

Inspection Report

30 April 2024



Laurelhill House

Type of service: Residential Care Home (RCH)
Address: 1a Ballymacash Park, Lisburn, BT28 3EX
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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

<p>Organisation/Registered Provider: South Eastern Health and Social Care Trust (SEHSCT)</p> <p>Responsible Individual: Ms Roisin Coulter</p>	<p>Registered Manager: Mrs Glynis Ellison</p> <p>Date registered: 22 December 2022</p>
<p>Person in charge at the time of inspection: Ms Nicola McIlwrath, Senior Care Assistant</p>	<p>Number of registered places: 30</p>
<p>Categories of care: Residential Care (RC): DE – dementia</p>	<p>Number of residents accommodated in the residential care home on the day of this inspection: 28</p>
<p>Brief description of the accommodation/how the service operates: Laurelhill House is a residential care home registered to provide health and social care for up to 28 residents living with dementia.</p>	

2.0 Inspection summary

An unannounced inspection took place on 30 April 2024, from 10.15am to 2.35pm. This was completed by a pharmacist inspector and 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.

The areas for improvement identified at the last care inspection will be followed up at the next care inspection.

As a result of this inspection one new area for improvement was identified regarding the management of distressed reactions; this is detailed in the quality improvement plan.

Whilst an area for improvement was identified, RQIA can conclude that overall, the residents were being administered their medicines as prescribed. 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.

RQIA would like to thank the residents 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. Discussions took place 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 the senior care assistant, one care assistant and the administrative assistant. Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs.

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

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, one questionnaire with positive responses regarding the management of medicines, 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 14 June 2023		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 19 (2) Schedule 4 (6) Stated: Second time	The registered person shall ensure that a system is put in place to provide assurances that staffs' pre-employment checks have been completed and evidence of safe recruitment is maintained on-site and available for inspection.	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 Residential Care Homes Minimum Standards, December 2022		Validation of compliance
Area for improvement 1 Ref: Standard 23.3 Stated: First time	The registered person shall ensure that staff complete their mandatory training requirements.	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 25.6 Stated: First time	The registered person shall ensure the duty rota is reflective of all staff working over a 24-hour period to include: <ul style="list-style-type: none"> • Full name of the staff member • The capacity in which they worked • The person in charge of the home in the absence of the manager 	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 3 Ref: Standard 25.5 Stated: First time	The registered person shall ensure that the registered manager has access to the necessary records to provide them with oversight and management of support services staff. <p>These records should include but are not limited to staff rotas, recruitment records, induction and training records.</p>	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 4 Ref: Standard 27 Stated: First time	The registered person shall ensure that repairs are completed to the paintwork, handrails, skirting boards and furniture in the identified unit.	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 5 Ref: Standard 20.10 Stated: First time	The registered person shall ensure audits are consistently completed and documented to outline deficits and actions taken.	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?

Residents in care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times the residents' 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.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. 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 residents' 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 good practice.

Residents 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 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 staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the resident's distress and if the prescribed medicine is effective for the resident.

The management of medicines prescribed on a "when required" basis for distressed reactions was reviewed. Directions for use were recorded on the personal medication records; however, patient specific care plans directing the use of these medicines were not in place for all patients prescribed these medicines. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain and other factors. However, the reason for and outcome of each administration were not always recorded. An area for improvement was identified.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required. Care plans were in place and reviewed regularly.

Some residents 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 resident 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 resident.

The management of thickening agents and nutritional supplements were reviewed. Records of prescribing and administration which included the recommended consistency level were maintained. A speech and language assessment report was in place and the manager agreed to update one care plan to include the recent addition of a prescribed thickener.

A care plan was in place when a resident required insulin to manage their diabetes.

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 resident'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 residents required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

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 residents to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. Records were found to have been accurately completed. The records were filed once completed and were readily retrievable for audit/review.

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.

Management audited medicine administration on a regular basis within the home. The date of opening was recorded on the majority of medicines so that they could be easily audited; staff were reminded that it should be recorded on all medicines.

Several residents have their medicines administered in food/drinks to assist administration: care plans detailing how the residents like to take their medicines were in place.

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 residents or residents returning from hospital. Written confirmation of the resident'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 learning shared with staff in order to prevent a recurrence. The audits completed at the inspection indicated that the large majority of medicines were being administered as prescribed. A discrepancy was identified for one inhaler preparation; this was highlighted for monitoring.

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 residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and they are supported. Policies and procedures should be up to date and readily available for staff.

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. Medicines management policies and procedures were in place.

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 Residential Care Homes Minimum Standards, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	1*	6*

* The total number of areas for improvement includes six 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 Ms Nicola McIlwrath, Senior Care Assistant, 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 Residential Care Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 19 (2) Schedule 4 (6) Stated: Second time To be completed by: Immediately and ongoing (14 June 2023)	<p>The registered person shall ensure that a system is put in place to provide assurances that staffs' pre-employment checks have been completed and evidence of safe recruitment is maintained on-site and available for inspection.</p> <hr/> <p>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.</p> <p>Ref: 5.1</p>
Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022	
Area for improvement 1 Ref: Standard 23.3 Stated: First time To be completed by: Immediately and ongoing (14 June 2023)	<p>The registered person shall ensure that staff complete their mandatory training requirements.</p> <hr/> <p>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.</p> <p>Ref: 5.1</p>
Area for improvement 2 Ref: Standard 25.6 Stated: First time To be completed by: Immediately and ongoing (14 June 2023)	<p>The registered person shall ensure the duty rota is reflective of all staff working over a 24-hour period to include:</p> <ul style="list-style-type: none"> • Full name of the staff member • The capacity in which they worked • The person in charge of the home in the absence of the manager <hr/> <p>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.</p> <p>Ref: 5.1</p>

<p>Area for improvement 3</p> <p>Ref: Standard 25.5</p> <p>Stated: First time</p> <p>To be completed by: Immediately and ongoing (14 June 2023)</p>	<p>The registered person shall ensure that the registered manager has access to the necessary records to provide them with oversight and management of support services staff.</p> <p>These records should include but are not limited to staff rotas, recruitment records, induction and training records.</p> <hr/> <p>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.</p> <p>Ref: 5.1</p>
<p>Area for improvement 4</p> <p>Ref: Standard 27</p> <p>Stated: First time</p> <p>To be completed by: Immediately and ongoing (14 June 2023)</p>	<p>The registered person shall ensure that repairs are completed to the paintwork, handrails, skirting boards and furniture in the identified unit.</p> <hr/> <p>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.</p> <p>Ref: 5.1</p>
<p>Area for improvement 5</p> <p>Ref: Standard 20.10</p> <p>Stated: First time</p> <p>To be completed by: Immediately and ongoing (14 June 2023)</p>	<p>The registered person shall ensure audits are consistently completed and documented to outline deficits and actions taken.</p> <hr/> <p>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.</p> <p>Ref: 5.1</p>
<p>Area for improvement 6</p> <p>Ref: Standard 6</p> <p>Stated: First time</p> <p>To be completed by: Immediately and ongoing (30 April 2024)</p>	<p>The registered person shall review the management of medicines prescribed for distressed reactions to ensure that a patient specific care plan is in place and that the reason for and outcome of each administration is recorded.</p> <p>Ref: 5.2.1</p> <hr/> <p>Response by registered person detailing the actions taken:</p> <p>A patient specific Care Plan is now in place for all residents who are prescribed medication for distressed reactions. The reason for administration of the medication and the outcome of each administration will be recorded. A monthly Audit will be completed by the registered Manager to ensure compliance.</p>

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