Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Tinnypark Nursing Home
Name of provider:	Tinnypark Residential Care Limited
Address of centre:	Derdimus, Callan Road, Kilkenny
Type of inspection:	Announced
Date of inspection:	09 May 2019
Centre ID:	OSV-0000707
Fieldwork ID:	MON-0022843

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Tinnypark Nursing Home is located approximately 2.5 miles from Kilkenny City, in a scenic rural setting. The nursing home is a large period house which has been extended to provide suitable accommodation for 47 residents. Bedroom accommodation comprises 39 single and four double rooms. All the bedrooms have full en-suite facilities with accessible showers. There are two dining rooms, and three sitting rooms for residents to use. The foyer is also a favourite place for residents and visitors to congregate. The walled garden to the rear provides a secure environment for leisurely strolls and residents also have free access to a number of enclosed patio seating areas.

Tinnypark nursing home accommodates both female and male residents aged 18 years and over. The service caters for the health and social care needs of residents requiring dementia care, respite care, convalescent care and general care in the range of dependencies low/medium/high and maximum. The service provides full time nursing care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	47

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
09 May 2019	11:30hrs to 20:30hrs	Mary O'Donnell	Lead
10 May 2019	09:45hrs to 15:00hrs	Mary O'Donnell	Lead
10 May 2019	09:45hrs to 15:00hrs	Margo O'Neill	Support

Views of people who use the service

Inspectors spoke with residents and family members and 14 residents completed a satisfaction questionnaire prior to the inspection. Residents felt safe and respected in the centre. Staff were described as 'Busy but lovely.' Residents told inspectors that staff were kind and they provided timely assistance during the day and at night time

Residents were pleased with the personal space available to them in their bedrooms and the additional storage space for their personal possessions. One resident wished for more storage for personal possessions. A relative was very pleased with the support they had to personalise their mother's room, to hang pictures and provide additional shelving for personal items. The food was good and there was a choice offered for all meals. Residents who took their meals in their rooms did so by choice and they were satisfied with the assistance offered. All residents who spoke with inspectors were pleased with the portions offered. Some residents said they would prefer if the supper was served later, they remarked that it was served too soon after their evening meal.

Residents knew the person in charge well. They said she as very approachable and they would not hesitate to raise a concern or to air a compliant with her. Some residents were pleased that their concerns were handled in a dignified manner.

Overall residents were pleased with the activities on offer. They especially enjoyed bingo, Mass and weekly appointments with the hairdresser. Some residents wanted a wider range of activities and a resident who didn't engage in activities in the centre, wished he could go out for a meal. Residents were pleased that they had the opportunity to vote in the local and European elections.

Families told inspectors that they were made to feel welcome when they called. They were supported to take family members out for trips.

Capacity and capability

This was an announces inspection to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centres for older people) Regulations 2013. Prior to this inspection unsolicited information had been received by the Office of the Chief Inspector, concerning insufficient staffing levels, infection control and laundry services. Inspectors found evidence that staffing levels were inadequate, especially in the evenings. Arrangements for identifying residents' clothing required review to ensure that laundry was returned to residents. Infection control practices

were not in line with National Standards for Infection prevention and control in community services (2018).

The governance and management in the centre was weak. The person in charge worked full time in the centre but she was not adequately supported to fulfil her role. The assistant director of nursing worked two days a week was rostered to work as a nurse for one of those days. Systems to monitor the safety and quality of the service were not effective. The annual schedule of audits was not comprehensive and audit reports did not include an action plan to inform continuous quality improvements. Inspectors found the recommendations from audits carried out in 2019 had not been followed up. Positive risk taking was not evident. There were high levels of restrictive practice evident and accidents and incidents were recorded but not analysed for learning purposes.

Although the two company directors were on site regularly, the provider did not have proper oversight of the service. Fortnightly management meetings were held with the provider representative and the person in charge. There was no standing agenda and the meetings were not minuted with clear actions and time lines for completion. The person charge kept a record of the topics discussed and it was evident that key quality indicators or audits were not discussed at management meetings.

The service was not adequately resourced to ensure the service provided was in line with the Statement of Purpose. Staff cuts were implemented in January 2019 and staffing levels were not increased as occupancy levels increased. Reduced staffing impacted on the supervision of residents and their care and welfare. Improvements were required to ensure there were sufficient housekeeping staff to maintain a high standard of cleanliness and to ensure that all staff had received mandatory and refresher training.

Safe recruitment practices were evident. All documents in relation to staff were available and maintained in accordance with schedule 2 of the regulations. All staff and volunteers had Garda vetting disclosures in place. Roles and responsibilities were set out in writing for volunteers who attended the centre. The person in charge assured inspectors that Garda Síochána (police) vetting was in place for all staff.

Regulation 14: Persons in charge

The person in charge is a registered nurse with the required experience in the area of nursing older people and she worked full-time in the centre. She completed a leadership and management programme and took took up the post of person in charge in 2015.

During the inspection she demonstrated her knowledge of the regulations, the standards and her statutory responsibilities. There was ample evidence of ongoing professional development.

The person in charge was very hands on and was observed frequently meeting with residents, visitors and staff throughout the inspection.

Judgment: Compliant

Regulation 15: Staffing

Inspectors were not assured that that the number and skill mix of staff was appropriate, having regard for the needs of residents and the size of the centre. Staffing levels were less than the staffing levels set out in the Statement of Purpose. Staff turnover was high. Records showed that 19 health care staff had left the service in 2018 and information about how many staff were recruited to fill these vacancies was not available when requested. Five health care staff left the service in 2019 and three staff were recruited with a fourth post advertised and there were no plans to recruit for the fifth post. Staff, residents and visitors all commented on the shortage of staff. A management decision was taken to reduce staffing in January 2019 and this impacted on the care and welfare of residents. Monthly falls audit reports were available up to April 2019. The audits showed an increase in the incidents of falls in the first quarter of 2019: January (8), February (11) and March (21). This included six repeat falls for one resident. Supervision of residents was an issue and according to the audit reports, six of the eight falls which occurred in a communal area in quarter one, were unwitnessed. Staff told and inspectors confirmed that the parlour, a favourite room for residents to congregate, was now out of bounds in the evenings because there was no staff available to supervise residents there.

Judgment: Not compliant

Regulation 16: Training and staff development

There were a matrix system to track staff training but oversight was weak and inspectors were not assured that staff had the required competencies to deliver person -centred, effective and safe services to residents. Supervision was not adequate to ensure that learning was implemented in practice.

Staff had access to a suite of online training programmes for mandatory training and other training pertinent to the care of older persons. With few exceptions, there was no face-to-face training, to follow up and ensure that staff achieved their learning objectives or to discuss the practical application of new learning.

There was good oversight to ensure that all staff attended fire safety training in the centre and the majority of staff completed optional online fire safety training.

Inspectors were satisfied that all staff who worked on night duty had completed both online and face to face fire training. All staff had completed both online and face-to-face moving and handling training. All except two staff had completed online safeguarding training and five staff were overdue refresher training. Most of the front line staff completed mandatory training in the management of complex behaviours but only six staff attended follow up face-to-face training. Forty two out of 53 staff had completed online infection prevention and control training. However additional training was required as the practices observed by inspectors and conversations with staff, did not indicate that all staff had a good understanding of infection prevention and control.

Staff appraisals were used to support staff to identify their learning needs. Additional training was provided such as dementia, health and safety and first aid. All nursing staff completed cardiopulmonary resuscitation training in 2019.

Inspectors were not assured that staff supervision was adequate, given that the staffing levels were reduced and staff turnover was high. Many of the long term staff had left and those who remained told inspectors that they had less time now to mentor and supervise new staff. Staff and relatives told inspectors about poor care practices they had witnessed in the centre. For example poor attention to grooming when assisting a resident to dress. Inspectors observed that nurses were not available to supervise health care staff in the mornings. The staff member who was tasked with supervising carers worked 30 hours per week and the assistant director of nursing worked part time. The household manager with responsibility for supervising household staff worked in the laundry full time. Inspectors found that supervision of household staff were inadequate and cleaning arrangements were not in line with best practice.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents was in place, which held the information required by the regulations.

Judgment: Compliant

Regulation 21: Records

Records as set out in Schedules 2,3 and 4 four were kept and made available for inspection. Records were stored securely and accessible.

A random sample of staff files were examined and held all the required information.

The person in charge confirmed that all staff had Garda Vetting on file.

Judgment: Compliant

Regulation 22: Insurance

Evidence was available that insurance was in place.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors were not assured that there was sufficient resources available to ensure care was delivered in accordance with the centre's statement of purpose. Staffing resources had been cut when occupancy was at 89% and had not been increased as occupancy levels reached 100%. There was a management structure in place and the person in charge worked full time. Neither of the company directors was present on the day of inspection. The person in charge told inspectors that one director was on site daily and the provider representative attended the centre on average three days, each week and held fortnightly meetings with the person in charge. There were no formal records of these meetings but the person in charge took notes about topics discussed at a meeting in May and April which did not provide assurances that the provider had oversight of the service.

There was a management structure in place but lines of authority and accountability were not clear. The person in charge was supported by the assistant director of nursing and the care team leader. The person in charge worked full time and the the two other managers worked part-time on opposite shifts. The assistant director of nursing worked two twelve hour shifts each week. She was responsible for auditing the service as well as supervising staff and was rostered to work as a nurse 50% of the time. She also worked extra hours when deputising for the person in charge. The household manager was responsible for supervising household staff and she also worked full time in the laundry. Her role and responsibilities also required review.

Systems to monitor the safety and quality of the service were generally informal and not robust. A resident satisfaction survey provided positive feedback on the service. The person in charge met with individual residents on a daily basis. Evidence from staff, residents and relatives indicated that she was very approachable and took action to address any issues that residents or relatives brought to her attention.

Inspectors found the schedule of audits was not comprehensive. Audit reports did

not have action plans to inform a process of continuous quality improvement and recommendations were not followed up to ensure that they were implemented. The 2019 audit reports were reviewed and management confirmed that none of the recommendations from audits had been followed up. There was no evidence of analysis of accidents and incidents as part of quality improvement processes or to inform learning for staff and management. Inspectors concluded that the systems in place to monitor the service were weak and did not provide assurances that the service was safe, consistent and effectively monitored

The annual review of the quality and safety of care delivered to residents was prepared but there was no evidence that consultation with residents and their families informed the review. Plans were in place to present the annual review at the next residents meeting.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Contracts for the provision of care were in place and outlined the services to be provided, the accommodation and the fees to be charged

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was currently being updated. Minor amendments were required to ensure that conditions of registration were stated, in line with the regulations and that the staffing whole time equivalent was correct.

Judgment: Substantially compliant

Regulation 30: Volunteers

There were some volunteers attending the centre at the time of inspection. They were Garda Vetted and their roles and responsibilities were set out in writing.

Judgment: Compliant

Regulation 31: Notification of incidents

Generally notifications were submitted in line with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was posted in the reception area and also in the Residents' Information Guide. The person in charge is the designated complaints officer for the centre. All verbal and written complaints were logged and records maintained of investigations and the outcome of each complaint, including whether or not the complainant was satisfied. Residents and relatives who spoke with inspectors, expressed their satisfaction with the service and said the person in charge was available to them, if they wished to raise any issue. The policy required updating to identify the person nominated to ensure that all complaints were appropriately responded to.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies and procedures were in place on matters set out in Schedule 5. Policies were reviewed at least three yearly and were available to relevant staff. However there was no system in place to ensure that staff read and understood the policies.

Judgment: Substantially compliant

Quality and safety

The centre was warm and suitably furnished; residents and families told the inspectors they enjoyed the open space and the homely atmosphere.

Residents were offered a choice of GP's who visited the centre and allied health services were available in the centre on a referral basis. Residents with medical cards were supported to access services they are entitled to in the community. Residents were referred to national screening programmes as appropriate and in accordance with their preference. Procedures were in place to

support residents to make informed choices about their future care needs and their wishes for end of life care. Care provided was informed by the wishes of the resident and their families.

Residents were safeguarded by effective procedures in the centre, and their rights were respected. Staff were knowledgeable of the signs of abuse and the reporting procedures in place.

Appropriate assessment and management of residents with responsive behaviours resulted in improved outcomes for residents. Behavioural support care plans guided staff to effectively care for these residents in a person centered way. Residents also had access to mental health services.

Positive risk management was not in evidence. The use of physical restraint was high and risk assessments were not comprehensive for the use of bed rails. Clinical and environmental risks were identified and assessed. The risk management policy and the risk register required review.

Infection control practices were not in line with National Standards for Infection prevention and control in community services (2018).

There were facilities and opportunities for residents to engage in recreational and occupational activities in the centre. The activity coordinators worked six days a week and offered a range of activities, informed by the interests and capabilities of residents. Residents were provided with food and drink to meet their assessed needs and they were complimentary about the meals provided. Residents' religious and civil rights were upheld.

Regulation 11: Visits

Visitors were made welcome in the centre except for protected mealtimes. Inspectors saw visitors attending the centre at various times over the two days. They spoke with several visitors who all confirmed that they were made feel welcome by staff. There were a number of rooms for residents to entertain visitors in private.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were satisfied that they retained control over their belongings and they had sufficient facilities to store their personal possessions and clothing. Residents also had a lockable space in their bedrooms for secure storage.

Residents could have their laundry attended to within the centre. Inspectors visited the laundry which was well organised and appropriately equipped. Measures in place for the return of laundered clothes to residents required improvement. Inspectors saw a large basket of clothes in the laundry that were unlabelled and so could not be returned to the residents. Inspectors randomly checked items of clothing in wardrobes and found that the majority of garments did not have identifiable markings. Improvement was required to ensure that items of underwear were marked discretely.

Judgment: Not compliant

Regulation 13: End of life

Residents were supported to make informed choices regarding their future health needs and end of life care. Their preferred priorities of care could then direct the care provided. Single room accommodation was on offer for end of life care. A resident who was discharged recently had been supported to return home in line with their expressed preference.

Caring for a resident at end of life was regarded by staff as an integral part of the care service provided. The person in charge stated that the centre received support from the local palliative care team if required.

Judgment: Compliant

Regulation 18: Food and nutrition

It was noted at the previous inspection that improvements were required to ensure that residents who took their meals in their bedrooms had necessary assistance and supervision. Inspectors noted that all residents including those who chose to eat in their rooms, were provided with timely assistance at mealtimes.

Inspectors saw that residents who required assistance with eating and drinking took their meals in the dining room. They had one-to-one assistance and mealtimes were an enjoyable experience. Inspectors noted that meals were nicely presented and the choice available was written on the blackboard in the dining room.

The nutrition committee, which included eight residents, identified areas for improvement, including alternative fish dishes and crispy vegetables. Action had been taken to increase the menu options for the evening meal.

Judgment: Compliant

Regulation 20: Information for residents

A residents' guide was in place and contained the information required by the regulations.

Judgment: Compliant

Regulation 26: Risk management

The centre's health and safety statement was up-to-date and equipment was well maintained in the centre. There was a risk management policy in place that included identification for risks specified in regulation 26 (1) (c), however controls to mitigate risks were not identified. The risk register in the centre was examined and it was noted that only environmental risks had been recorded. Adverse incidents were recorded and investigated and falls were audited on a monthly basis.

A missing person drill had been completed in the centre and the record was available on request. Manual handling and restraint risk assessments were carried out to assess residents in the centre. However the restraint assessment for bedrails required review as it did not include assessment for the risk of injury from entrapment or falling from the bed when the rails where in use. Arrangements were in place to evacuate residents to a local community centre in the event of a major incident in the centre. While this arrangement may be suitable as a short-term measure, suitable arrangements for overnight accommodation needed to be considered.

Judgment: Substantially compliant

Regulation 27: Infection control

Inspectors observed that the centre was visibly clean and sinks had been replaced and cleaned since the previous inspection. Hand sanitising dispensers were available throughout the centre. However inspectors found that practices in place were not in line with the National Standards for Infection prevention and control in community services (HIQA 2018).

Annual infection prevention and control training was mandatory and not all staff had completed infection prevention and control training. Staff training records identified that 11 staff had not completed an online learning module in infection control in the

preceding 12 months.

Inspectors observed that staff did not consistently apply standard infection control precautions when providing personal care or during group activities. Not all staff who engaged directly with residents were aware of the number of residents with a healthcare associated infection and therefore increasing the risk of cross infection and potentially impact on the safety of other residents.

Improvements were required in the laundry procedures to ensure best practice with regards to infection control measures; for example washing of bed linen at recommended temperatures and ensuring that laundry bags were washed regularly. A part-time laundry staff member had not completed infection prevention and control training.

Inspectors were not assured that there were adequate household/cleaning staff on duty. The centre was large, with 43 en suite bedrooms and five communal rooms. Some days there was one household staff member working until 17:00hrs and other days two staff worked until 15:00 hrs. Communal toilets were cleaned once a day and the person in charge confirmed to inspectors that there was no schedule for deep cleaning of the centre in place. Environmental cleaning audits were not done but a recent infection control and hygiene audit had been carried out in the centre. There was no evidence that the recommendations in the audit report had been followed up and risks identified in the report were evident on the days of inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors found that precautions against the risk of fire were in place but improvement was required to ensure that all staff completed on-line fire safety training and that fire drill records were comprehensive.

Annual fire safety refresher training was mandatory and all new staff had a briefing on fire safety as part of their induction. According to the training records, 100% of staff attended in-house fire training and 65% of staff had completed additional on-line fire safety training in the previous 12 months. One staff member who was employed for over five months had not completed on line fire safety training and had not attended in house training. Training records showed that all night staff had completed both on-line and in-house fire training.

Fire drills were held regularly and a recent fire drill simulated night time staffing levels, when staffing was at it lowest. The documentation of the fire drill showed the names of staff who participated, the scenario practiced and the time taken to complete the evacuation. The fire drill scenario was the evacuation of a room and

the exercised did not simulate the evacuation of a compartment which would be required in an emergency. Records of fire drills had gaps and did not consistently include the time taken to evacuate a specific room/s or compartment and learning/problems encountered. This information was required to ensure that in the event of a fire, all persons in the designated centre can be safely evacuated.

Staff who spoke with inspectors, were knowledgeable about evacuation procedures and the use of fire safety equipment. Inspectors examined records of daily and weekly fire safety checks. They walked the centre and noted that emergency exits in the centre were not obstructed and emergency lighting was working. There was evidence that fire equipment was serviced annually and emergency lighting, the fire panel and the fire alarm was serviced every three months.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were up-to-date policies and procedures in place in the centre for the prescribing, ordering, storage, administration, review and disposal of medications. There was a secure procedure in place for controlled medication, ensuring it was stored securely, recorded and administered appropriately.

There was a fridge available for medications requiring cool temperatures and a daily temperature check was maintained by staff. All out-of-date medication was returned to the pharmacist for disposal. Regular audits were completed by pharmacy staff at the centre, however feedback to staff required review to maximise learning from these audits.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Residents were assessed prior to admission, to ensure the service could meet the assessed needs of prospective residents. Comprehensive assessments were done upon admission to identify problems and potential problems. Social histories were taken and used to develop a plan to meet the social needs of each resident. Inspectors reviewed a sample of care plans and saw that in general they were person-centred and complete. The care plans were computerised and inspectors could not find consistent evidence that the resident or where appropriate, the relatives, were involved in the review of their care plans.

Inspectors saw that care plans were updated to reflect the recommendations of various members of the multidisciplinary team

Judgment: Substantially compliant

Regulation 6: Health care

Residents could retain the services of their own general practitioner(GP) and they also had access to a GP who visited the centre regularly and out-of-hours medical cover if required. Allied health services were accessible in the centre for example, chiropody, optical, speech and language and dietetic services. Dental services were available in the community. Residents who held a general medical services card were supported to access community services. National screening programmes were accessible and all residents were offered and referred as appropriate.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Some residents had episodes of responsive behaviours (how persons with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The majority of staff had completed on-line training and some staff had attended face to face training to support them to work therapeutically with these residents. Staff assessed behaviours to identify triggers and developed care plans, to guide the staff to provide a consistent approach to care. Inspectors found that staff were familiar with residents and viewed responsive behaviours as a resident trying to communicate an unmet need, such as pain or hunger. The centre was designed to support residents to walk around inside and they also had access to safe outdoor areas. This impacted positively on residents with responsive behaviours.

Inspectors reviewed the use of restraint and found ongoing efforts were required to reduce restraint usage. A restraint audit in March 2019 identified that 39% of the resident population used restraint. Low-low beds and half-length bed rails were used as an alternative to full-length bed rails. At the time of inspection, restraint was in place for 34% of residents who used bed rails(11), lap belts(3) and sensor bracelets(2). There was documented evidence that safety checks were completed when restraints were in use. However risk assessments for the use of bed rails were not comprehensive. Sensor mats on beds(14) and chairs(6) were also used but these were they not considered to be a restraint. The person in charge stated that they were used to mitigate the risk of some residents falling or to alert staff when a resident, who cannot use the call bell required attention. Inspectors held the view that restraint usage required ongoing review.

Judgment: Substantially compliant

Regulation 8: Protection

An up-to-date policy and measures were in place to inform the safeguarding of residents from abuse. Inspectors spoke with staff who could articulate their responsibilities to report any disclosures, suspicions or incidents they witnessed. There was evidence that allegations of abuse had been investigated and managed in line with the policy. All interactions between staff and residents that were observed during the inspection were supportive and kind and residents told inspectors they felt safe and that staff were kind.

However according to training records, five staff had not attended refresher training and two staff had not completed safeguarding training. There was no face to face training to supplement the online training and ensure that staff had read and understood the policy.

The provider did not act as a pension agent for any resident. Arrangements were in place whereby some residents' monies or petty cash was managed by staff. However there were no arrangements for spot checks or audits to protect against financial abuse. Inspectors checked three accounts and found a minor discrepancy with one of the accounts. This was discussed with the person in charge.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Social activities were provided seven days a week and residents had opportunities to participate in activities in accordance with their interests and capacities. The range of activities was revised based on residents' interests and their changing needs. One lady was delighted that she was able to take up painting again. The local library visited the centre to replenish book supplies and a trained dog also visited the residents in the centre. On Friday afternoons two residents ran a tuck shop which sold sweets and other essentials to residents and visitors. An external company was engaged to facilitate a weekly exercise group and volunteers sometimes supported residents to engage in activities.

The activity co-ordinator worked alone on the days of inspection to facilitate groups of 14- 19 residents.The activity co-ordinator said a second person was available to support residents who required assistance to participate in the activities such as art or crafts.

Residents were supported to maintain links with the community. One resident attended an active retirement group and another resident went home for sleep-

overs. Transition year students attended the centre and a local choir performed for residents. Residents had access to national and local newspapers, television and radio.

Inspectors found that residents' privacy and dignity was respected. Staff were observed knocking on bedroom and bathroom doors and signs were used to alert people not to enter. Adequate screening was available in twin rooms. The inspector observed staff interacting with residents in an appropriate and respectful manner, and there was good humoured banter between the residents, visitors and staff.

There was a residents' committee which met two monthly. The person in charge met each resident during the day and usually ascertained their level of satisfaction informally. A resident satisfaction survey was also carried out. Residents were satisfied that their religious and civil rights were upheld. Arrangements were in place for residents to vote in the centre, in the upcoming election.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: End of life	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant

Regulation 9: Residents' rights	Compliant

Compliance Plan for Tinnypark Nursing Home OSV-0000707

Inspection ID: MON-0022843

Date of inspection: 09/05/2019

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Following a review of residents needs, 1 hour HCA hours were added daily to facilitate residents' requirements on May 2nd 2019. HCA shifts have been rearranged to accommodate reopening the Parlour. 10th June, 1.5 hrs per day has been allocated to one HCA shift. This will be monitored daily for 1 month and adjusted according to residents' wishes. DON will appoint S/N each day to send a report via Epicare. DON will meet with ADON and CTL each week to discuss same. • The Statement of purpose has been updated to reflect staffing levels in existence. • All vacant HCA roles have been fulfilled. This has been achieved through the recruitment of three HCA's & the increasing of x4 part time HCA's to fulltime roles in May 2019. • The Nurses' station has been moved to the lobby to allow better supervision of residents in communal areas. • To date these changes have benefited the residents. • Two HCAs will be appointed as Supervisors Saturday & Sunday.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Staff have been notified that all online training including Infection Control, Safeguarding and Complex behavior is to be completed by 30th June 2019. • Reflective accounts will be reviewed by CTL and ADON. Further training will be provided for staff who require 3 attempts to pass exam or who do not show understanding of the course in their reflective account. DON and ADON will provide onsite infection control and safeguarding training to compliment online training. • New staff will be required to complete all online training and to read policies before	

commencing practical training. Administrator will monitor refresher training for all staff and report to DON monthly re: staff who have not completed training. Provider is reviewing staff training and plans to implement incentives to staff to complete training and further their professional development.
• CTL provides Induction training for HCAs. CTL will arrange reviews with new staff at regular intervals eg. 2 weekly, 6weekly, 3 monthly and 6 monthly. Training needs analysis will be undertaken, and further training given where required.
• CTL will conduct care audits and follow up with supervising care staff who need further training.
• Infection Control practices have been reviewed by an external consultant recommendations are being implemented at present.
• There is now 2 Household staff employed 5 days per week and 1 at the weekend. Household Managers role has been discussed with Household manager. Responsibilities have been clearly defined. Daily routines and line of accountability are clearly set out. Household schedules have been altered and deep cleaning schedules are now in place. This will be reviewed following the next infection control audit in July.
• Handover already in place at the change of each shift, a third handover to be introduced each afternoon to provide oversight of the day and highlight any issues for team discussion. This afternoon handover to be implemented through use of The Safety Pause. CTL/ADON to lead this handover Mon-Fri.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Meetings between Providers and Management will be comprehensive and scheduled to occur at forthnightly intervals. Meetings will include review of audits carried out and complaints received as well as staffing or other issues. Complaints to be discussed monthly and audits discussed quarterly or sooner if required.
• ADON & CTL both work in an administrative role Mon – Fri and are also responsible for supervising staff. CTL works 3 days and ADON works 2 days.
• Schedule of Audits has been prepared by ADON. They will be completed by ADON and CTL. Audits will be reviewed by DON and Providers. Plans will be implemented to correct findings from Audits and timeline set for completion. Audits will include analysis of accidents and incidents. Learning from analysis will assist with plans to implement strategies to reduce number of accidents and incidents. Plans will be SMART.
• The most recent falls prevention committee meeting in June showed a lower number of falls. Restrictive practices were reviewed and one residents bed rails were removed. Plans continue to removed further restrictive practice for current residents and consider alternatives for new residents.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• Statement of Purpose has been amended to reflect correct WTE of all staff. Conditions

of registration have also been included in Statement of Purpose. Supervision of Therapies, emergency admission criteria, room numbers and sizes and email address for concerns/feedback to HIQA.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • The Complaints policy now includes The Provider as the person nominated to ensure all complaints are appropriately responded to. • Complaints to be discussed at meetings between PIC & Service Provider monthly as part of the standing agenda.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • Staff are instructed to read Policies and mark as complete when "read and understood" online. The date staff read policy will be logged online. This can be monitored by Administrator. • Staff are given notice of policy to be discussed and invited to make comments. This policy will be discussed at handover each day for 1 week. • Policies will also be discussed at staff, committee & management meetings for continuous feedback & review.	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: • HCAs are currently searching through unlabelled laundry to locate the owners. Provider has purchased new equipment to label all personal laundry. • Families are requested to contact staff when new clothes are brought in for residents so they can be labelled immediately. This has been included in resident information booklet.	

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
• Risk Assessments will be more comprehensive to include methods tried to avoid restrictive practice, reasons for the type of restrictive practice implemented, residents/NOK understanding of risks involved when using restrictive practices. All consultations between NOK/residents to be documented.
• The risk register will be updated to include sensor alarms documenting their use in alerting staff to a resident's movements and that they are not to be used a restrictive practice.
• Risk register will be combined with Safety Statement to show all clinical risks as well as environmental risks.
• Local Hotel has been contacted to try formulating an agreement to accommodate residents in the event of a full evacuation

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Staff have been instructed to complete online Infection Control training.
• Independent consultant has reviewed infection control practices and other aspects of our services. Infection control practices are poor. Staff will be given guidance on which residents have HCAIs and what precautions are to be used. This will be communicated at handover and via Epicare messages. Independent consultant will review staff learning in July. Onsite training will take place end of July and will be rolled out until all staff have received training and have achieved a high standard of knowledge and practice in this area. This can be monitored reviewed by increasing frequency of infection control audits monthly.
• There are 2 Household Staff employed 5 days per week. Cleaning schedules which include plans for regular deep cleaning have been implemented.
• Household Managers role has been reviewed to ensure oversight of cleaning.
• Infection Control and Hygiene Audit will include plans to improve services with timeline for review of changes implemented.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Staff have completed evacuation of sub compartment and plans are in place to practice evacuation of full compartment. There is a template in place to record exact scenario of drill such as time to complete evacuation and number of residents in room or compartment. Drills will be audited by Manual Handling Instructor.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• Care plans will show evidence of resident/relative's participation in formulating care plans. Key nurse will meet with resident and/or relative and discuss care plan. Resident/relative will sign care plans to show agreement with these plans.
• Care plans are audited by ADON quarterly to ensure they are reflective of residents' needs.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• Risk assessments for use of restrictive practices, in particular use of bed rails will be comprehensive. All consultations and trials of other options prior to use of restrictive restraints will be documented.
• Sensor alarm mats are not used as a form of restrictive practice. This will be included in risk register.
• Risk Management Committee will be incorporated into Falls Committee and will be focused on reducing use of bedrails and alternatives to be used instead. Meetings will take place every 2 months or more often if number of falls increase.
• Training with Dementia Care Specialist will take place in house in August.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Staff have been instructed to complete online Safeguarding Training and read Safeguarding Vulnerable Adults policy. Onsite training will commence for all staff in August 2019.
• Administrator will audit residents' pocket money weekly against Epicare records, and when cash is lodged or withdrawn.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(b)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that his or her linen and clothes are laundered regularly and returned to that resident.	Not Compliant	Orange	30/06/2019
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated	Not Compliant	Orange	30/06/2019

	centre concerned.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/06/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2019
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	04/06/2019
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	04/06/2019
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively	Not Compliant	Orange	04/06/2019

	monitored.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	31/07/2019
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	30/06/2019
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Not Compliant	Yellow	31/07/2019
Regulation 26(2)	The registered provider shall ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential	Substantially Compliant	Yellow	30/06/2019

	services or damage to property.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/06/2019
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	31/07/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to	Substantially Compliant	Yellow	04/06/2019

	the designated centre concerned and containing the information set out in Schedule 1.			
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.	Substantially Compliant	Yellow	04/06/2019
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in paragraph (1)(f).	Substantially Compliant	Yellow	04/06/2019
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	31/07/2019
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared	Substantially Compliant	Yellow	31/08/2019

	under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	31/07/2019
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Yellow	31/07/2019
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	30/06/2019