The Regulation and Quality Improvement Authority

Inspection Report

1 May 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:** Mrs Mayvelyn Talag
Person in charge at the time of inspection: Mrs Mayvelyn Talag	**Number of registered places:** 72 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 Home (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:** 66
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 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 inspection took place on 1 May 2024 from 9.30 am to 5.00 pm by a Care Inspector

Due to an outbreak of infection at the time of the inspection precautionary measures were in place to restrict staff and patient movement, in order to minimise risk of the spread of infection. As a result of this, the inspection focused on the care delivery in the dementia unit.

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

As a result of this inspection, four areas for improvement were met, one area for improvement was carried forward for review at a future inspection and one new area for improvement was identified. Please see the Quality Improvement Plan (QIP) in Section 6 for further details.

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 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.

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

The inspector spoke with a number of staff, patients, and the management team during the inspection.

Patients spoke positively about the care that they received, and patients who were less able to tell us about how they found life in the home were seen to be relaxed in their surroundings.

Discussions with staff confirmed they were 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 provided to allow patients, relatives, visitors and staff unable to meet with the inspector, the opportunity to provide feedback on the home. One questionnaire was returned from a relative that indicated they were generally satisfied with the care provided in Laganvale, and the included comments were shared with the management for review and action as appropriate. There was no feedback received from the staff online survey within the allocated timeframe.

5.0 The inspection

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

Areas for improvement from the last inspection on 6 February 2024		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 2 **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.	**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 (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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 **Ref:** Standard 37	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.	**Met**

Stated: First time	**Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met. This is discussed further in section 5.2.2	
Area for improvement 3 **Ref:** Standard 29 **Stated:** First time	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.	**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.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a system was in place to ensure staff were recruited correctly to protect patients.

The staff duty rota accurately reflected the staff working in the home over a 24-hour period and identified the nurse in charge when the manager was not on duty.

Discussion with the manager confirmed that a system was in place to monitor the dependency levels of patients and ensure the number of staff on duty was regularly reviewed to assist in meeting the needs of patients. Observation during the inspection, evidenced that staff attended to patients' needs in a timely manner; and where patients required support on a 1:1 basis, care staff assisted them with their assessed care needs.

Review of records provided assurances that a system was in place to ensure all nursing 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).

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.

Staff should have the opportunity to attend, at minimum, two supervisions and an appraisal annually to review their roles and enhance their professional development. A review of records and discussion with the manager confirmed that a matrix had been developed and was ongoing.

Staff were seen to attend to patients' needs in a timely manner, and patients' were offered choices throughout the day.

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, and a handover record was available and included detailed meaningful information pertaining to patients' individual needs.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment, care plans were developed to direct staff on how to meet patients' needs. However, care plans for patients who required bespoke 1:1 care lacked personalised details pertaining to the 1:1 care arrangements; this was discussed with the manager for review and action as appropriate; an area for improvement was identified.

The previous inspection had identified an area for improvement pertaining to the management of the transfer of paper records to an electronic platform. This was reviewed and discussion with the manager and review of records evidenced that records were now held on an electronic platform with the exception of some records, for example choking risk assessments and hourly visual checks. The manager confirmed that a decision had been taken to retain these records on paper to ensure they were reflective of the home's policies and procedures.

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.

Management of wound care was examined. Review of a sample of care records confirmed that wound care was provided in keeping with care plan directions.

When a restrictive practice was implemented, such as the use of bedrails, a system was in place to evidence that care plans, risk assessments and consents were reviewed and updated appropriately.

Falls in the home were monitored on a regular basis to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to minimise the risk of further falls from occurring. Care records for patients who experienced a fall evidenced that care plans and risk assessments were reviewed and updated appropriately.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients' needs determine that they may require a range of support with eating and drinking; this may include simple encouragement through to full assistance from staff. Some patients may require their food to be modified and /or may require specific utensils to aid eating and drinking following assessment by the Speech and Language Therapist (SLT).

Staff told us how they were made aware of patients' nutritional needs to ensure they were provided with the right consistency of diet; and where patients preferred to have their meal in their own room, this was readily accommodated with support provided as required. The dining room was not in use during the inspection, as the home had implemented infection control measures to minimise and reduce the spread of infection. Patients were being served their meal in their bedroom or an area of their choice, for example, the dayroom with social distancing measures in place. Observation evidenced that staff attended to patients' dining needs in a caring and compassionate manner.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain, if required, records were kept of what patients had to eat or drink daily.

Daily records were also kept of how each patient spent their day and the care and support provided by staff.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was warm, clean and comfortable. Patients bedrooms were clean, tidy and personalised with items of importance to each patient, such as, family photos and sentimental items from home.

Appropriate precautions and protective measures were in place to manage the risk of infection. 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 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

Observation of life in the home and discussion with staff and patients established that staff engaged well with patients. Staff took time to chat to patients as they were going about the daily routine; they asked patients how they were, if they would like a drink and if they needed anything. The atmosphere throughout the home was warm, welcoming and friendly.

Discussion with staff identified that there was a range of activities provided for patients by activity staff. The activities included, for example, music and arts and crafts. Hairdressing services were also available for those patients who chose to attend.

Patients were observed enjoying listening to music, watching TV and some were observed having their nails painted.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Mayvelyn Talag has been the Registered Manager since November 2022. Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients.

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 patients' next of kin, their care manager and to RQIA.

There was a system in place to manage complaints. Discussion with the manager confirmed that complaints were seen as an opportunity for the team to learn and improve, this is good practice.

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 followed up to ensure that the actions were correctly addressed. These were available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and/or the Care Standards for Nursing Homes (December 2022)

	Regulations	Standards
Total number of Areas for Improvement	1	1*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with the management, 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 16 (1)** **Stated: First time** **To be completed by:** Immediate and ongoing from the date of inspection (1 May 2024)	The registered person shall ensure care plans for patients receiving 1 :1 care are personalised to clearly identify the assessed needs of the patients. Ref: 5.2.2 **Response by registered person detailing the actions taken:** All residents receiving 1:1 care have a personalised plan of care identifing their assessed needs.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **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. **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.**

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

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