Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Tymon North Community Unit
Name of provider:	Health Service Executive
Address of centre:	Tymon North Road, Tallaght, Dublin 24
Type of inspection:	Unannounced
Date of inspection:	08 December 2022
Centre ID:	OSV-0007793
Fieldwork ID:	MON-0038509

About the designated centre

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

Tymon North Community Unit opened in March 2020. The centre can accommodate 48 residents, primarily for male and female dependent older persons, over the age of 18 years. The following categories of care are provided: Long-term residential and respite specific care needs catered, general nursing care, active elderly, frail elderly, dementia/Alzheimer's, physical disability, intellectual disability, psychiatry of old age, and general palliative care. There are three floors in Tymon North Community Unit, the ground floor accommodates the day care and other rooms, 1st Floor has two units namely Clover and Primrose and the second floor has two units named as Cherry blossom and Bluebell. and is located centrally with local services in reach, e.g. frequent bus routes, community centre, Tymon Park, local library shops and a pub is nearby. Tymon North Community Unit provides a residential setting wherein residents are cared for, supported and valued within a care environment that promotes the health and well being of residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	44

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
Thursday 8 December 2022	09:00hrs to 18:00hrs	Noel Sheehan	Lead
Thursday 8 December 2022	09:00hrs to 18:00hrs	Frank Barrett	Support

What residents told us and what inspectors observed

The overall feedback from residents was that the centre was a nice place to live in and that staff were kind and considerate. The inspectors found that a person-centred approach was central to the philosophy of care for residents in this centre. Staff were observed to be kind and responsive to residents' needs. Interactions between staff and residents were meaningful and unhurried.

Following an introductory meeting with the assistant director of nursing, the inspectors spent time walking through the centre, which also gave them opportunity to meet with residents and staff as they prepared for the day. The inspector observed that many residents were relaxing in the largest communal sitting room. Some residents were enjoying a mid morning cup of tea or soup, chatting and watching television. Other residents were participating in group activities and the inspector observed that staff mingled among the residents, offering support and encouragement. The Inspectors observed residents moving around the centre throughout the day, either independently or with assistance from staff. All residents seen were smartly dressed and were wearing appropriate footwear.

The atmosphere in the centre was relaxed and cheerful. Conversations with residents throughout the day confirmed that they were happy with the medical and social care support provided by the centre. One resident told the inspectors, 'everyone is so good here.' The inspectors heard other positive comments such as ' you get all the services here ' and 'there's always a party.' It was evident from interactions that staff knew the residents' backgrounds and needs very well. The inspectors spent periods of time in the communal areas, talking with residents and observing the positive and therapeutic interactions between the staff and the residents they were caring for.

There are three floors in Tymon North Community Unit, the ground floor accommodates the day care and other rooms, first floor has two units namely Clover and Primrose and the second floor has two units named as Cherry blossom and Bluebell. The designated centre was accessed through a main entrance lobby on the ground floor that also served other areas of the building that were separate to the designated centre. This main lobby area could be accessed freely. Access to the designated centre was regulated through the use of a swipe card system. The designated centre is located on the ground and first floors with administration offices and a day care centre on the ground floor and residents' bedrooms and communal areas on the first floor. The entrance foyer of the centre was decorated with bright photographic murals of famous Dublin landscapes for residents' enjoyment. Residents' bedroom accommodation comprised of 40 single and 4 twin, ensuite bedrooms.

The design and layout of the centre supported the free movement of residents throughout, with wide corridors, armchair seating at corridor ends and clear signage to communal areas. On the day of the inspection, the centre was generally clean

and bright. The centre was homely and well furnished throughout. Items of traditional memorabilia that were familiar to residents were displayed throughout the centre. Residents who were engaging in activities told the inspector how much they liked the communal rooms. The inspectors observed that residents' bedrooms were bright and personalised with items of personal significance such as photographs and ornaments. Residents described that they were happy with their bedrooms. Some residents complimented the views of the enclosed courtyard from their bedroom windows. There was access to television and call bells in all bedrooms. The use of decorated, privacy screens in twin bedrooms ensured that the privacy and dignity of residents was protected. There was also reflective glass in the windows of resident bedrooms. Residents complimented efforts made by staff to decorate the centre with Christmas decorations. The walls were decorated with photographs of previous social events in the centre. There were sufficient handrails in place along all the corridors to support residents with their safe mobility.

There were two spacious dining rooms in the centre. The inspectors observed that a choice of meals were offered as well as a variety of drinks. Residents commented positively about the quality and variety of food provided in the centre and confirmed that they could get an alternative dish to those on offer if they wished. Meals appeared nutritious and appetising. The inspectors observed that residents were offered snacks and fluids regularly throughout the day. Menus were prominently displayed on a large board and also on each table.

Although not in use on the day of inspection, residents had unrestricted access to a number of enclosed courtyards.These outside spaces contained artificial grass, flowers and decorative features. One of the courtyards had a recently installed smoking shelter. The courtyards appeared to be well maintained and there was sufficient seating for resident comfort.

There was a schedule fo activities on offer daily, and residents could choose whether they wanted to participate in these or not. The activities were led by the dedicated activities staff. On the morning of the inspection Inspectors observed a choir from a local primary school singing Christmas carols. In there afternoon there was a Christmas party and another music session by a visiting singer. Residents could receive visitors in the centre in their bedroom or the sitting rooms. The inspectors spoke to some residents who chose to spend time in their rooms watching television and they expressed that this was their preference.

The inspectors observed adequate facilities and resources to support recreational activities for residents. The activities programme was scheduled over seven days and included ball games, arts and crafts, music and poetry and newspaper reading. Many residents were observed to partake in group and one-to-one activities during the inspection. The inspector observed that staff engaged with residents in a positive and supportive manner and were seen to knock and announce their presence before entering resident's bedrooms. Residents had access to telephones, newspapers and televisions. There were arrangements in place for residents to access an advocacy service.

Inspectors observed that staff wore face masks as recommended during the provision of direct care to residents. Alcohol hand gel dispensers and personal protective equipment (PPE) were readily available along corridors for staff use. The inspectors observed that staff were vigilant with hand hygiene and had access to high-specification hand washing sinks.

The next two sections of the report will present the findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed under the relevant regulations.

Capacity and capability

This inspection was a one day unannounced risk-based inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Overall, the inspectors found that Tymon North Community Unit was a well-governed service which ensured that residents received high quality, safe care in line with their needs and choices.

During this inspection, the inspectors followed up on all of the items outlined in the centre's compliance plan following the previous inspection, under the relevant regulations, and found that improvements were seen in all areas, and the required actions had achieved overall compliance. The inspectors found that management systems in the centre had improved, ensuring good quality care and support was delivered to the residents, in a premises that met their needs. The provider and person in charge demonstrated responsiveness to the last inspection's findings and were keen to meet regulatory compliance, however some improvements were required in relation to records, complaints, temporary absence and discharge, governance and management, fire safety, premises, and the notification of incidents. These are discussed under the relevant regulations.

Tymon North Community Unit is operated by the Health Service Executive. There is a clear organisational structure within the centre. The provider had assigned the general manager for Community Healthcare Organisation 7 (CHO7) as the person with responsibility for senior management oversight of the service. The person in charge reports directly to the general manager and is supported in their role by two assistant directors of nursing, two clinical nurse managers (CNMs), staff nurses and care staff. It was evident that senior HSE management personnel were familiar with issues arising in the centre and attended the feedback meeting at the end of the inspection. The person in charge sent an email on a weekly basis to the registered provider representative detailing resident care issues. However, it was not evident that monthly face to face meetings that were committed to in the compliance plan of the previous inspection were actually taking place.

On a day-to-day basis, the person in charge is supported in the centre by a team of two assistant directors of nursing, who are supernumerary to the nursing complement and deputise for the person in charge in her absence. Staff were well-supervised in their roles. The registered provider ensured there was sufficient and safe staffing levels to meet the assessed needs of the residents and to support a full social and activity programme. Adequate nursing, healthcare assistants, activity staff, catering and domestic staff supported the daily operations in the centre. Oversight of administration, human resources, finances and record-keeping was maintained by administration staff.

Since the previous inspection there was improved oversight by the management team of clinical and environmental risks in the centre, to ensure the sustained quality and safety of residents in the centre. Communication systems were strengthened across all staff grades, with regular clinical governance and quality and safety meetings being held detailing the actions required to come into compliance with the regulations and improve the overall service provided. Regular meetings were held across the various departments to communicate these plans. Quality management meetings were undertaken where all aspects of safety quality and risk are discussed and actioned. There were weekly multi disciplinary team (MDT) meetings, attended by GP, nursing staff, healthcare attendants and allied health professionals that reviewed the emerging and ongoing care needs of individual residents.

Training was provided through a combination of in-person and online formats. All staff had completed role-specific training in moving and handling, safeguarding, infection control and the management of behaviours that challenge. Additional training in open disclosure was also offered to staff. Healthcare assistants were seen to be supervised in the roles by the staff nurses on duty; each nurse coordinated the daily delivery of care to a group of residents, with allocated healthcare assistants to assist in the provision of direct care and support. This meant that there was continuity in care throughout the day by the same group of staff.

The inspectors saw evidence of monitoring the quality and safety of care provided to residents. This was through the collection of key clinical quality indicator data including falls, medication management, pain, dining experience, privacy and dignity, the assessment of risk, and health and safety. There was an audit schedule and system in place for auditing practices such as falls, tissue viability, medication management, the kitchen and the environment. There was a consistent approach to the monitoring and auditing of key aspects of the service to ensure all relevant details were captured, which could then inform comprehensive, tailored action plans for improvement.

The inspectors saw that an annual review of the quality and safety of care and support in the designated centre had been undertaken in accordance with the regulations. The were systems in place to safeguard the residents from abuse. Resident's told the inspectors that they felt safe in the centre and that they could talk to any staff member if they were worried about anything.

There were systems in place to manage critical incidents and risk in the centre and accidents and incidents in the centre were recorded, appropriate action was taken and they were followed up on and reviewed. However, not all incidents were notified to the Chief Inspector as required by the regulations. This is discussed further under regulation 31, Notification of incidents. On review of nursing documentation it was not evident, in two separate incidents where a resident required hospitalisation that these incidents were fully investigated.

A sample of staff files were reviewed and found to generally contained all the information required under Schedule 2 of the regulations including a Garda Siochana (police) vetting certificate for each staff member. Current registration with regulatory professional bodies was in place for all nurses. However, some files did not have a history of employment or reference checks.

The statement of purpose described the centres' objectives and services provided. However, it required updating to ensure that it accurately reflected the registration conditions under which the designated centre was currently operating.

It was apparent that the registered provider and person in charge encouraged and were responsive to feedback about the service from residents and families. Inspectors reviewed the complaints log and found that records available contained details on the nature of the complaint. There was evidence that the outcome of a complaint was documented and this included the complainant's level of satisfaction with the result. However, in a small number of instances the investigation carried out and follow up communication with the resident and family as required were not documented. The complaints procedure was displayed at the main entrance. Residents reported feeling comfortable with speaking to any staff member if they had a concern.

Regulation 14: Persons in charge

The person in charge worked full time in the designated centre and was well known to residents and staff. The person in charge was an experienced nurse who met the requirements of the regulations. They facilitated the inspection and were knowledgeable about their regulatory responsibilities.

Judgment: Compliant

Regulation 15: Staffing

There were adequate staffing resources available to ensure that care was provided in accordance with the centre's statement of purpose and to meet the assessed needs of the 44 residents living in the centre. During the inspection, staff were

observed to know the residents well and to provide dignified and person centred care to them.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided with a suite of training courses which were relevant to their individual roles. The training matrix maintained in the centre identified that important training such as safeguarding of vulnerable persons and fire safety was completed by all staff. The person in charge used a tracker to review training that was due for completion within 30 days or that was out of date.

There was an annual appraisal system and personal development plan in place for all staff.

Judgment: Compliant

Regulation 21: Records

Records were stored securely and readily accessible. A review of a sample of personnel records indicated that the requirements of Schedule 2 of the regulations were generally met. However, two of the staff files reviewed did not have a history of gaps in employment or curriculum vitae. Also, it was not evident from staff files that references of previous employers were verified or checked.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had sufficient resources to ensure the effective delivery of care within the centre. There was a clearly defined management structure in place and staff were aware of their roles and responsibilities. The person in charge was responsible for clinical management and supervision. However,

- On review of nursing documentation it was not evident, in two separate incidents where a resident required hospitalisation that these incidents were fully investigated.
- It was not evident that monthly face to face meetings that were committed to in the compliance plan of the previous inspection were actually taking place.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The current version of the statement of purpose and function for the centre did not contain the correct information set out in the certificate of registration.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge maintained a record of all of incidents and accidents occurring in the centre including falls and injuries sustained by residents. However, a review of records identified that not all notifiable incidents as outlined under Schedule 4 of the regulations had been submitted to HIQA as required, and within the specified time frames.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints policy in place and this was updated in line with regulatory requirements. The complaints procedure was displayed throughout the centre. Records of complaints were maintained in the centre and the inspector observed that these were acknowledged and investigated promptly and detailed the resolution and whether or not the complainant was satisfied. However, in a small number of instances the investigation carried out and follow up communication with the resident and family as required were not documented.

Judgment: Substantially compliant

Quality and safety

The inspectors observed that staff promoted each resident's rights and that their privacy and dignity was respected. The inspectors found that residents were free to exercise choice about how to spend their day. Residents were assisted to get up in

the morning at a time of their choosing and staff supported residents to maintain their individual style and appearance. Some residents were observed in the communal day rooms, sitting in the reception area, while others spent time alone in their bedroom. All residents spoken with were complimentary of the staff and the care they provided.

A pre-admission assessment was completed prior to admission to to ensure the centre could meet the residents' needs. All care plans reviewed were personalised and updated regularly and contained detailed information specific to the individual needs of the residents and were sufficiently detailed to direct care. Comprehensive assessments were completed using validated tools and these were used to inform the care plans. Care plans were maintained under regular review and updated as required.

The health care needs of residents were well met. There was evidence of good access to medical staff with regular medical reviews documented in residents' records. Residents had access to a range of social and health professionals which had continued throughout the pandemic with some reviews taking place online. Residents' weights were closely monitored and appropriate interventions were in place to ensure residents' nutrition and hydration needs were met. Residents had access to physiotherapy services and prescribed interventions were seen to be appropriately implemented by staff. Attendance at consultant and outpatient services was facilitated as required.

The centre had an up to date COVID preparedness plan that included cohorting procedures to help prevent and manage an outbreak of COVID-19. Staff were observed to have good hand hygiene practices and correct use of PPE. Sufficient housekeeping resources were in place and the centre appeared to be clean throughout. Staff had all received training in standard precautions, including hand hygiene and the appropriate use of personal protective equipment (PPE). The person in charge was aware of the requirements to manage visiting in line with each resident's wishes and the national guidance.

The centre was clean and nicely decorated throughout, providing a homely and pleasant environment for residents. Residents had access to private and communal rooms. Residents had the use of large day rooms and dining rooms in addition to smaller meeting rooms for residents to meet in private with visitors. Bedrooms and bathrooms were of an appropriate size and equipped with the necessary railings and facilities in line with the residents' needs. Some improvement was required in relation to the facilities available for residents to store personal possessions. In one of the twin rooms, inspectors found that a resident did not have access to a lockable storage area. This was brought to the attention of the person in charge on the day, and a suitable lockable storage area was provided.

Laundry facilities were located in a central area. The laundry was well equipped with a separate entrance and exit for clean and dirty laundry. However, inspectors found issues in relation to storage within the laundry. Inspectors found empty detergent containers stored on the floor of the laundry. In addition, there was insufficient space to accommodate the practice of stacking clean linen on trollies within the

laundry for distribution back to the residents. Inspectors noted that clean linen was also stored on trollies in the corridor outside the laundry. When this was brought to the attention of staff, it was immediately removed

Improvement was also required in relation to general storage facilitates throughout the centre. Inappropriate storage of kitchen-ware was found in the waste recycling room. This was brought to the attention of the person in charge and this was removed on the day of the inspection. A number of storage rooms were found to be overcrowded with items such as chairs, tables, unused bins, and bedding. A large amount of excess computer equipment was also stored in the communications room. The person in charge assured inspectors on the day that unused items would be removed from the building. Inappropriate storage of individual portable oxygen bottles was found in three areas and this was brought to the attention of the person in charge. Assurances were given that portable oxygen bottles would be removed from these areas to the oxygen tank storage areas and that appropriate storage for these portable bottles would be provided on the accommodation floor, if required.

Inspectors found a number of rooms where the ventilation system did not appear to be working properly. These rooms were the catering manager's office, the first-floor treatment room and the male staff-changing area. This resulted in a build-up of humidity within the rooms. As a result, the rooms were uncomfortably hot and the doors were propped open. The person in charge provided assurances on the day of inspection that the ventilation system would be serviced to rectify this issue.

The provider had taken precautions against the risk of fire. The provider had ensured that fire exit routes were well maintained with unrestricted access to emergency exits and adequate emergency lighting throughout the centre. Records of fire alarm and emergency lighting maintenance were available on the day and were up to date. Staff had received appropriate training in fire safety and training in this area was up to date. Staff also displayed a good knowledge of the evacuation procedures in the centre in conversation with inspectors. This included staff working in the kitchen and laundry who demonstrated a good knowledge of how to shut-off the gas in the event of an emergency. Fire safety was discussed at staff meetings as noted in the minutes of these meetings. The provider maintained records in relation to fire evacuation drills that had taken place within the centre. In addition, each resident had a personal evacuation plan that detailed the level of support they required in the event of an emergency evacuation. However, in reviewing these plans, inspectors noted that majority of residents would require the assistance of two staff to evacuate the centre safely and more than two staff members were needed in one instance. Night-time staffing arrangements were not adequate to ensure that these needs could be met. The person in charge reported that there were arrangements in place where staff working in other areas of the building, that were separate to the designated centre, would be available to assist in this event. However, no formal written protocol or policy outlining this arrangement was available. In addition, the night-time simulated drills completed in the centre were not reflective of this arrangement. Further, inspectors noted that the notice displayed in relation to the procedure to be followed in the event of fire was not correct. This was brought to the attention of the person in charge and assurances were given that this would be rectified brought to the attention of staff at a future

team meeting. In addition, inspectors noted that one emergency evacuation notice that showed the layout of the building was not clear. This had not been detected by the provider but assurances were provided that this would be addressed and reprinted.

Overall, staff worked to promote residents' rights and independence in the centre. Residents' comments and feedback to the inspector indicated that they were happy with their care and could choose how they spent their days. While for the most part, residents' privacy was respected, one communal bathroom did not support privacy, and this required attention by the registered provider to maximise resident's dignity. It was the responsibility of staff on duty to facilitate an activities programme, and facilities and materials were provided to allow for choice of activity. Residents were consulted with about the running of the centre, as evidenced by residents' meeting minutes and confirmed by residents to whom the inspector spoke. An independent advocacy group was available to residents and this information was signposted in the centre for residents' and families information. The centre had unrestricted visiting and visitors were observed in the centre throughout the day.

Regulation 11: Visits

Visiting arrangements were flexible, with many visitors being welcomed into the centre throughout the day of the inspection. The inspectors saw that residents could receive visitors in their bedrooms or in communal areas.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported to maintain control of their clothing and personal belongings. Residents had adequate storage space in their bedrooms, including a lockable space for their valuables if they wished. Arrangements were in place for the laundering, and prompt return, of clothing.

Judgment: Compliant

Regulation 17: Premises

The provider had ensured that the premises of the designated centre was appropriate to the number and needs of the residents as set out in the statement of purpose for the centre. However, improvement was required in relation to the availability of storage facilities within the centre. This included the storage of clean

laundry and the inappropriate storage of clean kitchen-ware within the waste recycling area. In addition, improvement was required in relation to the ventilation system in some areas of the building.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

A review of residents' records demonstrated that relevant information about the resident was not always provided to the receiving hospital or that on return to the designated centre, all relevant information was obtained from the discharge service and allied health professionals.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a risk management policy in place to inform the management of risks in the centre. There was a major incident emergency plan in place, in the event of serious disruption to essential services.The centre's risk register was well maintained with environmental and clinical risks identified and assessed, and measures and actions in place to control the risks.

Judgment: Compliant

Regulation 27: Infection control

The centre appeared to be clean, and completed cleaning schedule records were viewed by the inspector. There were sufficient hand hygiene stations and sinks throughout the designated centre. Cleaning trolleys were well organised and housekeeping staff who spoke to the inspector were knowledgeable about good infection prevention and control procedure. Inspectors saw evidence that bedpan washers were serviced regularly.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had taken precautions against the risk of fire. This included maintaining adequate emergency means of escape. The provider had also made arrangements for the detection and containment of fire. Fire alarm systems were installed and maintained. Staff had received training in fire safety. However, improvement was required in relation to the night-time evacuation procedures in the centre to ensure that all residents could be safely evacuated from the building in the event of a fire. In addition, improvement was required regarding emergency evacuation procedure notices in the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care plans reviewed by the inspectors were person centred with evidence that they had been developed with the resident, or where appropriate their family, the inspectors observed that as residents' care requirements changed care plans had been updated accordingly. However, in some of the care plans reviewed, falls assessment was generic and not person centred. Also, in the case of two instances where a resident had fallen and required medical attention, an investigation of the incident was not available and could not inform an update to the care plan. As a result, staff were not sufficiently guided on how to safely care for these residents, and that residents' care needs could not be appropriately evaluated and reviewed to inform continuity of care.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to their general practitioners (GPs) and residents are supported to retain the GP they attended before admission to the centre. An on-call medical service was accessible to residents out-of-hours if needed. Links with the community palliative care team were established and their expertise was being sought for care of residents receiving end-of-life care, as appropriate. Recommendations made by allied health professionals were implemented in residents' care and support interventions by staff with positive outcomes for residents' ongoing health. Residents were supported to safely attend out-patient and other appointments as scheduled.

Allied health professionals including dietician, speech and language therapy services, and tissue viability specialist were accessible to residents as needed. A physiotherapist was available on-site.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns. There was evidence that the person in charge had investigated an allegation of abuse and refresher communication and safe guarding training for staff had taken place.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had access to numerous opportunities to pursue their interests on their own or in organised group activities. Staff were available to assist residents who required additional support to participate in activities. Residents' rights were found to be upheld by staff and their privacy and dignity was maintained at all times.

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
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Tymon North Community Unit OSV-0007793

Inspection ID: MON-0038509

Date of inspection: 14/12/2022

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 1. Nurse management staff to review all existing staff personnel files for any employment history and reference deficits. 2. Liaise with DSKWW Community Healthcare Human Resource Department for sourcing any verifications required. 3. Nurse management staff to review and maintain all the relevant support documentations such as induction checklist are completed for any newly appointed staff comply in with HSE HR policies. 4. Nurse management office to store securely and accessible copies of staff personnel files with any gaps are addressed.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. Transfer discharge letter for any resident attending acute hospital will be stored in the resident's medical notes. A photocopy of the same will be held in nursing administration for easy access for all relevant staff. 2. Night CNMs will complete and maintain ongoing audits on support documentation for residents who returned back from acute hospital to ensure that the change in care needs are reflected in the care plan within 2 days of return. Any gaps will be addressed with relevant nurse managers and Care Plans will be rectified without delays 3. MDT meetings scheduled every 2 weeks to facilitate increased attendance and input from team members.	

4. Clinical audits planned as part of KPIs and audit reports subjected to discussions during clinical meetings.

5. Day CNMs to complete on a month basis record management audits through a nursing metrics process.

6. Meeting with represented registered provider (RRP) and DON scheduled following onsite attendance at Quality Patient Safety Meetings. Where a face to face meeting do not occur virtual support meeting will be conducted. RRP convene bi-month service improvement with the nurse management team and business manager with the support of the relevant DSKWW Community Healthcare advisor team.

7. DON will continue to provide weekly updates through emails to service provider and through the RRP fortnightly DSKWW Community Nursing Units.

8. Nurse management representative will support the planned establishment of DSKWW Community Healthcare Policies Residential Care for Older Person Group. A key objective of this group is to standardize policies improve health outcomes for patients, reduce variation in practice and improve the quality of clinical decisions that healthcare staff have to make promoting a Patient Centred Care (PCC) approach

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 updated with recommendations received as part of the registration renewal in October 2022.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

1. Standard Operating Procedure for Incident reporting is updated and will monitored ongoing by nurse management team to capture HIQA notification requirements for filling NFO3 for residents requiring hospital transfers following incidents.
2. Scheduled meetings between CNMs and Director of Nursing will have Reporting to external authority as an ongoing agenda item to capture and progress actions to address any gaps where they occur.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

1. DONS and ADONs to attend complaints management training offered by the Consumer Affairs service of DSKWW Community Healthcare management training scheduled for 8/2/23. There is commitment to provide an onsite workshop in the unit to disseminate the relevant learnings to all staff in the unit within 2 months post training.

2. New complaint management template introduced to allow more detail and follow up communication with resident and their family documented before signing off as complaint closure based on learnings to date.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

1. Audit completed to ensure all kitchen equipment are stored in appropriate presses in clean areas. Concerns raised regarding ventilation systems during inspection were reported to onsite maintenance manager with engagement to rectify in due course.

2. Audit to be completed of existing storage areas throughout the building to review option for enhancement and removal of any inappropriate storage

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:

1. Transfer discharge letter for any resident attending acute hospital will be stored in the resident's medical notes. A photocopy of the same will be held in nursing administration for easy access for all relevant staff
2. Nurse management to complete a standard operation procedures for Transfer of Resident to Acute Hospital Care
3. Night CNMs will complete and maintain ongoing audits on support documentation for residents who returned back from acute hospital to ensure that the change in care needs are reflected in the care plan within 2 days of return. Any gaps will be addressed with relevant nurse managers and Care Plans will be rectified without delays.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: 1. Master fire will design and supply with fire evacuation procedure notices to inform staff of the steps in case of a fire alarm activation. 2. Emergency evacuation notice modified to include the recommended changes and sent to HIQA for clarification. 3. TUH will continue fire training with the Centre training. 4. Fire policy is updated to reflect the night evacuation arrangements in the centre with TUH.	
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: 1. Staff nurses advised by nurse management to ensure care plans are updated promoting a person care centred approach for each individual resident. 2. CNMs have been tasked with auditing the care plans using a nurse metrics auditing tool which will identify areas for improvements and plans actioned by relevant nurse managers to address same. 3. Post fall assessments are completed ensuring identifies actions are documented and monitored for implementation. Residents care plans are then updated by the relevant staff nurses to reflect when these recommendations. 4. Care plan update assurance will be provided to DON and ADONs through weekly reporting from CNMs on days and Nights apart from the audits as per service Operational Plan.	

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	01/03/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	28/02/2023
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	Substantially Compliant	Yellow	26/01/2023

	effectively monitored.			
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Substantially Compliant	Yellow	26/01/2023
Regulation 25(2)	When a resident returns from another designated centre, hospital or place, the person in charge of the designated centre from which the resident was temporarily absent shall take all reasonable steps to ensure that all relevant information about the resident is obtained from the other designated centre, hospital or place.	Substantially Compliant	Yellow	26/01/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at	Substantially Compliant	Yellow	26/02/2023

	suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	26/01/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	02/02/2023
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	26/01/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs,	Substantially Compliant	Yellow	26/01/2023

	the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	20/01/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	01/02/2023