

Inspection Report

Name of Service: Larne Care Centre

Provider: Electus Healthcare (Larne) Ltd

Date of Inspection: 14 October 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:	Electus Healthcare (Larne) Ltd
Responsible Individual:	Mr Ed Coyle
Registered Manager:	Miss Joanne Alderdice, not registered
Service Profile: Larne Care Centre is a nursing home registered to provide nursing care for up to 87 patients. The home is divided in 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 ground floor provides care for people living with dementia.	

2.0 Inspection summary

An unannounced inspection took place on 14 October 2025, from 10.00am to 2.30pm. 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 areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Review of medicines management found that satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care plans 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.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, 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. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

No completed questionnaires or responses to the staff survey were received 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.

Copies of patients' prescriptions 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, insulin and epilepsy was 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. Directions for use were clearly recorded on the personal medication record and patient-centred care plans were in place. One care plan needed the prescribed dose updated in line with the most recent prescription; this was addressed during the inspection. 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. Records of each administration were kept. Staff were reminded to ensure the reason for and the outcome of each administration is recorded.

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, which included the recommended consistency level, were maintained. However, a small number of prescribing records reviewed listed the number of scoops rather than the consistency level; this was discussed with staff and the manager for immediate corrective action and on-going vigilance. One personal medication record and administration record was not up to date with the most recent recommended consistency level, although the correct consistency level was being administered. This was updated during the inspection.

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 and additional training had been arranged for new nurses.

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 medicines requiring cold storage, the storage of controlled drugs and safe disposal of medicines. One refrigerator lock was broken on the day of inspection, this had already been escalated to management and action was taken to replace the lock during the inspection.

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. Most of the records were found to have been accurately completed. A small number of missed signatures were brought to the attention of the manager for review and ongoing monitoring. 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 mostly satisfactory arrangements in place for the management of controlled drugs. Staff were reminded to consistently include the form of medication on each page and to ensure that reconciliation checks are signed at the time of handover. This was discussed with nurses and the manager for on-going review.

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. Written consent and care plans were in place when this practice occurred.

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 action plans had been implemented and addressed. The date of opening was recorded on medicines to facilitate audit and disposal at expiry.

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.

There had been no recent admissions/readmissions to the home. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the patient's medicines and this was shared with the GP and community pharmacist.

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. However, audit discrepancies were observed in the administration of a small number of medicines. 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 their 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.

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

4.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	3*	10*

* the total number of areas for improvement includes 13, which were carried forward for review at the next inspection.

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Miss Joanne Alderdice, Manager, and other members of the management team, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 12 (1) (a) (b) Stated: First time To be completed by: 17 April 2025	The registered person shall ensure the following in relation to the use of bedrails: • there is a system in place to ensure bedrails are regularly checked and evidence of these checks are retained • care plans and risk assessments include the type of bedrails in use, the safety checks to be completed and the rationale for use
	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: 2.0
Area for improvement 2 Ref: Regulation 27 (4) (c) Stated: First time To be completed by: 16 April 2025	The registered person shall ensure fire exit routes are maintained clear at all times.
	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: 2.0
Area for improvement 3 Ref: Regulation 14 (2) (a) Stated: First time To be completed by: 16 April 2025	The registered person shall ensure as far as reasonably practical that all parts of the home to which patients have access are free from hazards to their safety.
	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: 2.0
Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 1 Ref: Standard 4 Stated: Third time To be completed by: 17 April 2025	The registered person shall ensure that the daily fluid intake of patients is meaningfully and regularly reviewed by nursing staff.
	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: 2.0

Area for improvement 2 Ref: Standard 41 Stated: Second time To be completed by: 17 April 2025	The registered person shall ensure that the staff duty rota is maintained in keeping with legislation and best practice guidance.
	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: 2.0
Area for improvement 3 Ref: Standard 23 Stated: Second time To be completed by: 17 April 2025	The registered person shall ensure that where a patient required repositioning this is completed in accordance with their care plan and reflected within the supplementary recording charts.
	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: 2.0
Area for improvement 4 Ref: Standard 46 Stated: Second time To be completed by: 30 April 2025	The registered person shall ensure all storage areas are kept tidy, free from inappropriate items and that items are not stored on the floor.
	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: 2.0
Area for improvement 5 Ref: Standard 35 Stated: Second time To be completed by: 30 April 2025	The registered person shall ensure that patient weight audits evidence a clear time bound meaningful action plan.
	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: 2.0
Area for improvement 6 Ref: Standard 12 Stated: First time To be completed by: 17 April 2025	The registered person shall ensure that the daily menu reflects the actual food served.
	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: 2.0

Area for improvement 7 Ref: Standard 12 Stated: First time To be completed by: 30 April 2025	The registered person shall ensure the dining experience is reviewed in the Glenarm unit to ensure it meets the needs of the patients. 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: 2.0
Area for improvement 8 Ref: Standard 37 Stated: First time To be completed by: 17 April 2025	The registered person shall ensure that any record in the home which details patient information is securely stored in accordance with the General Data Protection Regulation (GDPR) and the best practice guidance and that records are not accessible to visitors to the home. 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: 2.0
Area for improvement 9 Ref: Standard 4 Stated: First time To be completed by: 23 April 2025	The registered person shall ensure detailed and patient centred care plans are in place for those availing of bespoke one to one 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: 2.0
Area for improvement 10 Ref: Standard 4 Stated: First time To be completed by: 23 April 2025	The registered person shall ensure detailed and patient centred care plans are in place for those patients living with a diagnosis of dementia. 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: 2.0



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