

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Tinnypark Nursing Home
Centre ID:	OSV-0000707
Centre address:	Tinnypark, Callan Road, Kilkenny.
Telephone number:	056 777 1550
Email address:	tinnypark@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Tinnypark Residential Care Limited
Provider Nominee:	Seamus Killeen
Lead inspector:	Louisa Power
Support inspector(s):	Mary O'Mahony, Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	17
Number of vacancies on the date of inspection:	30

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Compliance 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 Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 10 July 2015 08:30 To: 10 July 2015 16:40

The table below sets out the outcomes that were inspected against on this inspection.

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

The inspection was an unannounced inspection, took place over one day and was the second inspection of the centre by the Authority. The centre had opened in December 2014. The inspection was prompted by the submission of a plan to transition 10 residents from another designated centre to this centre on a temporary basis on Monday 13 July 2015. The inspection followed up on actions from the registration inspection in March 2013. The Authority had received notification of a planned change to the governance structure and inspectors interviewed the new person in charge.

As part of the inspection process, inspectors met with a director of the company, person in charge, assistant director of nursing, residents, relatives, visitors and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures, risk management documentation and staff records. Residents and relatives with whom inspectors spoke confirmed that they had been consulted with in relation to the temporary transition plans.

Overall, inspectors found that the person in charge and staff ensured that residents' medical and nursing needs were met to a good standard. Residents looked well and cared for and provided positive feedback on the staff, care and services provided. Inspectors found evidence of good practice in a range of areas. The person in charge and staff all interacted with residents in a respectful, warm and friendly manner and demonstrated a thorough knowledge of residents' needs, likes, dislikes and preferences. There was evidence of a person-centred approach to the care delivered to residents.

A number of improvements were identified to enhance the evidence of good practice and to comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The required improvements are set out in detail in the action plan at the end of this report and include:

- residents' finances
- management of challenging behaviour including training and positive behaviour support plans
- fire safety precautions in smoking area
- documentation in relation to complaints
- medication management
- review of evening/night staffing levels.

Compliance with Section 41(1)(c) of the Health Act 2007 and 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 Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was evidence of a clearly defined management structure that identified the lines of authority and accountability, specified roles, and details of responsibilities for all areas of service provision. Staff with whom the inspectors spoke confirmed that a director of the company was present in the centre on an almost daily basis. Members of the management team attended staff meetings. Minutes of regular management meetings were made available to inspectors where issues relating to the quality of care, activities provision and human resources were addressed. The person in charge outlined that the provider nominee was accessible and supportive. Inspectors were satisfied that the management system in place ensured that service provided was safe, appropriate, consistent and effectively monitored.

The management team outlined that governance arrangements would be further strengthened following the appointment of the person in charge as the provider nominee. As a result, the provider nominee would be present in the centre five days per week from mid-August 2015 and would take on responsibilities in areas such as policy development and human resources.

Staff with whom inspectors spoke were clear about the management structure and the reporting mechanisms. Inspectors saw evidence of continued investment in the centre to ensure effective delivery of care in accordance with the statement of purpose including additional staff role.

The centre had opened officially in December 2014; the person in charge and a director of the company stated that there would be a meaningful annual review of the quality and safety of care for residents completed at the end of 2015 in consultation with residents.

Inspectors saw that there was a programme of ongoing audit and quality improvement.

Audits were completed in pertinent areas to review and monitor the quality and safety of care and the quality of life for residents. Improvements were brought about as a result of learning from audits such as review of policies and improvements in documentation.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The designated centre was managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of service. The person in charge demonstrated in-depth knowledge of residents, their care needs, and a strong commitment to ongoing improvement of the centre and the quality of the services provided. She was seen and reported to be visible, accessible and effective by staff, residents and relatives. Throughout the inspection, inspectors observed that the person in charge had strong clinical knowledge and leadership.

As previously outlined the person in charge had been appointed as the provider nominee and would take up the post in mid-August 2015. A notification to the Authority was made in line with the requirements of the Regulations outlining that the assistant director of nursing would be appointed as person in charge in mid-August 2014. The assistant director of nursing had been previously employed as the person in charge in another designated centre and had been employed in the centre since December 2014. The new person in charge would be employed full time and was a nurse with more than three years experience in the area of nursing of the older person within the previous six years. Inspectors found that she was knowledgeable of the relevant legislation and of her responsibilities under the legislation. The assistant director of nursing stated that she would retain a strong clinical role as person in charge.

The assistant director of nursing demonstrated her commitment to her own professional development and education. For example she had completed courses and attended workshops and seminars in relation to dementia, infection prevention and control, food safety, health and safety and cardio-pulmonary resuscitation. The assistant director of nursing outlined that she would be involved in the governance, operational management and administration of the centre on a regular and consistent basis. Inspectors observed a good and supportive working relationship between the person in charge and the assistant director of nursing.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Only the documentation relating to the outcomes inspected against were considered as part of this inspection.

As outlined in outcome 7, the person in charge confirmed that the policy in relation to supporting residents with challenging behaviour was part of the Care of Residents with Dementia policy.

As outlined in outcome 9, inspectors observed that medication administration records were left blank at a number of times where medicines were due to be administered. Therefore, there was not a complete record of the medicines administered or the reasons why medicines were not given.

Judgment:

Non Compliant - Moderate

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors found that systems were in place to protect residents from being harmed or suffering abuse. Residents were provided with support that promoted a positive approach to behaviour that challenges. A restraint-free environment was promoted. However, improvements were required in relation to the management of residents' finances, provision of training to support residents with behaviour that challenges and positive behaviour support plans.

The person in charge and all the staff spoken with confirmed that there had been no incidents of alleged, suspected or reported abuse in the centre since the previous inspection.

There was an organisational policy in place in relation to the protection of residents from abuse which had been reviewed in March 2015. The policy was comprehensive, evidence based and would effectively guide staff.

Training records confirmed that all staff had received training in relation to responding to incidents, suspicions or allegations of abuse. Staff with whom inspectors spoke were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. Residents with whom inspectors spoke confirmed that they felt safe in the centre, the staff were 'very kind' and that they knew who to talk to if they needed to report any concerns of abuse. There was a nominated person to manage any incidents, allegations or suspicions of abuse. Residents and staff were able to identify the nominated person.

An inspector reviewed the systems in place for the management of residents' finance. The inspector noted that the required documentation and cash ledger were not in place for a resident who had recently come to live in the centre and, therefore, monies had been received but not adequately recorded.

There was a policy in relation to the management of behaviours that challenge but this policy was part of a policy relating to residents with dementia. The policy required review to ensure that this was a standalone document and provided guidance to staff in relation to supporting residents with behaviours that challenge who may not have dementia; this is discussed in outcome 5. Records indicated that training had not been completed by relevant staff in the response and management of behaviour that is challenging.

Inspectors reviewed a sample of positive behaviour support plans and noted that they lacked sufficient detail and clear strategies to support residents in the management of all the behaviours exhibited. Evidence based tools such as Antecedent Behaviour Consequence (ABC) charts were not consistently used to map and track behaviours to identify triggers and develop a proactive management plan which may reduce the incidence of such behaviours.

The policy in relation to restraint was a policy document published by the Department of Health. Inspectors observed that while bedrails and lapbelts were in use, their use was guided by this policy and followed an appropriate assessment. A risk balance tool was used prior to the use of a bedrail or lapbelt, multi-disciplinary input was sought and signed consent from residents was secured where possible. However, there was no documented monitoring and observation of a resident whilst a bedrail was in place; this is covered in outcome 8.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Overall there was evidence that the provider was committed to protecting and promoting the health and safety of residents, staff and visitors but some improvements were required in relation to hazard identification, implementation of control measures and documented learning from incidents.

There was evidence that the actions from the previous inspection had been satisfactorily implemented. A risk management policy was in place. A viewing panel was provided in the smoking room. Safety mechanisms had been fitted to all windows and exit doors. Safe and suitable storage was provided in all en-suite bathrooms.

The health and safety policy and statement were made available to inspectors and had been last reviewed in November 2014. These documents were augmented by a risk register which included a range of centre-specific risks, an assessment of each risk and the controls identified as necessary to reduce each risk. The risks identified specifically in the Regulations were included in the risk register. There was evidence that the risk assessments were regularly reviewed and updated. However, inspectors noted that some risks had not been identified and assessed. These included the storage of latex gloves which may pose a choking risk and unrestricted access to an unused part of the centre. Controls were not always put in place to adequately mitigate against the risk posed to residents. For example, as outlined in outcome 7, there was no documented monitoring and observation of a resident whilst a bedrail was in place.

A comprehensive emergency plan was in place which covered events such as loss of heat, light and water. A generator was available and had been serviced in November 2014.

Inspectors reviewed a sample of incident forms and saw that accidents and incidents were identified and there were arrangements in place for investigating accidents and incidents. However, inspectors found that learning from incidents, including medication incidents, was inconsistent. Actions to prevent recurrence of incidents were not always recorded on incident forms. The preventative actions outlined were not always adequate and did not reflect a systems-based approach to risk management.

Suitable fire equipment was observed to be provided throughout the centre. There was an adequate means of escape. Fire records were comprehensive, accurate and easily retrievable. Records of regular fire checks were made available to inspectors which included daily checks of exits, emergency lighting and fire equipment. The clear procedure for safe evacuation of residents and staff in event of fire was also displayed prominently in a number of areas throughout the centre.

The training matrix confirmed that fire training was up to date for all staff. Staff demonstrated good knowledge on the procedure to follow in event of a fire.

A personal emergency evacuation plan (PEEP) was seen to have been developed for residents. The PEEPs outlined the number of staff required to evacuate the resident, the ideal means and route of evacuation and the location of the resident.

The fire alarm was serviced on a quarterly basis and was serviced on the day of inspection. Fire safety equipment was serviced on an annual basis, most recently in February 2015. Emergency lighting had been serviced annually, most recently in August 2014.

A designated indoor smoking room was provided and the person in charge confirmed that residents also smoked outside under the supervision of staff. The indoor smoking area was mechanically ventilated. Adequate fire fighting equipment was provided in the indoor smoking room but inspectors observed that fire fighting equipment was not stored near the outdoor smoking area. Inspectors observed that residents who smoked were supervised by staff and staff stored cigarettes and lighters for residents to minimise the risk of fire. Inspectors observed that ashtrays provided were not sufficiently sturdy and may pose a risk of fire.

Staff demonstrated a good understanding of the use of the hoist and contemporary moving equipment. The person in charge confirmed that an individualised sling was not provided for each resident which could lead to potential harm during moving and handling. Safe moving and handling practices were observed. Residents had a personalised manual handling plan which was reviewed every four months or more frequently if a resident's condition changes. Hand rails and grab rails were installed throughout the centre.

Inspectors observed that improvements were required to ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority, are implemented. Inspectors saw and staff confirmed that there were adequate supplies of personal protective equipment (PPE) available. Inspectors observed that there were hand hygiene facilities available to staff

and visitors. Designated hand washing facilities were provided in the sluice and laundry rooms. Supplies of alginate bags were provided for contaminated linen. Training in infection prevention and control had been facilitated for staff in 2014/15. However, inspectors observed that the management and storage of some urinals may not adequately prevent and minimise the spread of healthcare associated infections.

There was a contract in place for the disposal of clinical waste and records were maintained of removal and transport.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The centre-specific policies relating to medication management were made available to inspectors and had all been reviewed in 2014. The policies were comprehensive and covered the ordering, receipt, storage, prescribing, administration, refusal and crushing of medicines. Records available which confirmed that staff had read and understood the policy. Staff with whom inspectors spoke demonstrated adequate knowledge of this document.

Medicines for residents were supplied by a local community pharmacy. There was evidence that the pharmacist was facilitated to meet his/her obligations to residents, including medication usage review and resident counselling.

Handling and storage of controlled drugs was safe and in accordance with current guidelines and legislation. Medications requiring refrigeration were stored in a designated refrigerator and the temperature of the refrigerator was recorded daily. However, the refrigerator was observed to be unlocked and located in a room accessible to non-nursing staff. This was brought to the attention of the assistant director of nursing who arranged for the refrigerator to be locked.

Medication management training was facilitated regularly and nursing staff demonstrated knowledge and understanding of professional guidance in medication management. Inspectors observed resources relating to medication management were available to staff.

A sample of medication prescription sheets and administration records were examined

by an inspector. The inspector saw medication reconciliation did not occur in a timely fashion following discharge from hospital and this could lead to error. Medicines discontinued in hospital were not cancelled from the prescription sheet and medicines commenced were not added to the prescription sheet. For example, changes following a resident's discharge from hospital in mid-May had not been recorded by the prescriber on the prescription sheet and nurses were administering medicines using a photocopied discharge prescription which is not an original prescription as per the Medicinal Products (Prescription and Control of Supply) Regulations. The inspector was satisfied that medicines had been administered in line with the discharge prescription.

Medication administration sheets examined identified the medications on the prescription sheet, contained the signature of the nurse administering the medication and allowed space to record comments on withholding or refusing medications. The times of administration matched the prescription sheet. However, as outlined in outcome 5, the medication administration records were not always complete.

Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal.

A system was in place for reviewing and monitoring safe medicines management practices. Results of medication management audits were made available to the inspectors. The most recent audit had been completed in April 2015 and examined a number of areas including documentation, management of controlled drugs, storage and staff competency. Pertinent deficiencies were identified and the actions were seen to be completed in a timely fashion.

Inspectors saw that processes were in place for the identification, recording, investigating and learning from medication incidents. However, as outlined in outcome 8, learning from medication incidents was inconsistent.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was evidence that access to health care services was facilitated for all residents. A choice of general practitioner (GP) was available to residents. An "out of hours" GP service was also available if required. In line with their needs, residents had ongoing access to allied healthcare professionals including dietetics, speech and language therapy, optical and chiropody. The records confirmed that the care delivered encouraged the prevention and early detection of ill health through regular blood profiling, regular medication review and annual administration of the influenza vaccine. Residents were enabled to make healthy living choices such as smoking cessation and healthy eating.

Inspectors reviewed a selection of care plans and saw that assessments, care planning processes and clinical care was in line with evidence-based practice. There was evidence of a pre-assessment undertaken prior to admission for residents. After admission, there was a documented assessment of all activities of daily living, including mobility, communication, breathing, eating and drinking, elimination, personal care, sleeping and social care needs. There was evidence of a range of evidence based assessment tools being used and ongoing monitoring of falls risk, skin integrity and nutritional need. The assessments were reviewed every four months, or more frequently in line with residents' changing needs or circumstances. Care plans were developed for each resident which detailed their needs and choices. Each resident's care plan was kept under formal review as required by the resident's changing needs or circumstances and was reviewed no less frequently than at four-monthly intervals, in consultation with residents or their representatives. The assessments and care plans were person-centred and individualised to each resident. Inspectors observed that care plans guided the care delivered to residents by staff.

Wound management was in line with national best practice. Wound management charts were used to describe the cleansing routine, emollients, dressings used and frequency of dressings. The dimensions of the wound were documented and photos were used to evaluate the wound on an ongoing basis.

There was a strategy in place to prevent falls whilst also promoting residents' independence. An evidence-based assessment tool was used to assess residents' risk of falls every four months. Care plans were developed which outlined interventions to reduce falls such as ultra low beds and sensor mats. Inspectors noted that the interventions outlined had been implemented.

Residents' weights were monitored on a monthly basis and the Malnutrition Universal Screening Tool (MUST) was also utilised in practice. Referrals were made as required to specialist services.

Residents' social care needs were met and residents had opportunities to participate in meaningful activities, appropriate to their interests and preferences. A social assessment had been completed for each resident outlining the resident's social contacts and the hobbies and activities they enjoy. A well-stocked library was available to residents. On the morning of inspection, inspectors observed residents enjoying an indoor gardening activity. Other activities offered included a popular café club, arts and crafts, board

games and bingo.

Comprehensive information was provided on transfer to and from hospital. A resident's right to refuse treatment was respected and documented.

Judgment:

Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The location, design and layout of the premises was suitable for its stated purpose and met the residents' individual and collective needs in a comfortable and homely way.

The premises comprised a listed building over four floors with a large ground floor extension which was constructed in 2007. The original building was not registered for the accommodation of residents.

The accommodation overall was bright, modern, clean, suitably decorated and naturally ventilated. The premises and equipment were maintained to a high standard.

In total there were 44 bedrooms in the extension, 40 single rooms and four double rooms all with assisted and accessible en-suite facilities containing assisted showers, wash hand basins, sinks and call-bells. All bedrooms contain call-bells, telephones and televisions. Ample storage space was provided for residents' personal possessions and rooms were seen to be personalised. Inspectors saw that bedroom 19 was not being used for the purposes of accommodating residents. Bedroom 25 was vacant at the time of inspection and the person in charge and director confirmed that any potential occupants for this bedroom would be independently mobile.

There is an additional assisted shower room on the ground floor and a separate bathroom also available and adaptations had been made to the bath so that it was suitable for use by persons with a disability. Four accessible residents' toilets were provided close to communal areas. An accessible visitors' toilet was located close to the entrance foyer.

A number of communal areas were provided for residents. The large entrance lobby had ample seating, a large day room and a smaller quiet room were located off the entrance lobby. A library was located adjacent to the dining facilities and led into a conservatory. As outlined in outcome 8, an indoor smoking area was provided for residents.

The dining area was split into two sides and some residents opted to eat in the conservatory. The dining area was spacious and tables were invitingly set with napkins and table cloths. Catering facilities were situated adjacent to the dining area and had suitable and sufficient cooking facilities, kitchen equipment and tableware.

The sluice room was appropriately and adequately equipped. A suitably equipped and spacious laundry room is available and there is adequate general storage space available throughout. Separate hand washing facilities were provided in both the laundry and sluice rooms. A treatment room, nurses' station, hairdressing room, cleaning and chemical storage rooms, administrative offices and meeting rooms were also provided.

Safe floor covering, grab rails and handrails were provided throughout. The corridors and doorways were observed to be sufficiently wide to allow residents to mobilise independently or in wheelchairs.

There is a large secure walled garden and four secure internal courtyards which can be accessed easily by residents and visitors. A resident with whom inspectors spoke outlined that she always had a love of gardening and was supported to assist in the maintenance of the gardening.

Judgment:

Compliant

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The complaints of each resident, his/her family, advocate or representative, and visitors were listened to and acted upon and there was an effective appeals procedure in place. However, there were some gaps seen in how the documentation was maintained.

Inspectors noted that there was a centre-specific complaints policy, last reviewed in October 2014. The complaints policy identified the nominated complaints officer and

also included an independent appeals process as required by legislation. A summary of the complaints procedure was displayed prominently. The policy states that annual audit is to be undertaken to ensure that complaints are appropriately responded to and records were maintained.

An inspector reviewed the complaints log detailing the investigation, responses and outcome of any complaints. The complaints recording form did not include whether the complainant was satisfied. The inspector also noted that the documentation in relation to the outcome of a complaint was not complete.

Judgment:

Substantially Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a planned roster in place. Based on a review of the roster and incident forms, a review of evening and night staffing complement was required to ensure that staff numbers and skill-mix were appropriate to meeting the assessed needs of residents as many of the slips, trips and falls recorded occurred between 22:00 and 07:00.

There was a registered nurse on duty at all times and a record is maintained of current registration details of nursing staff. Staff were observed to competently deliver care and support to residents that reflects contemporary evidence based practice.

A sample of staff files was reviewed and contained all of the required elements. Inspectors saw that there was a selection of healthcare reading materials and reference books stored in the each nurses' station. Inspectors noted that copies of both the Regulations and the Authority's Standards were available.

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge and competencies; the programme reflected the needs of residents. All staff employed had attended mandatory fire,

manual handling and elder abuse training. Further education and training completed by staff included dementia, infection prevention and control, CPR, medicines management, food safety, first aid and chemical safety.

Minutes of staff meetings were made available to inspectors. Meetings took place every two months. Items discussed at carers' meetings included activity provision, hydration, introduction of an additional refreshments round, nutrition, infection prevention and control and arrangements for religious ceremonies. At the most recent nurses' meeting, medicines management was discussed in detail. Topics discussed at the catering, household and laundry staff meeting included infection prevention and control, nutrition and laundry management.

Effective and robust recruitment procedures were in place including the verification of references. An induction programme was provided for newly recruited staff and there was documentary evidence that this had been completed for all staff.

The person in charge confirmed that agency staff and volunteers were not utilised within the centre at the time of inspection.

Judgment:

Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Louisa Power
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Tinnypark Nursing Home
Centre ID:	OSV-0000707
Date of inspection:	10/07/2015
Date of response:	03/09/2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The policy in relation to supporting residents with challenging behaviour was part of the Care of Residents with Dementia policy.

1. Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

<p>Please state the actions you have taken or are planning to take:</p> <p>The Policy that supports Residents with Challenging Behaviours has been divided into a separate policy from its original site Care of the Elderly with Dementia.</p>
<p>Proposed Timescale: 20/08/2015</p>
<p>Theme:</p> <p>Governance, Leadership and Management</p> <p>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Medication administration records were left blank at a number of times where medicines were due to be administered</p> <p>2. Action Required:</p> <p>Under Regulation 21(1) you are required to: 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.</p> <p>Please state the actions you have taken or are planning to take:</p> <p>Meetings were held with Nursing Staff to ensure that all medications are signed for and to emphasise the importance of completing the MAR Sheets accurately.</p>
<p>Proposed Timescale: 21/08/2015</p>

<p>Outcome 07: Safeguarding and Safety</p>
<p>Theme:</p> <p>Safe care and support</p> <p>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</p> <p>Positive behaviour support plans were not sufficiently comprehensive to guide staff in the proactive support of residents with behaviour that challenges.</p> <p>Evidence based tools were not consistently used to proactively monitor and support residents with behaviour that challenges.</p> <p>3. Action Required:</p> <p>Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.</p> <p>Please state the actions you have taken or are planning to take:</p> <p>This issue has since been addressed and behavioural management charts have been formulated for a number of residents that exhibit challenging behaviours. Training and Support has been given to Care Staff in the use of ABC Charts. Training for all new care</p>

staff in relation to residents is ongoing.

Proposed Timescale: 10/07/2015

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Training had not been completed by relevant staff in the response and management of behaviour that is challenging.

4. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:

Training in "Non Violent Personal Training and De-Escalation Training" has been sourced and staff members are due to attend in October 2015.

It is proposed to source in-house training in this area for all staff.

The CPN nurse specialist in Dementia Care has already given an Education and Advisory session for all staff prior to the inspection and will continue to do.

Proposed Timescale: 31/12/2015

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The system to manage residents' finances was not always followed.

5. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:

The Resident in question was a new resident whose finances are controlled by the Finance Officer in the HSE in St Dymphnas, Carlow. The money that was received was his cigarette money only. The Cash Ledger for this resident is now in place and kept locked in the Nurses Station Safe together with the money.

Proposed Timescale: 10/07/2015

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A risk management policy was in place but some risks had not been assessed.

6. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:

Risk Assessments on identified areas of concern including latex gloves have been carried out.

Whilst there was a restraint and release chart for residents in the use of lap belts, there is now a monitoring chart for Bed Rails. Training was given to staff which is ongoing.

We plan to install key pads to restrict access to the unused part of the House.

Proposed Timescale: 1 and 2 13.07.15. 3. 31.12.15

Proposed Timescale: 31/12/2015

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Learning from incidents, including medication incidents, was inconsistent and did not reflect a systems-based approach to risk management.

7. Action Required:

Under Regulation 26(1)(d) you are required to: 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.

Please state the actions you have taken or are planning to take:

We have addressed this issue at a meeting with Nursing Staff and have requested a further training session with the Nursing Home Pharmacist for continued advice. There will be ongoing Training for new Nursing Staff in relation to Medication Management. All Incidents will be reviewed on a monthly basis at Management Meetings and also at the regular staff meetings and during staff handover.

Proposed Timescale: 31/10/2015

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Individualised sling was not provided for each resident which could lead to potential harm during moving and handling.

There was no documented monitoring and observation of a resident whilst a bedrail was in place

8. Action Required:

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:

Individualised slings have now been purchased for each resident that requires one.

While a Restraint and Release Chart was in use for Residents that require lap-belts, there is now a monitoring chart for residents who require bedrails.

Proposed Timescale: 13/07/2015

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The management and storage of some urinals may not adequately prevent and minimise the spread of healthcare associated infections

9. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:

Urinals are now being stored in the residents' bedrooms or the Sluice Room exclusively.

Proposed Timescale: 10/07/2015

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Fire fighting equipment was not stored near the outdoor smoking area and ashtrays provided were not sufficiently sturdy and may pose a risk of fire.

10. Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:

1. Since 10.7.15, Residents who wish to smoke may do so in the designated Smoking Room only.
2. Suitable Ashtrays for the smoking room have now been purchased and are in place.

Proposed Timescale: 11/07/2015

Outcome 09: Medication Management

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Medication reconciliation did not occur in a timely fashion following discharge from hospital and this could lead to administration errors.

11. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:

We are reviewing operations with our Resident Pharmacist to ensure compliance with the regulations and safety for residents.

Proposed Timescale: 31/10/2015

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The record relating to the outcome of a complaint was not complete.

12. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

Please state the actions you have taken or are planning to take:

The Complaint Recording form has now been adjusted to include a section to ascertain whether the Complainant was satisfied with the outcome of the complaint.

The Senior Manager is attending a regional meeting with the Ombudsman in relation to managing complaints within Nursing Homes on September 8th and the Complaint Recording Form will be adjusted again if necessary after this meeting to ensure compliance.

Proposed Timescale: 30/09/2015

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The complaints recording form did not include whether the complainant was satisfied.

13. Action Required:

Under Regulation 34(1)(f) you are required to: 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.

Please state the actions you have taken or are planning to take:

The Complaint Recording form has now been adjusted to include a section to ascertain whether the Complainant was satisfied with the outcome of the complaint.

The Senior Manager is attending a regional meeting with the Ombudsman in relation to managing complaints within Nursing Homes on September 8th and the Complaint Recording Form will be adjusted again if necessary after this meeting to ensure compliance.

Proposed Timescale: 30/09/2015

Outcome 18: Suitable Staffing**Theme:**

Workforce

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

A review of evening and night staffing complement was required to ensure that staff numbers and skill-mix were appropriate to meeting the assessed needs of resident.

14. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

A review of all Staff has been completed and we have added an extra Care Assistant for night shifts from the 13.07.15. This will reviewed on an ongoing basis as resident numbers and/or dependency levels increase.

We have also recruited extra staff in Household/Laundry and Kitchen Staff to facilitate the smooth operation of the additional unit.

Proposed Timescale: 13/07/2015