The Regulation and Quality Improvement Authority

Inspection Report

2 December 2021

Tullywest Manor

Type of Service: Residential Care Home
Address: 12 Tullywest Road, Saintfield, BT24 7LX
Tel no: 028 9751 1234

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: Tullywest Manor **Responsible Individuals:** Dr. James McKelvey Mrs. Anne McCleery	**Registered Manager:** Mr Philip James McCleery **Date registered:** 30 July 2019
Person in charge at the time of inspection: Mr Philip McCleery	**Number of registered places:** 26
Categories of care: Residential Care (RC): I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of residents accommodated in the residential care home on the day of this inspection:** 22
Brief description of the accommodation/how the service operates: This is a registered residential care home which provides social care for up to 26 persons. Resident bedrooms are located over two floors. Residents have access to a communal lounge, a dining room and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 2 December 2021 from 9.30am to 12.30pm. This inspection was conducted by a pharmacist inspector and focused on medicines management within the home.

The inspection also assessed progress with four of the seven areas for improvement identified at the last care inspection. Following discussion with the aligned care inspector, it was agreed that the remaining three areas for improvement identified at the last care inspection would be followed up at the next care inspection.

Review of medicines management found that residents were being administered their medicines as prescribed. There were robust arrangements for auditing medicines and medicine records were generally well maintained. Arrangements were in place to ensure that staff were

trained and competent in medicines management. One new area for improvement was identified relating to care planning.

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. To complete the inspection a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines were reviewed.

4.0 What people told us about the service

The inspector met with the one member of staff and the manager.

Staff were warm and friendly and it was evident from their interactions that they knew the residents well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The staff member spoken with expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs. They said that the manager was very supportive of staff and readily available to discuss any issues and concerns should they arise.

Feedback methods included a staff poster and paper questionnaires which were provided to the registered 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, no questionnaires 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 last inspection?

Areas for improvement from the last inspection on 18 May 2021		
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 29.1 **Stated:** Second time	The registered person shall ensure that all actions recommended in fire risk assessments are addressed and signed and dated when completed.	**Met**
	Action taken as confirmed during the inspection: The actions recommended in fire risk assessments had been addressed and signed and dated when completed.	
Area for improvement 2 **Ref:** Standard 23.3 **Stated:** First time	The registered person shall ensure that mandatory staff training is brought up to date, specifically fire training and fire drills, COSHH, and MCA / DoLS.	**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 25.6 **Stated:** First time	The registered person shall ensure the staff duty rota shows the following: • the capacity in which staff work in the home • the identity of the person in charge when the manager is not on duty.	**Met**
	Action taken as confirmed during the inspection: The staff rotas had been updated to include the required additional information, as specified above.	

Area for improvement 4 **Ref:** Standard 17.10 **Stated:** First time	The registered person shall ensure that the system for recording complaints is amended to note the following: • full details of any investigation and any action taken • whether the complainant is satisfied with the response • any further signposting needed • the signature and date of completion by the manager.	**Met**
	Action taken as confirmed during the inspection: The system for recording complaints had been amended to include the required additional information, as specified above.	
Area for improvement 5 **Ref:** Standard 21.1 **Stated:** First time	The registered person shall ensure the home's falls policy is updated to include the following: • that care plans and risk assessments are to be reviewed after each fall • the procedure to be followed in the event that a resident has a head injury, including those residents who are prescribed anti-coagulant medications.	**Met**
	Action taken as confirmed during the inspection: The home's falls policy had been updated as required.	
Area for improvement 6 **Ref:** Standard 6.2 **Stated:** First time	The registered person shall ensure the following: • care plans are reviewed to include clear direction for how any actual or suspected head injury is managed • risk assessments are reviewed after any fall	**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 7 **Ref:** Standard 8.2 **Stated:** First time	The registered person shall ensure the following: • post falls observation records are implemented • a post falls assessment is shared with the resident's GP.	**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 medical practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times the residents' needs will 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 and 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 records when they were written and updated to provide a double check that they were accurate.

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 the management of distressed reactions was reviewed for two residents. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour and were aware that this change may be associated with pain. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available in the medicines file. These medicines were seldom used.

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. The records of three residents who were prescribed regular medication for the management of pain were reviewed. For two of the residents a pain management care plan was not in place and for the other resident the medicines prescribed were not specified in the care plan. Whenever a resident is prescribed regular medicines for the management of pain this should be reflected in a care plan. An area for improvement was identified.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines 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 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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Appropriate arrangements were in place for the 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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. The records were found to have been fully and accurately completed. The completed records were filed once completed.

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 are recorded in a controlled drug record book. Satisfactory arrangements were in place for the management of controlled drugs. The controlled drugs record book had been maintained to the required standard.

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.

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.

The management of medicines was reviewed for two residents who had been admitted and for one resident who had a recent hospital stay and was discharged back to this home. Either a hospital discharge letter or a printout provided by the GP practice of the resident's prescribed medicines had been received. The residents' personal medication records and MARs had been accurately written and signed by two members of the care staff. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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.

The audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported.

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

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 that they are supported. Policies and procedures should be up to date and readily available for staff use.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction. A written record was completed for induction and competency assessments. The incorporation of staff medicines management competency reviews into the annual appraisals was discussed with the manager and deputy manager.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led in relation to the management of medicines.

This inspection also assessed progress with four of the seven areas for improvement identified during the last care inspection. The outcome of this inspection concluded that the four areas for improvement had been addressed.

Based on the inspection findings and discussions held RQIA was satisfied that this service is providing safe and effective care with respect to the management of medicines and is being well led by the manager. Whilst one new area for improvement was identified, RQIA was assured that the residents were being administered their medicines as prescribed by their GP.

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

7.0 Quality Improvement Plan/Areas for Improvement

One new area for improvement has been identified were action is required to ensure compliance with the Residential Care Homes Minimum Standards (2021)

	Regulations	Standards
Total number of Areas for Improvement	0	4*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr. Philip McCleery, Registered 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 (2021)	
Area for improvement 1 **Ref:** Standard 23.3 **Stated:** First time **To be completed by:** 30 September 2021	The registered person shall ensure that mandatory staff training is brought up to date, specifically fire training and fire drills, COSHH, and MCA / DoLS. **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: 5.1
Area for improvement 2 **Ref:** Standard 6.2 **Stated:** First time **To be completed by:** 18 May 2021	The registered person shall ensure the following: • care plans are reviewed to include clear direction for how any actual or suspected head injury is managed • risk assessments are reviewed after any fall **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: 5.1
Area for improvement 3 **Ref:** Standard 8.2 **Stated:** First time **To be completed by:** 18 May 2021	The registered person shall ensure the following: • post falls observation records are implemented • a post falls assessment is shared with the resident's GP **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: 5.1

Area for improvement 4 **Ref:** Standard 6 **Stated:** First time	The registered person shall ensure that whenever a resident is prescribed regular medicines for the management of pain this is reflected in a care plan. Ref: 5.2.1
To be completed by: 2 January 2022	**Response by registered person detailing the actions taken:** Any precribed medication for the management of pain is recorded in the appropriate section of the care plan.

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews