

Inspection Report

18 July 2023



The Tilery

Type of service: Nursing Home

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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: The Tilery Responsible Individuals: Mrs Claire Stranney and Mr Stephen Stranney	Registered Manager: Miss Nicola Scovell Date registered: 13 April 2018
Person in charge at the time of inspection: Miss Nicola Scovell	Number of registered places: 40 The home is approved to provide care on a day basis to two persons. There shall be a maximum of one named patient in category NH-LD.
Categories of care: Nursing (NH): I – old age not falling within any other category	Number of patients accommodated in the nursing home on the day of this inspection: 38
Brief description of the accommodation/how the service operates: The Tilery is a nursing home registered to provide nursing care for up to 40 patients. Accommodation is on a ground floor level.	

2.0 Inspection summary

An unannounced inspection took place on 18 July 2023, from 10.15am to 4.10pm. This was completed by a pharmacist inspector. The inspection focused on medicines management within the home. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

RQIA received information on 15 June 2023 which raised concerns in relation to the ordering of medicines in the home. In response to this information RQIA decided to focus the inspection on reviewing the ordering, receipt, administration and disposal records of medicines in particular Schedule 5 controlled drugs.

Review of medicines management found that the majority of medicines were administered as prescribed. Medicine related care plans were well maintained. Staff had received training and had been deemed competent to manage medicines. However, improvements were necessary

in relation to record keeping, the management of controlled drugs and the cold storage of medicines.

Following the inspection, the registered person submitted an action plan detailing how the issues had been /would be addressed. The medication related issues and home's action plan were discussed with the acting senior pharmacist inspector in RQIA. It was decided that the home would be given a period of time to implement the necessary improvements and that a follow up inspection would be undertaken to determine if the necessary improvements had been implemented and sustained.

The areas for improvement identified at the last care inspection have been carried forward and will be followed up at the next care inspection.

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

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. The inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke with management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with the clinical lead nurse, the deputy manager and the manager. Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

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.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any patient 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 the last inspection?

Areas for improvement from the last care inspection on 10 May 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for Improvement 1 Ref: Regulation 27(2)(t) Stated: First time	The registered person shall risk assess all free standing wardrobes in accordance with current safety guidance with subsequent appropriate action.	Carried forward to the next inspection
	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.	
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022		Validation of compliance
Area for Improvement 1 Ref: Standard 11(1) Stated: First time	The registered person shall put a review in place so that there is an adequate and meaningful programme of activities in place to meet patients' needs.	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?

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 the GP, the 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 at the inspection 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 state that they were accurate. However, obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the patient. An area for improvement was identified.

Copies of patients' hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the discharge letter.

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 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 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 records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. The majority of records included the reason for and outcome of each administration. Management gave an assurance that this would be closely monitored.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans and pain assessments were in place and reviewed regularly.

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. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained. One administration record required an update to reflect the most up to date recommended consistency level. Staff agreed to complete this immediately following the inspection.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside the recommended range.

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 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 of medicines ordered, received into the home, administered and disposed of must be accurately maintained in order to provide a clear audit trail and confirm that medicines have been administered as prescribed. A review of these records for two patients showed that the records of receipt and disposal had not been clearly maintained for all medicines. For medicines prescribed at variable dose the actual dose administered was not always recorded. The registered person was requested to investigate apparent discrepancies for two identified medicines (Schedule 5 controlled drugs). The outcome of the investigations, including the action taken to prevent a recurrence was submitted to RQIA on 31 July 2023. The registered person must ensure that records of medicines ordered, received into the home, administered and disposed of are accurately maintained. An area for improvement was identified.

The records inspected showed that the majority of medicines were available for administration when patients required them. Management were reminded to report any out of stock medicines where a patient has missed a dose of their prescribed medicine to RQIA as a medicines incident. See Section 5.2.5. 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 patient could be easily located. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately.

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 current, maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. The current temperature of the medicine refrigerator was within the required range. However, the maximum and minimum temperatures were not recorded. An area for improvement was identified.

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 patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. The majority of records reviewed were found to have been fully and accurately completed. However, as detailed in Section 5.2.2, when a medicine is prescribed at variable dose, the actual dose administered was not always recorded. The 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 in Schedule 2 and Schedule 3; stock balances were checked at each handover of responsibility. However, no additional audits were completed for controlled drugs in Schedule 4 and Schedule 5. Based on the inspection findings, the registered person should review the home's standard operating procedure for controlled drugs to ensure that all controlled drugs are managed safely in the home. An area for improvement was identified.

Management audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on the majority of boxed medicines so that they could be easily audited. This is good practice. The manager had identified that there was inconsistent recording of opening dates on medicines at a previous audit and had been closely monitoring this. The majority of audits completed at the inspection indicated that medicines had been administered as prescribed. It was agreed that the audit process would be further developed to include all areas for improvement identified at this inspection. See also Section 5.2.5

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.

A review of records indicated that mostly satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The majority of medicine records had been accurately completed. See Section 5.2.2.

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. A robust audit system will help staff to identify medicine related incidents.

There has been no medicine related incidents reported to RQIA since the last medicines inspection. Management and staff were familiar with the type of incidents that should be reported. The manager was directed to the guidance issued by RQIA on the notification of medication related incidents and agreed to share this with staff.

With the exception of the two discrepancies detailed in Section 5.2.2, the audits completed at the inspection indicated that 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 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 they 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.

It was agreed that the findings of this inspection would be shared with all staff for ongoing improvement.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	4*	2*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Nicola Scovell, Registered Manager, as part of the inspection process. The findings were also discussed with Mrs Claire Stranney, Registered Person, via telephone call. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 27(2)(t) Stated: First time To be completed by: 10 June 2023	<p>The registered person shall risk assess all free standing wardrobes in accordance with current safety guidance with subsequent appropriate action.</p> <hr/> <p>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.</p> <p>Ref: 5.1</p>
Area for improvement 2 Ref: Regulation 13 (4) Stated: First time To be completed by: With immediate effect 18 July 2023	<p>The registered person must ensure that records of medicines ordered, received into the home, administered and disposed of are accurately maintained.</p> <p>Ref: 5.2.2, 5.2.3 & 5.2.4</p> <hr/> <p>Response by registered person detailing the actions taken:</p> <p>At time of new cycle of drugs arriving, the medications will be signed in by 2 registered staff and any medications that were not ordered or not in a 0 will be recorded at the received box. At the end of the cycle the night staff will ensure the carried forward amounts are accurately tallied up and correspond with the amount in cupboard and trolley to ensure ease of audit. All hand written prescriptions must be checked and counted by 2 staff and the amount recorded to ensure right amount is received</p> <p>A running balance must be recorded at the bottom of every boxed medication and counted after every administration, not just assumed the person before has done it correct. This must be clearly recorded as many are illegible. Again for traceability of drugs.</p> <p>The new pharmacy sheet will be used to record all drugs ordered into the building and will be signed by a member of pharmacy and nurse in charge.</p> <p>All medications which are discontinued, to be denatured ,out of date or changed must be recorded in the pink destruction book reason given. Not just put in the destruction/denature pot</p> <p>All medications given as PRN must have date, time, initial, name of drug ,dose and reason recorded and running balance recorded at back of mar and revisited with the effect time and initial recorded for every time it is administered.</p> <p>On first day of cycle a random drug count for carried forward meds will be conducted and issues in action plan. If there are any trends the staff member will be given supervision and if</p>

	<p>continues disciplinary. Also extra training will be offered to the staff member and support where needed</p> <p>Monthly medication audit will be conducted by manager/deputy monthly and a more in-depth audit which captures more information to be used and monthly at this time a complete audit of prn boxed meds and benzodiazepines will be conducted and any discrepancies reported to the RQIA</p>
<p>Area for improvement 3</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p> <p>To be completed by: With immediate effect 18 July 2023</p>	<p>The registered person shall ensure that medicine refrigerator temperatures are monitored and recorded daily including maximum, minimum and current temperatures and that appropriate action is taken if the recorded temperature is outside the recommended range of 2-8°C.</p> <p>Ref: 5.2.2</p> <p>Response by registered person detailing the actions taken: Temperature monitoring and recording is being conducted daily including maximum, minimum and current temperatures. If any deviations appropriate action taken.</p>
<p>Area for improvement 4</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p> <p>To be completed by: 31 August 2023</p>	<p>The registered person shall review the home's standard operating procedure for the management of controlled drugs to ensure that all controlled drugs are managed safely in the home.</p> <p>Ref: 5.2.3</p> <p>Response by registered person detailing the actions taken: All schedule 2,3,4,& 5 drugs procedures have been reviewed and are maintained in the controlled drug book and managed safely. All control drug in the building are entered into the reconciliation folder and controlled drug book being checked at the beginning and end of shift by 2 staff at all times to ensure no discrepancies in the future. Any discrepancy will be reported in a timely manner to the RQIA. All controlled drugs are being destroyed via denaturing kit, entries made into destruction book by 2 nurses and also update controlled drug book by 2 nurses at all times.</p>

Action required to ensure compliance with the Care Standards for Nursing Homes December 2022	
Area for improvement 1 Ref: Standard 11(1) Stated: First time To be completed by: 10 June 2023	The registered person shall put a review in place so that there is an adequate and meaningful programme of activities in place to meet patients' needs.
	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 29 Stated: First time To be completed by: With immediate effect 18 July 2023	The registered person shall ensure that obsolete personal medication records are cancelled and archived. Ref: 5.2.1
	Response by registered person detailing the actions taken: All personal medication records have been updated for all residents and obsolete have been removed and archived.

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