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:	Tramore Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Newtown, Tramore, Waterford
Type of inspection:	Unannounced
Date of inspection:	31 July 2023
Centre ID:	OSV-0008484
Fieldwork ID:	MON-0039657

About the designated centre

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

Tramore Nursing Home is a purpose-built facility which can accommodate a maximum of 93 residents. It is a mixed gender facility catering for dependent, persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care.
Tramore Nursing Home is situated in a seaside resort on the Golf Links road close to amenities such as The Guillemene, The Donneraile Walk, Tramore Golf Club and The Promenade. We are accessible by car, walking and we are on a local bus route.

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
Monday 31 July 2023	10:45hrs to 17:00hrs	Mary Veale	Lead
Tuesday 1 August 2023	09:30hrs to 17:00hrs	Mary Veale	Lead

What residents told us and what inspectors observed

This was a pleasant centre where residents for the most part enjoyed a good quality of life and were supported to be independent. Resident's rights and dignity was supported and promoted by kind and competent staff. Care was led by the needs and preferences of the residents who were mostly happy and well cared for in the centre. The overall feedback from residents was of satisfaction with the care and service provided. Residents' whom the inspector spoke with were positive about their experience of living in Tramore Nursing Home. The inspector greeted all the residents over the days of inspection and spoke at length with ten residents. The inspector spent time observing residents daily lives and care practices in order to gain insight into the experience of those living in Tramore Nursing Home.

On arrival the inspector was met by the person in charge and signed the centres visitors book. Following an opening meeting with the person in charge to discuss the format of the inspection, the person in charge accompanied the inspector on a walkabout of the premises. The centres healthcare manager was available in the centre on both days of inspection.

Tramore Nursing Home is a purpose built three storey building registered to provided care for 93 residents on the outskirts of the seaside town of Tramore in County Waterford. The centre was registered and opened as a designated centre in March 2023. There were 43 residents living in the centre and one resident was in hospital on the days of this inspection.

The design and layout of the premises met the individual and communal needs of the residents'. Residents had access to communal spaces on the ground and first floors which included two large day rooms, two large dining rooms, two activities rooms, two lounge areas, two quiet rooms and an oratory on the ground floor. Residents also had access to a hair salon on the ground floor. The environment was modern, clean and decorated tastefully. Armchairs and sofas were available in all communal areas. The centre had a production kitchen, laundry, offices, store rooms, a staff canteen, staff changing rooms and maintenance rooms located in the basement of the centre. There was an outdoor smoking shelter for residents who chose to smoke. Alcohol hand gels were available in all corridor areas throughout the centre to promote good hand hygiene practices.

Bedroom accommodation consisted of 81 single and six twin bedrooms, all with large en-suite toilet facilities. The privacy and dignity of the residents in the multi-occupancy rooms was protected, with adequate space for each resident to carry out activities in private and to store their personal belongings. At the time of inspection the majority of the residents were living on the ground floor and a small number of residents were living on the first floor.

Residents had access to two enclosed courtyard garden areas, one was accessible from the main reception area and the other from a corridor area. The courtyards

had level paving, comfortable seating, tables, and flower beds. The inspector was informed that residents were encouraged to use the garden spaces. On the days of the inspection all doors to the internal courtyards were open and courtyards were easily assessable for residents. There was a secure garden to the rear of the centre, however at the time of inspection the inspector was informed that this area was not used by residents as garden works were required to make it an attractive usable space for residents.

The inspector spoke with a total of 10 residents in detail, over the course of the two days and the feedback was generally positive. Residents who spoke with the inspector said that staff were good to them and treated them very well. Residents' said they felt safe and trusted staff. A number of residents on the ground floor and all the residents on the first floor were living with a cognitive impairment and were unable to fully express their opinions to the inspector. The inspector spent time in communal areas observing resident and staff interaction and found that staff were kind and caring towards residents at all times during the inspection.

Visitors whom the inspector spoke with were mostly complimentary of the care and attention received by their loved one. Visitors were observed attending the centre over the days of the inspection. Visits took place in communal areas and residents bedrooms where appropriate. There was no booking system for visits and the residents who spoke with the inspector confirmed that their relatives and friends could visit anytime. A resident was observed walking on the grounds at the front of the centre with their visitor on the first day of the inspection.

The inspector observed a calm atmosphere in the centre throughout the two days. It was evident that residents' choices were respected. For example; some residents got up from bed early while others chose to remain in bed until mid-morning. Thought out the days of the inspection, the inspector observed residents attending activities and spending their days moving freely through the centre from their bedrooms to the communal spaces and the reception area. Residents were observed engaging in a positive manner with staff and fellow residents throughout the days and it was evident that residents had good relationships with staff. Although the centre was opened since March 2023 a number of residents had build up friendships with each other and were observed sitting together and engaging in conversations with each other. The provider had recently recruited an activities co-ordinator who was establishing, organising and providing a programme of activities with residents. There was a varied activity schedule which included, bingo, baking, flower arranging exercises, and music sessions. The residents committee had been established and a meeting had recently taken place in the centre. Residents informed the inspector that they were looking forward to their summer party which was arranged in the weeks following the inspection.

The inspector observed many examples of kind, discreet, and person- centred interventions between staff and residents throughout the days of inspection. The inspector observed that staff knocked on residents' bedroom doors before entering to provide personal care to many of the residents. Residents very complementary of the person in charge, staff and services they received.

All residents whom the inspector spoke with were very complimentary of the home cooked food and the dining experience in the centre. The daily menu was displayed in both dining rooms. There was a choice of two options available for the main meal. The inspector observed the dining experience for residents on the ground floor on the second day of inspection. The meal time experience was busy but residents were not rushed. Staff were observed to be respectful and discreetly assisted the residents during the meal time. The inspector observed homemade baked snacks been offered to residents outside of meal times.

Residents' spoken with said they were very happy with the activities programme in the centre and some preferred their own company but were not bored as they had access to newspapers, books, radios and televisions. The weekly activities programme was displayed on notice boards throughout the centre and a monthly activities programme was available in the resident's bedrooms. Residents told the inspector they were delighted that the local library was attending the centre and a mobile library was available on the ground floor. The inspector observed an interactive table been used by the residents. The inspector observed residents reading newspapers, watching television, listening to the radio, singing and engaging in conversation. On the first day of inspection, residents were observed attending an exercise class and a quiz session. On the second day residents were observed attending a baking session and a music quiz. Two residents told the inspector that there was no access to WI-FI in the centre which they felt was disappointing as they had access to smart televisions in their bedrooms but could not access any streaming channels.

The centre provided a laundry service for residents. The majority of residents' whom the inspector spoke with on the days of inspection preferred to have their clothes laundered by a family member and those that had availed of the laundry service were happy with the laundry service and there were no reports of items of clothing missing.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection carried out to monitor compliance with the regulations and standards following the centres registration in March 2023. The inspector also followed up on notifications and two pieces of unsolicited information submitted to the Chief Inspector of Social Services. On this inspection, the inspector found that actions was required by the registered provider to address Regulation 7: managing behaviour that is challenging and areas of Regulation 5: individual assessment and care plan, Regulation 8: protection, Regulation 9: Residents rights, Regulation 16: training and staff development, Regulation 23: governance and

management, Regulation 27: infection prevention and control and Regulation 34: complaints procedure.

Mowlam Healthcare Services Unlimited Company is the registered provider for Tramore nursing home. The company is part of the Mowlam Healthcare group, which has a number of nursing homes nationally. The company had three directors, one of whom was the registered provider representative. The person in charge worked full time and was supported by a clinical nurse manager, a team of nurses and healthcare assistants, an activities co-ordinator, housekeeping, catering, administration and maintenance staff. The management structure within the centre was clear and staff were all aware of their roles and responsibilities. The person in charge was also supported by a healthcare manager, a catering manager and had access to facilities available within the Mowlam Healthcare group, for example, human resources. There were sufficient staff on duty to meet the needs of residents living in the centre on the days of inspection.

Management systems in place to monitor the quality and safety of care delivery to residents required review. The centre was establishing an extensive suite of meetings in line with the Mowlam group meeting schedule. Since March 2023, healthcare governance management meetings, local management meetings and staff meetings, had taken place in the centre. Meetings took place monthly in the centre. Minutes of meetings detailed items discussed, actions and persons responsible. The person in charge monitored key performance indicators (KPI's) on a weekly basis such as falls, skin tears, weights, pressure sores, and restrictive practice. There was evidence of a comprehensive schedule of audits in the centre for 2023, for example; restrictive practice, medication management, infection prevention control, clinical care and incidents of falls were completed. Audits were objective and identified improvements. However, the centre had a vacant nurse manager post which was impacting on the supervision of staff and the effective delivery of care in accordance with the centres statement of purpose. This is discussed further under Regulation 23: governance and management.

There was a schedule of training in the centre and management had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and training was up to date. There was a high level of staff attendance at training in areas such as fire safety, safeguarding vulnerable adults, management of responsive behaviour, and infection prevention and control. Staff with whom the inspector spoke with, were knowledgeable regarding fire evacuation procedures and safe guarding procedures. The person in charge and clinical nurse manager provided support and supervision for staff. However, arrangements to ensure all staff were supervised on an appropriate basis according to their roles required review.This is discussed further under Regulation 16: training and staff development.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

All paper based and electronic records and documentation were well presented, organised and supported effective care and management systems in the centre. All requested documents were readily available to the inspector throughout the days of inspection. Staff files reviewed contained all the requirements under Schedule 2 of the regulations. Garda vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available in the designated centre for each member of staff. As identified under Regulation 8: Protection, one of the Garda vetting disclosures was not in place prior to the staff member commencing employment.

The registered provider had integrated the update to the regulations (S.I 298 of 2022), which came into effect on 1 March 2023, into the centre's complaints policy and procedure. The management team had a good understanding of their responsibility in this regard. The inspector reviewed the records of complaints raised by residents and relatives. Details of the investigation completed, communication with the complainant and the outcome was included. The complaints procedure was available at the reception area. Residents spoken with were aware of how and who to make a complaint to. However, there was no documentary evidence to confirm the complainant's satisfaction of the concern raised.

The inspector followed up two pieces of unsolicited information that had been submitted to the Chief Inspector since March 2023. The unsolicited information received related to resident's rights, protection, staffing, training and staff development and governance and management. All these regulations were reviewed, staffing was found to be compliant and further improvements were required in resident's rights, protection, training and staff development, and governance and management.

Regulation 14: Persons in charge

The person in charge worked full time in the centre and displayed a good knowledge of the residents' needs and had a good oversight of the service. The person in charge was well known to residents and their families.

Judgment: Compliant

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the days of the inspection. The registered provider ensured that the number and skill-mix of staff was appropriate, to meet the needs of the residents. There were a minimum of two registered nurses in the centre day and night for the number of residents living in the centre at the time of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Arrangements to ensure all staff were supervised on an appropriate basis according to their roles required review. While staff had attended training according to their roles and responsibilities, they did not have sufficient knowledge in managing behaviours that are challenging and therefore did not implement the principles of their training in practice. Increased supervision and additional training in managing behaviour that is challenging was required to facilitate their application of knowledge into practice.

Judgment: Substantially compliant

Regulation 21: Records

All records as set out in schedules 2, 3 & 4 were made available to the inspector. Retention periods were in line with the centres' policy and records were stored in a safe and accessible manner.

Judgment: Compliant

Regulation 23: Governance and management

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by:

- There was a commitment to a whole time equivalent (WTE) post of an assistant director of nursing, a house keeping supervisor, an additional activities therapist post, and two additional chef posts as outlined in the statement of purpose when the centre reached an occupancy of 40.
- The vacant nurse manager post was impacting on supervision of staff and safety of residents as further discussed under Regulation 7: managing behaviour that is challenging, Regulation 16: training and staff development and Regulation 29: medicines and pharmaceutical services.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Residents had a written contract and statement of terms and conditions agreed with the registered provider of the centre. These clearly outlined the room the resident occupied and additional charges, if any.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in the centre which was displayed at the reception. There was a nominated person who dealt with complaints and a nominated person to oversee the management of complaints. Complaints viewed by the inspector did not consistently record if the complainants were satisfied with the outcome.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies and procedures as set out in schedule 5 were in place, up to date and available to all staff in the centre.

Judgment: Compliant

Quality and safety

Overall, residents and visitors expressed satisfaction with the care provided and the quality of life experienced in Tramore Nursing Home. On this inspection improvements were required in managing behaviour that is challenging and areas of individual assessment and care plan, protection, residents rights, infection prevention and medicines and pharmaceutical services.

Residents' health and well-being was promoted and residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as psychiatry of old age, physiotherapy, dietitian and speech and language, as required. Residents had access to local dental and optician services. Residents who were eligible for national screening programmes were supported and encouraged to access these.

The provider continued to manage the ongoing risk of infection from COVID-19 and other infections while protecting and respecting the rights of residents to maintain meaningful relationships with people who are important to them. Visitors were reminded not to come to the centre if they were showing signs and symptoms of infection. There was no restriction to visits in the centre and visiting had returned to pre-pandemic visiting arrangements in the centre. Residents could receive visitors in their bedrooms where appropriate, the centres communal areas or outside areas. Visitors could visit at any time and there was no booking system for visiting.

The centre did not act as a pension agent for any of the residents. Resident's had access to and control over their monies. Residents who were unable to manage their finances were assisted by a care representative or family member. There was ample storage in bedrooms for residents' personal clothing and belongings. Laundry was contracted to a private provider and some residents chose to have their clothing laundered at home.

The premises was meeting the requirement of the regulations and was appropriate to the needs of residents. The centre was new, bright, and generally tidy. The décor of the communal spaces was modern. The centre was cleaned to a high standard, alcohol hand gel was available in all bedroom corridors. Storage areas were observed to be clean, tidy and organised. Many residents had personalised their bedrooms with family photograph's, paintings and furniture brought from their home. Residents in shared rooms had privacy curtains and ample space for their belongings. Grab rails were available in all corridor areas, toilets and en-suite bathrooms. Call bells were available in all residents' bedrooms, en-suite bathrooms and communal toilets. Overall the premises supported the privacy and comfort of residents.

The centre had established routines and schedules for cleaning and decontamination. The person in charge had completed infection control and environmental audits and actions required were discussed at the centres management meetings. There was an up to date infection prevention and control policies which included COVID 19 and mutli-drug resistant organism (MDRO) infections. The centre had an antimicrobial stewardship register and the person in charge had good over sight of antibiotic usage. Alcohol hand gel was available throughout the centre. Sufficient housekeeping resources were in place on the days

of inspection. Intensive cleaning schedules and regular weekly cleaning programme were available in the centre. The centre had a cleaning schedule for curtains. Decontamination stickers were observed in use to ensure that equipment did not pose a risk of cross-infection. At the time of inspection the centres laundry service was contracted to a private provider. The centre had a laundry room which was not in use at the time of inspection. The laundry room included a work system flow for dirty to clean laundry which prevented a risk of cross contamination. Risk assessments had been completed for actual and potential risks associated with COVID-19 and the provider had put in place many controls to minimise the risk of harm to residents and staff. Some improvements were required in infection control procedures which are discussed under regulation 27: Infection control.

The centre had a risk management policy that contained actions and measures to control specified risks and which met the criteria set out in regulation 26. The risk registered contained site specific risks such as risks associated with individual residents and centre specific risks, for example; fire safety risks, individual residents risks such as mobility and manual handling, and the use of portable screens in showers.

There were effective systems in place for the maintenance of the fire detection, alarm systems, and emergency lighting. The provider had installed external lighting to allow safe evacuation from the centre and had amended the centres fire evacuation maps to include the size, and location of fire compartment boundaries used for progressive horizontal evacuation. These fire evacuation maps were displayed in all compartments throughout the centre. All doors to bedrooms and compartment doors had automated closing devices. All fire doors were checked on the days of inspection and were in working order. Fire training had been completed by all staff. There was evidence that fire drills took place monthly in the centre. There was evidence of fire drills taking place in each compartment with simulated night time drill taking place in the centres largest compartment. Fire drills records were detailed containing the number of residents evacuated, how long the evacuation took, and learning identified to inform future drills. There was a system for daily and weekly checking, of means of escape, fire safety equipment, and fire doors. A staff member was nominated as a fire marshal on each shift. All fire safety equipment service records were up to date. All escape routes were assessable, free from obstructions and the assembly point was accessible. The centre had an L1 fire alarm system. Each resident had a personal emergency evacuation plan (PEEP) in place which were up to date. Staff spoken with were familiar with the centres evacuation procedure. There was evidence that fire safety was on the agenda at meetings in the centre. On the days of the inspection there were five residents who smoked and detailed smoking risk assessments were available for these residents. A call bell, fire blanket, fire extinguisher and fire retardant ash tray were in place in the centre's smoking area.

The centre had arrangements in place to protect residents from abuse. There was a site-specific policy on the protection of the resident from abuse. Safeguarding training had been provided to all staff in the centre in 2023. Staff were familiar with the types and signs of abuse and with the procedures for reporting concerns. However, improvements were required in the procedures to ensure staff were Garda

vetted prior to employment. This is discussed further in the report under Regulation 8: protection.

There was a centre specific policy in place to guide nurses on the safe management of medications. Medicines were administered in accordance with the prescriber's instructions in a timely manner. Medicines were returned to pharmacy when no longer required as per the centres guidelines. A pharmacist was available to residents to advise them on medications they were receiving. However, improvements were required in the storage of medications and the checking of controlled drugs balances which is discussed further in the report under Regulation 29: medicines and pharmaceutical services.

The use of bed rails in the centre was low. There were low beds and crash mats available to support the reduction of restrictive practices and the centre was not using any sensor safety alert devices. There was open access to the centre's internal courtyards and residents enjoyed accessing this space when the weather allowed. The centre maintained a weekly restrictive practice register and staff had access to a local restrictive practice guideline. Improvements were required in the documentation of restrictive practice to come in line with best practice as set out in the national guidance on restrictive practice.

Some residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The management of residents who displayed responsive behaviours required review in line with the centres policy, this is discussed further in this report under Regulation 7: managing behaviour that is challenging.

The inspector observed that the resident's pre- admission assessments were paper-based and nursing assessments and care plans were maintained on an electronic system. Residents' needs were comprehensively assessed prior to and following admission. Resident's assessments were undertaken using a variety of validated tools and care plans were developed following these assessments. The majority of residents had been admitted to the centre within the previous 4 months of inspection, therefore most care plans were due to be reviewed by staff and consulted with the resident or where appropriate that resident's family in the weeks and months following the inspection. Further improvements were required to residents care plans which is discussed under Regulation 5: individual assessment and care planning.

There was a rights based approach to care in this centre. Residents' rights, and choices were respected and promoted. Residents were actively involved in the organisation of the service. A resident committee had been established and a meeting had taken place. The residents had access to SAGE advocacy services. The advocacy service details were displayed in the reception area and advocacy leaflets were available for residents. The monthly activities calendar was displayed in all day spaces. Residents has access to daily national newspapers, weekly local newspapers, books, televisions, and radio's. Mass took place each week in the centre. Residents were supported and encouraged to maintain links with their

families and the wider community through visits and trips out when possible. However, improvements were required in relation to privacy and dignity of the residents in their bedrooms which is discussed further under Regulation 9: Residents rights.

Regulation 11: Visits

Visiting had resumed in line with the most up to date guidance for residential centres.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate space in their bedrooms to store their clothes and display their possessions. Residents clothes were laundered in the centre by a private provider and the residents had access and control over their personal possessions and finances.

Judgment: Compliant

Regulation 17: Premises

The premises was appropriate to the needs of the residents and promoted their privacy and comfort.

Judgment: Compliant

Regulation 26: Risk management

There was good oversight of risk in the centre. Arrangements were in place to guide staff on the identification and management of risks. The centre's had a risk management policy which contained appropriate guidance on identification and management of risks.

Judgment: Compliant

Regulation 27: Infection control

The inspector observed practices that were not in line with the National standards and guidance for the prevention and control of associated infections. Oversight in this area required improvement as evidenced by the following:

- Two sharps bin containers in the treatment room on the ground floor did not have temporary closures in place.
- A store room on the first floor required review as clean laundry was stored with incontinence wear and PPE which posed a high risk of contamination and risk of transmission of infection.
- A small number of staff were observed wearing masks incorrectly on the second day of inspection. This posed a risk of transmission of infection and was brought to the attention of person in charge.
- The storage of residents' wash basins required review as there was a potential risk of cross contamination.
- Dirty linen was observed stored on the floor in the sluice room on the first floor which posed a risk of transmission of infection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had good oversight of fire safety. Training was provided and systems were in place to ensure fire safety was monitored and fire detection and alarms were effective in line with the regulations. Bedroom doors had automatic free swing closing devices so that residents who liked their door open could do so safely. Evacuation drills were practiced monthly since March 2023 based on lowest staffing levels in the centre’s largest compartment.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Actions were required in the safe storage of medications and checking of control drugs balances in the centre. For example;

- Control drugs balances were not checked at each shift change over. This is a requirement by the Misuse of Drugs Regulations 1988 and as per guidance issued by An Bord Altranais agus Cnáimhseachais na hÉireann, a count of controlled drugs should be carried out at all staff changeover shifts.

- Medicines were not stored securely on the first floor in the centre. The inspector observed pre-packed medication dossier packs for residents on the first floor left on the counter work top in the treatment room and the door to the room was not always secure. On the first day of inspection, the inspector found the door open which posed a risk to the safety of the residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Improvements were required to ensure that all residents had a care plan consistent with their assessed needs. In a sample of nursing notes viewed not all residents had a care plan in place to guide staff to meet their assessed needs. For example:

- Residents whom were assessed to require bed rails as a restrictive device did not have a care plan to guide staff on measures to provide safe nursing care when bed rails were in use.
- There were no individualised care plans to support residents with behaviour that is challenging or to guide staff to manage residents who experienced challenging behaviour.
- A resident's care plan did not clearly reflect their current pressure ulcer grading stage and plan of care of the pressure ulcer wound.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. GP's routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professional as appropriate.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Improvements were required in the documentation of behavioural assessment charts to enable nursing staff to develop care plans to deescalate responsive behaviours. This would provide clearer steps for staff in managing residents with

responsive behaviours in accordance with the centre's policy. For example:

- Antecedent - Behavioural - Consequence (ABC) assessment charts were not completed for residents identified as having behaviours that were challenging. This was a missed opportunity as this evidence based assessment chart would have assisted staff to identify factors that trigger a behavioural incident. Accurate documentation of the behavioural incident would also support staff to work therapeutically with residents, to manage the behaviours effectively and improve the residents' quality of life.

Improvements were required in the documentation of restraint use in accordance with the national policy, for example:

- There were no individualised care plans for the use of bed rails.
- There was no consent forms available for the residents who used bedrails as a restrictive device.
- Safety checks for bedrails in use were not completed in line with the national policy.

Further training was required for staff in the risks and safe use of bed rails as outlined in the centres restraint policy.

Judgment: Not compliant

Regulation 8: Protection

A review of a sample of staff files identified that one staff member had commenced employment one month prior to a Garda vetting disclosure being obtained. This was not in adherence with the centre's own recruitment, selection and vetting of staff policy, and could pose a safeguarding risk to residents.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Action was required to ensure that all residents dignity and privacy was maintained. For example:

- Residents bedrooms had net curtain screening installed, a number of screens were observed out of place on the days of inspection allowing a clear view of the residents in their bedroom which prevented residents to undertake activities in private.

Judgment: Substantially 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	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Tramore Nursing Home OSV-0008484

Inspection ID: MON-0039657

Date of inspection: 01/08/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The PIC has introduced a mid-shift safety pause for Nurses and HCAs to come together to ensure there is transparency and clinical oversight of all residents and any issues/concerns that may have arisen during the shift. This is led by the Nurse in Charge on each shift. • To enhance supervision and to support the PIC, the Senior Staff Nurses are allocated Clinical Management shifts to provide oversight and guidance for staff. • ABC Charts have been implemented for residents with behaviours that are challenging, and these are regularly reviewed by the Person in Charge, CNM and Senior Staff Nurses. Such events are discussed and handover and safety pauses. • The PIC will arrange additional training in managing behaviour that is challenging. The aim of the training is to ensure all staff are competent in assessing, managing and documenting incidents of responsive behaviour, and to help staff recognise triggers and improve residents' quality of life by preventative management.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • We are actively recruiting to fill the vacant posts as outlined in our Statement of Purpose in line with resident occupancy. • As an interim measure two senior staff nurses have taken on clinical management responsibilities and have supernumerary time to provide clinical supervision, oversight	

and guidance for staff. The CNM continues to support all staff in the home and support the governance and management of the home.
• We will backfill vacant posts with the use of agency staff in the interim, and we will ensure that agency staff are appropriately inducted and supervised.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The PIC will ensure that learning outcomes and the level of satisfaction of the complainant are consistently recorded as part of the outcome of the complaint

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Arrangements for cleaning and IPC in the home have been reviewed by the registered provider to ensure the home is safe and cleaned in line with National Standards for infection prevention and control in community services.

• The PIC will ensure that sharps bins are stored appropriately and safely and this will be audited on the centre's audit management system with appropriate actions in place to ensure compliance.
• The PIC has reviewed the storage of equipment in the centre, and we will ensure that all equipment and items are stored safely and appropriately. The PIC will monitor compliance and will carry out random spot checks on clinical walkaround in the centre.
• The PIC has instructed staff on the correct method of wearing face masks if they choose to wear them.
• Extra hooks have been placed in resident bathrooms to ensure wash basins are stored off the floor.
• The PIC has instructed staff on the correct management of dirty linen.
• There are ongoing IPC and environmental audits completed in the home with monthly review of quality improvement plans.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • Nursing staff check controlled drugs at every handover shift, and this is recorded in the controlled drugs record book. • A locked drugs trolley is now in place to store resident medication packs safely on the first floor.	
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: • The PIC has reviewed the assessments and care plans of all residents with bed rails and there are now appropriate care plans in place to safely guide care in line with the national guidelines. • The PIC has reviewed the assessments and care plans of all residents who present with behaviour that is challenging. Episodes of challenging behaviour are being monitored and behavioural charts are completed for each episode. This will help staff to identify triggers to the behaviours and thus plan care in a way that minimizes or eliminates exposure to the known triggers. All care plans will be updated on an individual basis. • The PIC has reviewed all wound assessments and care plans, and where appropriate referred to the Tissue Viability Nurse. Wounds are now appropriately graded, and care plans are in place. • In addition, all care plans will be reviewed by a senior staff nurse or CNM using the clinical care audit to ensure all aspects of care are appropriately assessed, planned and evaluated. Additional learning needs identified as a result of this ongoing audit will be provided.	
Regulation 7: Managing behaviour that is challenging	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: • ABC Charts have been implemented for residents with behaviours that are challenging and regularly reviewed by the Person in Charge, CNM and Senior Staff Nurses. Such events are discussed during handover and safety pauses. This is also audited in the	

Clinical Care Audits. The results are discussed with individual staff members and a quality improvement plan will be implemented for any actions required.
• Bed rails care plans also form part of the clinical care audits and are audited as above. To date all resident with a bed rail now have an appropriate care plan in place.
• Where bed rails are in use, the residents have signed a consent form.
• Safety checks for bed rails have been incorporated in the resident safety checks and in line with the national policy on restrictive practice.
• The use of bedrails is discussed on an individual resident basis with the resident, nurse and Person in Charge. Additional training will be completed by nurses and HCA staff as per regulation 16.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• All staff employed in the centre have received Garda Clearance and we will not allow any new employee to commence in post before Garda Clearance has been received.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Voile privacy curtains are in place in every bedroom to allow residents privacy while allowing in maximum daylight. Residents can choose, if they wish, to open the privacy voile or leave them closed. Staff have been reminded to ensure screens in resident rooms are appropriately positioned to ensure resident privacy and dignity.

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 16(2)(c)	The person in charge shall ensure that copies of relevant guidance published from time to time by Government or statutory agencies in relation to designated centres for older people are available to staff.	Substantially Compliant	Yellow	30/11/2023
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 effectively monitored.	Substantially Compliant	Yellow	15/09/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and	Substantially Compliant	Yellow	15/09/2023

	control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	15/09/2023
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	15/09/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's	Substantially Compliant	Yellow	31/10/2023

	admission to the designated centre concerned.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	30/11/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	15/09/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	15/09/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	15/09/2023