The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Tullywest Manor

Provider: Tullywest Manor

Date of Inspection: 28 January 2025 & 4 February 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:	Tullywest Manor
Responsible Persons:	Mrs Anne McCleery Mr James McKelvey
Registered Manager:	Mr Philip James McCleery
Service Profile: Tullywest Manor is a registered residential care home which provides care for up to 26 persons. 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 28 January 2025, from 10.10am to 1.30pm and on 4 February 2025 from 10.45am to 12.30pm. The inspection was completed by a pharmacist inspector and a finance inspector. The inspection focused on medicines management and the management of residents' finances and property within the home.

The inspection was undertaken to evidence how medicines and residents' finances 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 and the management of residents' finances. The inspection also reviewed the area for improvement identified at the last medicines management inspection. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. The majority of medicines were stored securely. Medicine records and medicine related care plans were well maintained. However, improvements were necessary in relation to staff training records, medication storage, out-going medication records, audits and reporting incidents.

Mostly satisfactory arrangements were in place for the safe management of medicines. The majority of records were well maintained and there was evidence that the medicines were administered as prescribed.
However, areas for improvement were identified in relation to the secure storage of medicines, the auditing system, the management of medication incidents, records of the transfer of medicines at discharge and training on the management of dysphagia.

Robust systems were in place for the management of residents' finances.

The area for improvement in relation to care plans for regular pain relief identified at the last medicines management inspection was assessed as met. Details of the inspection findings, including areas for improvement carried forward for review at the next inspection and 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).

Residents were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the residents 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 residents, 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 residents 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 resident 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?

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

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

With one exception, personal medication records were in place for all residents. 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 majority of 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 personal medication record was not in place for one resident; there was evidence that their medicines were administered as prescribed. It was agreed that a personal medication record would be written immediately following the inspection (See Section 3.3 4).

All residents 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 distressed reactions, pain and thickening agents was reviewed.

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 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 clearly recorded on the personal medication records and 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. Medicines for distressed reactions were used infrequently. It was agreed that resident-centred care plans for distressed reactions and reason and outcome sheets would be put in place.
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 was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and administration were maintained; thickening agents were being administered in accordance with the most recent recommendations. Staff were reminded to include the recommended consistency level on personal medication records and administration records. (See Section 3.3.6)

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 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.

Records reviewed 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 trolleys were observed to be securely locked to prevent any unauthorised access, however one medicines storage area were observed to be unlocked, some topical creams were observed on top of the medication trolleys and one medication trolley was not secured to a wall. Medicines must be stored securely to prevent unauthorised access. An area for improvement was identified.

Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Mostly satisfactory arrangements were in place for medicines requiring cold storage. There were a small number of missed entries in the temperature log in the previous four weeks, this was discussed the manager and staff for ongoing monitoring.

Satisfactory arrangements were in place for the storage of controlled drugs and the safe disposal of medicines.

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 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. 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.

Occasionally, residents 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 resident's care plan. One care plan needed to be updated, this was actioned during the inspection.

Staff audited the administration of medicines on a regular basis within the home; however, the audits did not cover all areas of medicines management and had not identified the issues identified at this inspection. The manager should implement a robust audit system which covers all aspects of the management and administration of medicines including those identified at this inspection. Any shortfalls identified should be detailed in an action plan and addressed. An area for improvement was identified.

The date of opening was recorded on medicines to facilitate audit and disposal at expiry. The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed.

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 arrangements were in place to manage medicines at the time of admission or readmission to the home. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the community pharmacy. There was evidence that staff had obtained further supplies of medicines in a timely manner to ensure that the correct medicines were available for administration. A personal medicine record was not in place for one recent admission; it was agreed that this would be addressed immediately after the inspection. See Section 3.3.1.

A review of records for medicines transferred out of the home at discharge indicated that there were no recent records kept of medication discharged with a resident. An area for improvement was identified.

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.

There had been no medicine related incidents reported to RQIA since the last medicines management inspection. A review of the home's medication audits identified that action was not taken when a discrepancy was identified indicating that management and staff were not familiar with the type of incidents that should be reported. A link to the provider guidance in relation to the statutory notification of medication related incidents available on the RQIA website was shared after the inspection. An area for improvement was identified.

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 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 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.

Records of staff training in relation to medicines management were reviewed. Staff had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction; however, no further competency records were available for review. Competency should be assessed regularly. There were no records of dysphagia training available for review. Staff should receive training on the management of dysphagia. An area for improvement was identified.

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

3.3.7 What arrangements are in place for the management of residents' finances?

A safe place was provided within the home for the retention of residents' monies and valuables. There were satisfactory controls around the physical location of the safe place and the members of staff with access to it. A review of a sample of records of residents' monies confirmed that the records were up to date. No valuables were held on behalf of residents at the time of the inspection.

Discussion with the manager confirmed that no bank accounts were used to retain residents' monies and no member of staff was the appointee for any resident, namely a person authorised

by the Department for Communities to receive and manage the social security benefits on behalf of an individual.

Records confirmed that reconciliations (checks) between the monies held on behalf of residents and the records of monies held were undertaken on a regular basis. The records were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.

Three residents' finance files were reviewed; written agreements were retained within all three files. The agreements showed the weekly fee paid by, or on behalf of, the residents. A list of services provided to residents as part of their weekly fee was also included in the agreements. The agreements reviewed were signed by the resident, or their representative, and a representative from the home.

Review of records confirmed that a weekly third party contribution (top up) was paid on behalf of a number of care managed residents. Discussion with the manager confirmed that the third party contribution was not for any additional services provided to residents but the difference between the tariff for the home and the regional rate paid by the health and social care Trusts.

Discussions with the manager confirmed that no resident was paying an additional amount towards their fee over and above the amount agreed with the Trusts.

A sample of records of monies deposited at the home, on behalf of a resident, evidenced that the records were signed by a member of staff and the person depositing the monies.

Discussions with the manager confirmed that it was policy for the home to either pay for services, such as hairdressing and podiatry, in advance and subsequently invoice the residents' representatives for the services provided, or sign monies over to the resident to pay for the services directly.

A review of a sample of invoices issued to residents' representatives showed that the amounts on the invoices reflected the amounts detailed in the records provided by the hairdresser and podiatrist. These records listed the names of the residents availing of the service, the type of service provided and the amount charged to each resident.

The manager informed the inspector that no other transactions were undertaken on behalf of residents. Other items, such as toiletries, were purchased by residents or provided by family members.

A sample of one resident's file evidenced that a property record was in place. The record was updated with additional items brought into the residents' room following admission. There was no recorded evidence to show that the personal possessions were checked at least quarterly. The manager informed the inspector that the system for recording all residents' personal property was under review and provided assurances that a revised system would be implemented by 15 March 2025. This will be reviewed at the next RQIA inspection.

Discussion with the manager confirmed that no transport scheme was in place at the time of the inspection.

No new finance related areas for improvement were identified during the inspection.

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	4*	5*

* the total number of areas for improvement includes four which were 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 Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect (28 January 2025)	The registered person shall ensure that medicines are stored securely to prevent unauthorised access. Ref: 3.3.2
	Response by registered person detailing the actions taken: Downstairs medication trolley is securely fixed to the wall and a keypad lock system is in place on the upstairs store. Medication training completed and staff reminded of importance of keeping medications secure.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect (28 January 2025)	The registered manager shall implement a robust audit system which covers all aspects of the management and administration of medicines including those identified at this inspection. Any shortfalls identified should be detailed in an action plan and addressed. Ref: 3.3.3
	Response by registered person detailing the actions taken: The medications management audit tool has now been implemented as part of our medications audits.
Area for improvement 3 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** With immediate effect (28 January 2025)	The registered person shall ensure that any discrepancies identified in the administration of medicines are fully investigated and reported to the relevant authorities including RQIA. Ref: 3.3.5
	Response by registered person detailing the actions taken: Provider guidance reviewed and the appropriate staff have been made aware of discrepancies / incidents that need reported. This was also reviewed during medicatio training.
Area for improvement 4 **Ref:** Regulation 14 (2)(a)(c) **Stated:** Second time **To be completed by:** 23 April 2023	The registered person shall ensure that substances hazardous to the health of residents, such as toilet cleaner and cleaning chemicals, are safely stored in accordance with COSHH requirements. Domestic stores also need to be kept locked.
	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 Residential Care Home Minimum Standards, December 2022	
Area for improvement 1 **Ref:** Standard 31 **Stated:** First time **To be completed by:** With immediate effect (28 January 2025)	The registered person shall ensure that records of medications transferred out of the home on discharge are maintained. Ref: 3.3.4
	Response by registered person detailing the actions taken: A record of medications transferred out of the home is in place and will be completed as appropriate. Medications transferred out of the home are also recorded on the MARR sheet.
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 28 February 2025	The registered person shall ensure that staff receive training on the management of dysphagia. Records of staff training, including competency assessment should be available for review. Ref: 3.3.6
	Response by registered person detailing the actions taken: Dysphagia has been arranged for 25/04/25, competency will be assessed during and after training..
Area for improvement 3 **Ref:** Standard 19 **Stated:** First time **To be completed by:** 23 April 2024	The registered person shall ensure that staff are recruited in accordance with relevant statutory employment legislation. This is stated in relation to recording a full employment history, and any gaps in employment being explored.
	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 6 **Stated:** First time **To be completed by:** 23 May 2024	The registered person shall ensure that care plans contain a picture of the resident, and are signed by the resident or representative. If the resident or representative is unable to sign, this is recorded.
	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 20.10 **Stated:** First time **To be completed by:** 23 May 2024	The registered person shall ensure that the range of audits in the home is increased to include resident's weights. There is a clear action plan when deficits are identified, indicating actions taken. **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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The Regulation and Quality Improvement Authority

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James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews