare for the medicines management aspect of the 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 spoke with staff and management about how they plan, deliver and monitor the management of medicines in the home.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

A poster was provided to the manager detailing how staff could provide their views and opinions by completing an online questionnaire. Questionnaire leaflets were also provided, to allow patients and those who visit them, the opportunity to provide feedback after the inspection with their views of the home.

The daily life within the home was observed and how staff went about their work. A range of documents and records were examined to determine that effective systems were in place to manage the home.

4.0 What people told us about the service

During the inspection the inspectors met with eleven patients, nine staff and members of the management team.

Patients spoke positively about the care that they received. Patients told us that they felt well cared for and that staff were very helpful and kind. One patient said, “couldn’t be better”, whilst another said “I’m very happy here”.

Discussions with staff confirmed that they felt positive about their roles and duties, the provision of care, staffing, teamwork, and managerial support.

As stated in section 3.0, questionnaires and a poster with a link to an online survey were left with the management, to allow patients, relatives, visitors and staff unable to meet with the inspector the opportunity to provide feedback on the home. No questionnaires were returned and no feedback was received from the staff online survey.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 22 July 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 rowspan="2">Area for Improvement 1

Ref: Regulation 19 (1)(a) Schedule 3 (2)

Stated: First time</td><td>The responsible person shall ensure that a system is in place which ensures a recent photograph of the patient is included in patient care records as required.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was evidence that this area for improvement was met.</td></tr>
</table>

Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time	The responsible person shall make suitable arrangements to minimise the risk of infection. This is in relation to; soap and paper towel dispensers, a door handle, two bed mattresses, bathroom bins, the floor mount for an assisted bath, bedroom walls, bed rail bumpers, a room used for smoking and completion of the daily cleaning schedules.	**Met**
	Action taken as confirmed during the inspection: Observation, review of the environment and discussion with the manager confirmed that this area for improvement has been met.	
Area for improvement 3 **Ref:** Regulation 14 (2)(a) **Stated:** First time	The responsible person shall ensure that cleaning chemicals are not left unattended and accessible to patients.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 4.9 **Stated:** First time	The responsible person shall ensure that repositioning charts accurately reflect the delivery of care prescribed in the patient's care plan.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

Area for improvement 2 **Ref:** Standard 44 **Stated:** First time	The responsible person shall ensure that the premises and equipment are well maintained and fit for purpose including an assisted bath, bedside and bathroom cabinets, a bed frame and a number of chairs and sofas.	**Met**
	Action taken as confirmed during the inspection: Observations, review of the environment and discussion with the manager confirmed that this area for improvement has been met. This is further discussed in Section 5.2.3. This area for improvement as stated was met.	
Area for improvement 3 **Ref:** Standard 46.2 **Stated:** First time	The responsible person shall ensure that the home's IPC audit tool is robust in identifying deficits in the home's environment and staff practice.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. A review of a sample of recruitment records evidenced that not all employment gaps had been explored prior to the appointment of staff. This was discussed with the management who readily agreed to review the process; an area for improvement was identified.

Staff confirmed they were provided with an induction programme to support them in the tasks associated with their role and duties. There were systems in place to ensure staff were trained and supported to do their job. Mandatory training was progressing for staff and the manager confirmed that training compliance was kept under review.

Records reviewed and discussion with the manager provided assurances that a system was in place to ensure all relevant staff were registered with the Nursing and Midwifery Council (NMC). There was also a system in place to monitor registration status of care staff with the Northern Ireland Social Care Council (NISCC) to ensure staff were either registered or in the process of registering.

The staff duty rota reflected the staff working in the home on a daily basis and identified the person in charge when the manager was not on duty. On the first day of the inspection, it was identified that staffing levels were below the planned levels due to staff reporting sick at short notice. This was discussed with the manager who confirmed that where possible contingency measures were explored to address deficits.

It was observed that staff responded to the needs of the patients in a timely way. Staff were seen to be responsive to requests for assistance and to treat patients with respect and kindness. The manager informed us that patients' dependencies were reviewed at least monthly to determine required staffing levels.

Patients told us that they were satisfied with the delivery of care, attentiveness and support received from staff; one patient commented "the staff are first class".

5.2.2 Care Delivery and Record Keeping

Staff said they met for a handover at the beginning of each shift to discuss any changes in the needs of the patients.

Staff demonstrated their knowledge of individual patients' needs, preferred daily routines, likes and dislikes, for example, where patients preferred to sit and what they liked to eat. Staff were observed to be skilled in communicating with the patients and to treat them with patience and understanding.

Patients who are less able to mobilise were assisted by staff to mobilise or change their position as required. It was observed that, where required, there were care plans in place to direct care for the prevention of pressure ulcers and pressure relieving equipment was in use as directed.

Falls in the home were monitored on a monthly basis to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to prevent further falls from occurring.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need support with meals; ranging from simple encouragement to full assistance from staff. Lunch was a calm and unhurried experience for the patients. The food served was attractively presented and smelled appetising and a variety of drinks were served with the meal.

Staff attended to patients' dining needs in a caring and compassionate manner and where required, staff engaged with patients' on a one to one basis to assist them with their nutritional needs. Some patients preferred to have their meal in their own room and this was readily accommodated with support provided as required. A menu was displayed to inform patients of the menu choice available.

Staff maintained a record of what patients had to eat and drink, as necessary. Patients spoke positively in relation to the quality of the meals provided.

A review of a sample of care records identified that not all care plans had been reviewed at regular intervals. This was discussed with the management; an area for improvement was identified.

Daily records were kept of how each patient spent their day and the care and support provided by staff. A discussion with the manager confirmed that patient care records were held confidentially and securely.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was observed to be clean, tidy and had no malodours. The communal areas were suitably furnished and pleasantly decorated. Patients' bedrooms were personalised with items important to them reflecting their individuality.

Fire exits were observed to be clear of obstruction and where inappropriate storage was observed, for example manual handling equipment and a carpet roll in an identified communal area; the manager agreed to review the storage arrangements. Following the inspection confirmation was received that the identified communal area no longer contained any inappropriate storage.

An area for improvement identified at the previous care inspection concerning maintainence of premises and equipment was reviewed; significant improvements were noted with the remaining outstanding areas, for example repair of an identified bathroom cabinet, confirmed by the manager as actioned following the inspection.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of personal protective equipment (PPE) had been provided. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance.

5.2.4 Quality of Life for Patients

Discussion with staff confirmed that patients were able to choose how they spent their day. Staff members were observed to offer patients choices throughout the day, and took time to chat to patients as they were going about the daily routine. Discussion with staff confirmed that regular activities were provided for patients, for example they included music and arts and crafts. The weekly activity schedule was located in a central part of the home with selected activities themed for Halloween. It was also observed that the home was decorated for Halloween; one patient commented how much they liked the decorations.

Patients spoken with did not raise any concerns about the daily routine. Patients said that they felt staff listened to them and took time to chat and enquire how they were.

Staff recognised the importance of maintaining good communication with families, and visiting arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Geetha Rajappan has been the manager in this home since the 5 August 2015.

Staff commented positively about the manager and described her as supportive and always available for guidance.

Discussion with the manager and a review of records, evidenced that a system of auditing was in place to monitor the quality of care and other services provided to patients.

Each service is required to have a person, known as the adult safeguarding champion; the manager was identified as the appointed safeguarding champion for the home.

It was established that the manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patient's next of kin, their care manager and to RQIA. A review of a sample of the records identified an incident that had not been appropriately notified; this was discussed with management and a retrospective notification was received.

There was a system in place to manage complaints and the manager confirmed that complaints were used as a learning opportunity to improve the quality of services provided by the home.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were reviewed at a subsequent visit. It was noted that the relatives/ representatives had not been provided an opportunity to provide feedback for these reports. This was discussed with the management who readily agreed to review; an area for improvement was identified.

5.2.6 Medicines Management

Personal medication records

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

This is safe practice. Nurses were reminded that when supplementary personal medication records were maintained they should be referenced on the primary personal medication record, for example insulin.

Medicine supply and storage

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.

Records of medicines received into the home must be accurately maintained to provide a clear audit trail to show that medicines have been received into the home in a timely manner, commenced without delay and administered as prescribed.

The records inspected showed that medicines were available for administration when patients required them. Nurses 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. The manager advised that there were plans in place to refurbish the treatment room. Temperatures of the treatment room and medicines refrigerator were monitored and recorded to ensure that medicines were stored appropriately.

A small number of out of date vaccines were removed from the refrigerator for disposal. Inhaler spacer devices were individually labelled to denote ownership. However, some needed to be cleaned or replaced. It was agreed that this would be actioned following the inspection and monitored through the audit process.

Satisfactory arrangements were in place for the safe disposal of medicines.

Medicine administration

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 medicine administration records was reviewed. Records were found to have been accurately completed. The deputy manager advised that the layout of the medication administration records would be reviewed following the inspection to provide more space. Records were filed once completed and were readily retrievable for audit/review.

Management and staff audited medicine administration on a regular basis within the home. The majority of medicines were supplied in a monitored dosage system. Running stock balances were maintained for medicines which were not supplied in the monitored dosage system. The audits completed at the inspection indicated that medicines were administered as prescribed. A small number of minor discrepancies were discussed with the manager for ongoing close monitoring.

Care plans in relation to medicines management

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 manager advised that although prescribed for several patients these medicines were seldom needed. Directions for use were recorded on the personal medication records. However, care plans were not in place. The reason for and outcome of administration had been recorded in the daily care notes on some occasions. Care plans for the management of distressed reactions should be in place. The reason for and outcome of administration should be clearly recorded and easily available for review. An area for improvement was identified.

The management of pain was reviewed. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Detailed care plans were in place.

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. Speech and language assessment reports and care plans were in place. Records of prescribing and administration included the recommended consistency level.

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 their target range.

A small number of patients have their medicines administered covertly. This had been authorised by a multidisciplinary team as being in the patients' best interests. One care plan was not in place. The manager advised that it would be written immediately after the inspection and would include details of how each medicine was administered.

Staff training and competency assessment

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 are supported. Policies and procedures should be up to date and readily available.

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 with staff and at annual appraisal. Medicines management policies and procedures were in place.

Controlled drugs

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. There were satisfactory arrangements in place for the management of controlled drugs.

The management of medicines on admission and medication changes

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 patients new to the home 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 and there was evidence that medicines were administered in accordance with the most recent directions.

Governance and audit

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.

The medicine related incident which had been reported to RQIA since the last inspection was discussed. There was evidence that the incident had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence. The type of incidents that should be reported and reporting responsibilities were discussed with the manager.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	1	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Geetha Rajappan, Registered Manager and members of the management team 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 Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** Immediate and ongoing (20 October 2022)	The registered person shall ensure that during the monthly monitoring visits, feedback from the patients' relatives/representatives is sought on the running of the home. Ref: 5.2.5 **Response by registered person detailing the actions taken:** During the monitoring visits all feedback from patients' relatives/representatives will be documented in the monthly report.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 38 **Stated:** First time **To be completed by:** Immediate and ongoing (20 October 2022)	The registered person shall ensure that any gaps in previous employment records are explored and explanations are recorded. Ref 5.2.1 **Response by registered person detailing the actions taken:** Any gaps from employment will be fully explored and recorded on company interview documentation.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Immediate and ongoing (20 October 2022)	The registered person shall ensure that all care plans are reviewed at regular intervals. Ref: 5.2.2 **Response by registered person detailing the actions taken:** Care plans are reviewed at least on a monthly basis and relevant staff members have been reminded at recent RGN's meeting.

Area for improvement 3 **Ref:** Standard 28 **Stated:** First time **To be completed by:** Immediate and ongoing (25 October 2022)	The registered person shall review the management of distressed reactions as detailed in the report. Care plans should be in place. The reason for and outcome of administration should be recorded. Ref 5.2.6
	Response by registered person detailing the actions taken: All care plans are in place and the reason for and outcome of administration is recorded in the daily evaluations. Further care plan training was provided by the Trust on 1st December '22.

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

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