The Regulation and Quality Improvement Authority

Inspection Report

26 September, 3 and 4 October 2023

Towell House

Type of Service: Residential Care Home
Address: 57 Kings Road, Belfast, BT5 7BS
Tel no: 028 9040 1642

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: The Towell Building Trust **Responsible Individual:** Gillian Sarita Brooker	**Registered Manager:** Ms Nicolle Forsythe - not registered
Person in charge at the time of inspection: Mrs Michelle Twist, Training Manager	**Number of registered places:** 90
Categories of care: Residential Care (RC) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment.	**Number of residents accommodated in the residential care home on the day of this inspection:** 86
Brief description of the accommodation/how the service operates: This home is a registered Residential Care Home which provides health and social care for up to 90 residents. The home is divided over three floors. The home has a large garden that residents can access.	

2.0 Inspection summary

An unannounced inspection took place on 29 September 2023 from 10.30am to 2.30pm by two pharmacist inspectors, and on the 3 and 4 October, from 9.45am to 4.45pm by a care inspector.

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

We found that there was safe, effective and compassionate care delivered in the home and the home was well led by the manger/management team.

It was evident that staff were knowledgeable and well trained to deliver safe and effective care.

One new area requiring improvement was identified as a result of the care inspection. Please refer to the Quality Improvement Plan (QIP) for details.

Residents said that living in the home was a good experience. Residents unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

RQIA were assured that the delivery of care and service provided in Towell House was safe, effective, compassionate and that the home was well led. Addressing the areas for improvement will further enhance the quality of care and services in Towell House.

The findings of this report will provide the manager with the necessary information to improve staff practice and the residents' experience.

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, registration information, and any other written or verbal information received from residents, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with residents, 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.

Questionnaires were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Mrs Michelle Twist at the conclusion of the inspection.

4.0 What people told us about the service

Residents commented positively regarding the home and said they felt they were well looked after. A resident told us of how, "The care is excellent, I am well looked after. The food is good and there is plenty of activities." Another resident spoke of how "I feel safe here, there is plenty of choice, and the staff are attentive."

A relative spoke of how," The care is excellent in the home, I could not ask for more."

Staff told us they were happy working in the home, that there was enough staff on duty and felt supported by the Manager and the training provided.

Three questionnaires were returned from relatives following the care inspection, indicating a high degree of satisfaction with the home, and the services provided. No additional feedback was received from residents, or staff following the inspection.

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 13 & 14 December 2022		
Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022) (Version 1:2)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 6.2 **Stated:** First time	The registered person shall ensure that the identified residents care plans contains detail about the settings for their pressure relieving mattresses.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

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

There were systems in place to ensure staff were trained and supported to do their job.

Staff said there was good team work and that they felt well supported in their role, were satisfied with the staffing levels and the level of communication between staff and management.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty.

Staff told us that there was enough staff on duty to meet the needs of the residents.

It was noted that there was enough staff in the home to respond to the needs of the residents in a timely way; and to provide residents with a choice on how they wished to spend their day.

Staff told us that the residents' needs and wishes were very important to them. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

5.2.2 Care Delivery and Record Keeping

Staff were observed to be prompt in recognising residents' needs and any early signs of distress or illness, including those residents who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs.

Staff met at the beginning of each shift to discuss any changes in the needs of the residents. In addition, resident care records were maintained which accurately reflected the needs of the residents. Staff were knowledgeable of individual residents' needs, their daily routine wishes and preferences.

It was observed that staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly.

Examination of records and discussion with staff confirmed that the risk of falling and falls were well managed.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff.

The dining experience was an opportunity of residents to socialise, and the atmosphere was calm, relaxed and unhurried. It was observed that residents were enjoying their meal and their dining experience. Staff had made an effort to ensure residents were comfortable, had a pleasant experience and had a meal that they enjoyed.

There was choice of meals offered, the food was attractively presented and smelled appetising, and portions were generous. There was a variety of drinks available. lunch was a pleasant and unhurried experience for the residents.

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

Residents' 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 residents' needs; and included any advice or recommendations made by other healthcare professionals. Residents care records were held confidentially.

Care records were well maintained, regularly reviewed and updated to ensure they continued to meet the residents' needs. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate.

Residents' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each residents' care needs and what or who was important to them.

Daily records were kept of how each resident spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

Each resident had an annual review of their care, arranged by their care manager or Trust representative. This review should include the resident, the home staff and the resident's next of kin, if appropriate. A record of the meeting, including any actions required, was provided to the home.

5.2.3 Management of the Environment and Infection Prevention and Control

Observation of the home's environment evidenced that the home was clean, tidy and well maintained.

Residents' bedrooms were personalised with items important to the resident. Bedrooms and communal areas were well decorated, suitably furnished, and comfortable. Residents could choose where to sit or where to take their meals and staff were observed supporting residents to make these choices.

Not all resident's bedrooms had a lockable storage space for them to keep valuables in for example. This was discussed with the manager and an area for improvement was identified.

Fire safety measures were in place and well managed to ensure residents, staff and visitors to the home were safe. Staff were aware of their training in these areas and how to respond to any concerns or risks.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases.

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 PPE had been provided.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

5.2.4 Quality of Life for Residents

Discussion with residents confirmed that they were able to choose how they spent their day. For example, residents could have a lie in or stay up late to watch TV.

Residents also told us that they were encouraged to participate in regular resident meetings which provided an opportunity for residents to comment on aspects of the running of the home. For example, planning activities and menu choices.

It was observed that staff offered choices to residents throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

The home creates a newsletter for residents and relatives each month, on events and news happening in the home.

Residents' needs were met through a range of individual and group activities, such as bingo, arts and crafts, bowling and musical activities.

5.2.5 Management and Governance Arrangements

There has been a change in the management of the home since the last inspection. Ms Nicolle Forsythe is the acting manager of the home.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to residents. There was evidence of auditing across various aspects of care and services provided by the home.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

Residents spoken with said that they knew how to report any concerns and said they were confident that the Manager would address these.

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 residents, care practices or the environment.

It was established that the manager had a system in place to monitor accidents and incident that happened in the home. Accidents and incidents were notified, if required, to residents' next of kin, their care manager and to RQIA.

There was a system in place to manage complaints.

Residents and their relatives said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

Staff commented positively about the manager and described her as supportive, approachable and always available for guidance.

The home was visited each month by a representative of the registered provider to consult with residents, 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 are available for review by residents, their representatives, the Trust and RQIA.

5.2.6 Medicines Management

The audits completed at the inspection indicated that the medicines were being administered as prescribed.

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 staff member had checked and signed the personal medication records when they were written and updated to state that they were accurate.

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. The records were found to have been fully and accurately completed.

Care plans were in place residents prescribed medicines for management of pain and distressed reactions. Other appropriate care plans were in place, for example, when insulin was prescribed for the management of diabetes. Advice was provided on ensuring that resident specific detail, including the name of the prescribed medicines, is included in the care plan as necessary.

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.

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 resident could be easily located. Temperatures of medicine storage areas were 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.

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.
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 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.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

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.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Residential Care Homes' Minimum Standards (December 2022) (Version 1:2)**

	Regulations	Standards
Total number of Areas for Improvement	0	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Michelle Twist, Training 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 Residential Care Homes Minimum Standards (December 2022) (Version 1:2)	
Area for improvement 1 **Ref:** Standard E26 **Stated:** First time **To be completed by:** 01 January 2024	The registered person shall ensure that each residents bedroom has a lockable storage space, for use by the resident. Ref: 5.2.3
	Response by registered person detailing the actions taken: Twenty bedrooms had been renovated as part of the refrubishment plan, lockable storage spaces were installed within two days of the inspection.

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

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