The Regulation and Quality Improvement Authority

Inspection Report

25 April 2023

Larne Care Centre

Type of service: Nursing Home
Address: 46-48 Coastguard Road, Larne, BT40 1AU
Telephone number: 028 2827 7979

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Electus Healthcare (Larne) Ltd **Responsible Individual:** Mr Ed Coyle	**Registered Manager:** Mr Frank Mudie (Acting)
Person in charge at the time of inspection: Mr Frank Mudie	**Number of registered places:** 87 A maximum of 31 patients in category NH-DE accommodated in the Glenarm Unit. A maximum of 25 patients in categories NH-PH and PH(E) accommodated in the Carnlough and Olderfleet Units. The home is approved to provide nursing care for two named patients in categories NH-LD and LD(E) accommodated in the Carnlough Unit. The home is approved to provide residential care for one named resident in category RC-I accommodated in the Ballygally Unit. The home is also approved to provide care on a day basis to five persons in categories NH- I, PH and PH(E).
Categories of care: Nursing Home (NH) I – Old age not falling within any other category TI – Terminally ill DE – Dementia PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 66
Brief description of the accommodation/how the service operates: Larne Care Centre is a registered nursing home which provides nursing care for up to 87 patients. The home is divided into four units over two floors. The Carnlough and Olderfleet units on the ground floor and first floor provide care for people with learning and physical disabilities. The Ballygally unit on the first floor provides general nursing care and the Glenarm unit which is on the first floor provides care for people living with dementia.	

2.0 Inspection summary

An unannounced inspection took place on 25 April 2023, from 9.55am to 2.25pm. This was completed by two pharmacist inspectors.

The inspection focused on medicines management within the home. 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.

One of the areas for improvement identified at the last care inspection was reviewed. The other three areas for improvement identified at the last care inspection were not reviewed and are carried forward to be followed up at the next care inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were generally 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 area for improvement was identified in relation to the medicines administration records.

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 manager, operations manager and 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, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspectors also spoke to 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 the manager, the operations manager and three nurses.

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.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

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 questionnaires 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 21 & 22 April 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure as far as is reasonably practicable that all parts of the home to which the patients have access are free from hazards to their safety, and unnecessary risks to the health and safety of patients are identified and so far as possible eliminated. This area for improvement is made with specific reference to the safe storage and supervision of food and fluid thickening agents.	**Met**
	Action taken as confirmed during the inspection: Food and fluid thickening agents were safely stored in each unit.	

Area for improvement 2 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the training for staff on IPC measures is embedded into practice. For example, staff can clearly describe the steps for hand hygiene; know when to take opportunities for hand hygiene and the donning and doffing of PPE is carried out as per regional guidelines.	**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.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 35.16 **Stated:** First time	The registered person shall ensure that the annual quality report integrates the views of patients, their relatives and staff into the evaluation and review of the quality of care.	**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 43 **Stated:** First time	The registered person shall ensure that all patients have effective access to the nurse call system or nurse supervision as required.	**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 medical 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.

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 on 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 the management of 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. Records included 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.

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. Nurses advised that they had received training and felt confident to manage medicines and nutrition via the enteral route. Records of the training were available for inspection.

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 too low or too high. Care plans were also in place for the covert administration of medicines and epilepsy management.

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 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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Medicine refrigerators and controlled drugs cabinets were available for use as needed.

In Glenarm unit, one eye-preparation was observed to be in use 19 days after its recommended shelf life once opened. This matter was drawn to the attention of the manager and operations manager for further discussion with the nursing staff.

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. Most of the records were found to have been fully and accurately completed. However, some handwritten entries were not verified and signed by two members of staff. Also the start dates were not written on some handwritten medicines administration record sheets. An area for improvement was identified.

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 mostly satisfactory arrangements in place for the management of controlled drugs. However, in Glenarm unit, there were several occasions on which only one nurse had signed the record of the controlled drugs reconciliation stock check. This observation was discussed with the manager and operations manager who stated that this issue had been discovered during a recent audit and was being followed up.

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. This 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 mostly satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. In most instances, written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. However, for one patient written confirmation of their medicine regime had not been obtained. This matter was drawn to the attention of the manager and operations manager who gave an assurance that it would be discussed with the nursing staff and included in audits. 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 nurses 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 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.

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.

6.0 Quality Improvement Plan/Areas for Improvement

One new area for improvement has been identified where action is required to ensure compliance with the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	1*	3*

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

The new area for improvement and details of the Quality Improvement Plan were discussed with Mr Frank Mudie, Manager, and Ms Angela Dorrian, Operations 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 (7) **Stated:** First time **To be completed by:** 22 May 2022	The registered person shall ensure that the training for staff on IPC measures is embedded into practice. For example, staff can clearly describe the steps for hand hygiene; know when to take opportunities for hand hygiene and the donning and doffing of PPE is carried out as per regional guidelines.
	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, April 2015	
Area for improvement 1 **Ref:** Standard 35.16 **Stated:** First time **To be completed by:** 28 February 2022	The registered person shall ensure that the annual quality report integrates the views of patients, their relatives and staff into the evaluation and review of the quality of care.
	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 43 **Stated:** First time **To be completed by:** 22 May 2022	The registered person shall ensure that all patients have effective access to the nurse call system or nurse supervision as required.
	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:** Immediate action required (25 April 2023)	The registered person shall ensure that handwritten entries on the medicines administration records are verified and signed by two members of staff. Also, the start dates should always be specified on the medicines administration record sheets. Ref: 5.2.3
	Response by registered person detailing the actions taken: A meeting has been held with our pharmacy to ensure that MAR sheets are printed for the monthly medications and that nursing staff do not have to hand write MAR sheets. For occasions where MAR have to be hand written staff have been made aware that the handwriting must be legible, accurate, have a start date and 2 signatures. The manager will be carrying out random checks during the month as well as an audit at the start of each medication cycle to ensure compliance.

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