



The Regulation and
Quality Improvement
Authority

Inspection Report

Name of Service: Laganvale Care Home
Provider: Ann's Care Homes
Date of Inspection: 6 November 2025

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:	Ann's Care Homes
Responsible Individual:	Mrs Charmaine Hamilton
Registered Manager:	Mrs Clare McBride
Service Profile: Laganvale Care Home is a nursing home which is registered to provide nursing care for up to 72 patients. The home is divided into two units and care is provided over two floors. The unit on the ground floor 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 6 November 2025, from 10.00am to 4.30pm. The inspection was completed by two pharmacist inspectors and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The inspection also reviewed the area for improvement identified at the last medicines management inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records 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. However, improvements were necessary in relation to management of medicines for distressed reactions, cold storage and expired medicines.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, patients were being administered their medicines as prescribed.

The area for improvement in relation to medicines for the management of epilepsy, identified at the last medicines management inspection, was assessed as met. The area for improvement identified at the last care inspection was carried forward for review at the next inspection. Details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients well.

RQIA would like to thank the staff for their assistance throughout the inspection.

3.0 The inspection

3.1 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 against the regulations and standards, 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

3.2 What people told us about the service and their quality of life

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. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each patient liked to take their medicines and medicines were administered in accordance with individual patient preference. Staff also said that they prioritised patients who required pain relief and time-critical medicines during each medicine round.

RQIA did not receive any completed questionnaires or responses to the staff survey following the inspection.

3.3 Inspection findings

3.3.1 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 a GP, a 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 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 confirm that they were accurate. A small number of minor discrepancies were highlighted for immediate corrective action and on-going vigilance.

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.

The management of pain, thickening agents, insulin, warfarin and epilepsy were reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed.

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 staff 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 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. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. However, one personal medication record did not reflect the most recent prescribed dose. Frequent administration had not been referred to the prescriber for review. In addition, records of administration did not

include the reason for and outcome of each administration. An area for improvement was identified.

3.3.2 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.

Records reviewed showed that medicines were available for administration when patients 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 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. Satisfactory arrangements were in place for the safe disposal of medicines and the storage of controlled drugs.

Medicines which require cold storage must be stored between 2°C and 8°C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. The recorded temperature of the medicine refrigerator in one treatment room was outside the required range on a number of occasions and staff had not taken corrective action. This does not provide evidence that the temperature is maintained within the required range at all times. An area for improvement was identified.

3.3.3 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. The records were found to have been accurately completed. 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 painkillers. 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 plan. Care plans contained sufficient detail to describe how the patient's medicines were administered and appropriate arrangements were in place.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits had been discussed with staff and addressed. The date of opening was recorded on the majority of medicines to facilitate audit and disposal at expiry. One box of expired medicine which was still in use was identified in the medicines trolley. This was highlighted to the nurse in charge for immediate disposal and replacement and an area for improvement was identified.

3.3.4 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 at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

3.3.5 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 the majority of medicines were being administered as prescribed. The audits were discussed in detail with the nurses on duty and the manager for on-going monitoring.

3.3.6 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 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. Medicines management policies and procedures were in place.

Records of staff training in relation to medicines management, epilepsy awareness, and buccal midazolam were available.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

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

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Clare McBride, Registered Manager, and the regional 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 (4) Stated: First time To be completed by: 6 November 2025	<p>The registered person shall ensure that the temperature of medicines refrigerators is maintained between 2°C and 8°C and that corrective action is taken if the temperature is outside of this range.</p> <p>Ref: 3.3.2</p>
	<p>Response by registered person detailing the actions taken: The fridge temperature is recorded daily and staff have been advised where the temperature of the fridge is out of range they must take appropriate action. Staff will record the action taken and report to the manager if the issue continues.</p>
Area for improvement 2 Ref: Regulation 13 (4) Stated: First time To be completed by: 6 November 2025	<p>The registered person shall ensure that robust systems are in place to monitor the expiry dates of medicines to ensure that medicines are not administered after expiry.</p> <p>Ref: 3.3.3</p>
	<p>Response by registered person detailing the actions taken: All medications were rechecked following the inspection to ensure in date. The out of date medication was removed when advised on the day of the inspection. Staff have been reminded that they must check the dates all on PRN medication when it is being carried over to the next cycle.</p>
Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 1 Ref: Standard 18 Stated: First time To be completed by: 6 November 2025	<p>The registered person shall review the management of medicines prescribed to manage distressed reactions, to ensure safe systems are in place as detailed in the report.</p> <p>Ref: 3.3.1</p>
	<p>Response by registered person detailing the actions taken: The medication was checked against the prescription from the GP when identified. The care plan, MARS and PMR are all now corresponding. Staff have been reminded to ensure all changes are reflected correctly.</p>

<p>Area for improvement 2</p> <p>Ref: Standard 40</p> <p>Stated: First time</p> <p>To be completed by: 8 May 2025</p>	<p>The registered person shall ensure staff have recorded individual supervision at least twice a year.</p>
	<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: 2.0</p>



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