# Health Information and Quality Authority

**Regulation Directorate**

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Tinnypark Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000707</td>
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<tr>
<td>Centre address:</td>
<td>Derdimus, Callan Road, Kilkenny.</td>
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<tr>
<td>Telephone number:</td>
<td>056 777 1550</td>
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<tr>
<td>Email address:</td>
<td><a href="mailto:info@tinnyparknursinghome.com">info@tinnyparknursinghome.com</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Tinnypark Residential Care Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Anne Walpole</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Ide Cronin</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>46</td>
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<td>Number of vacancies on the date of inspection:</td>
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About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
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 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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From: 08 August 2017 09:10  
To: 08 August 2017 16:00  
09 August 2017 08:20  
09 August 2017 13:45

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

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<th>Outcome</th>
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<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 06: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 08: Governance and Management</td>
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<td>Non Compliant - Moderate</td>
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**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The inspector incorporated an additional outcome to this inspection as the governance arrangements had changed since the previous inspection. The inspection also followed up on progress of the action plans from the last inspection of the centre, reviewed notifications and other relevant information.

The centre did not have a dementia specific unit and at the time of inspection there were 24 of the 47 residents living in the centre that had a formal diagnosis of dementia. The inspector observed that many of the residents required a high level of
support and monitoring due to their individual needs and dependencies.

The provider had submitted a completed self-assessment tool on dementia care to the Health Information and Quality Authority (HIQA) with policies and procedures requested prior to the inspection. The judgments of the self-assessment and the inspection findings are stated in the table above. The inspector observed that the management team and staff working in the centre were committed to providing a quality service for residents with dementia. However audit systems to monitor the quality of the service had not been consistently undertaken in 2017 particularly in areas of clinical risk such as medicines management. Therefore the quality of care and experience of residents was not monitored effectively as deficits in practice were not identified and could not positively inform improvements in the safety and quality of care or the quality of life of residents.

The inspector met with residents and staff members on this inspection. She reviewed the assessed care needs of residents and tracked the journey of a sample of residents with dementia within the service. Care practices and interactions between staff and residents who had dementia were observed using a validated observational tool. The inspector also reviewed documentation such as care plans, policies relating to dementia care, medical and nursing records and staff files.

The inspector found that residents’ healthcare needs were met. Residents had access to general practitioners (GPs) and allied support services such as physiotherapy, speech and language therapists and community health services were also available. Residents’ accommodation was provided at ground floor level. The design and layout of the centre met its stated purpose to a good standard and provided a comfortable environment for residents with dementia.

Matters requiring review are discussed throughout the report and the action plan at the end of the report contains actions that are required to be completed to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016).
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 Standards for Residential Care Settings for Older People in Ireland.

### Outcome 01: Health and Social Care Needs

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The inspector tracked the journey of residents with dementia and also reviewed specific aspects of care such as nutrition, end-of-life care and management of responsive behaviours. The inspector found that there were systems in place to optimise communications between the resident/families, the acute hospital and the centre. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, that relevant and appropriate information about their care and treatment was readily available and shared between providers and services. Pre-admission assessments were undertaken by the person in charge.

Comprehensive nursing assessments, using validated assessment tools were carried out on admission of all residents including those with dementia. Each resident had a care plan developed to address their individual needs. Residents' care plans were reviewed and updated if necessary every four months or more frequently in response to their changing needs. Care plans for residents with dementia or responsive behaviours were person-centred and specific to guide staff and manage the needs identified.

The inspector saw that residents with dementia had good communication plans in place to support a consistent approach by staff. The inspector observed that where a small number of residents exhibited aspects of responsive behaviours which were related to the behavioural and psychological symptoms of dementia (BPSD), the care plans described effective positive behavioural strategies for use by staff to manage these behaviours.

There was evidence that residents received timely access to health care services, including support to attend out-patient appointments. Residents' documentation reviewed by the inspector confirmed they had access to GP care including out-of-hours medical care. Residents had good access to allied healthcare professionals. Physiotherapy, occupational therapy, dietetic, speech and language therapy, dental, ophthalmology and podiatry services were available to residents as necessary. Community psychiatry of older age specialist services attended residents in the centre.
Residents' positive health and wellbeing was promoted with regular exercise as part of their activation programme, an annual influenza vaccination programme, regular vital sign monitoring and medicine reviews. Residents in the centre had access to palliative care services for support with management of their pain and for symptom management during end-of-life care as necessary. Staff demonstrated good knowledge and understanding of each resident’s background in conversation with the inspector. Staff told the inspector that residents/relatives were involved in the care planning process, and there was documentary evidence that residents or their representative were involved in the development and review of their care plan.

Arrangements were in place to meet the nutritional and hydration needs of residents with dementia. A nutrition audit had been completed in 2016. There were systems in place to ensure residents' nutritional needs were facilitated and monitored. The menu of the day was written on a board in main the dining area. The inspector saw that residents were offered choice at each meal. There was evidence of efforts made to ensure residents with dementia had their individual food tastes and choices met as observed by inspectors.

Residents were assisted with their meals by staff and were observed to encourage residents to maintain their independence with eating and drinking. However, the inspector observed some institutionalised practices at meal times such as a care staff member feeding two residents at the same time. This practice does not reflect a person-centered approach to care. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Referrals for review by a diettian and or speech and language therapist were prompted following assessment and reviews. The inspector spoke with catering staff who were aware of each resident's dietary requirements.

There were no residents in the centre in receipt of end-of-life care on the day of inspection. Staff spoken with demonstrated an understanding of the principles that underpinned the centre's approach to end-of-life care and also an individual commitment to those principles of dignity and respect for the wishes and preferences of residents at the end of their lives. There was an end-of-life care policy and there was an end-of-life committee in place. Palliative care services were available to support residents and staff with symptom control, including pain management. However, there was inconsistent evidence that the end-of-life needs and wishes of all residents’ with dementia were discussed with them and/or their next of kin as appropriate and documented in a care plan.

The inspector reviewed the practices and documentation relating to medicines management in the centre. There were written policies in place relating to the ordering, prescribing, storing and administration of medicines to residents. There were procedures in place for the handling and disposal of unused and out of date medicines.

The inspector found that some practices in relation to administration recording and review of medicines did not meet with professional or regulatory requirements. Some residents were not sufficiently protected by medicines management practices and procedures found in the sample of residents’ records inspected. Issues identified
*There were gaps identified in some medicine administration records reviewed, therefore it was impossible to ascertain if the resident had taken their medicines or not. *The date of opening was not recorded for a medicine that had a reduced expiry date when opened. Therefore, staff could not identify when the medicine would expire. The inspector observed that another medicine had expired. *The inspector saw that the medicines management policy did not reflect practices in the centre. For example the centre’s medicines management policy outlined that the crushing medicines must always be ordered by a medical practitioner. The inspector saw in one instance that this was not consistently implemented in relation to the modification of dosage forms. *The prescription sheets reviewed were legible and distinguished between p.r.n (a medicine given as the need arises), regular and short term medicines. However, the maximum doses of p.r.n medicines to be given in 24 hours were not prescribed in all of the medicine charts reviewed by the inspector. *Transcribing practices required improvement. The centre’s policy in relation to transcribing and guidance issued by An Bord Altranais agus Cnáimhseachais was not consistently implemented in practice. In one instance the inspector observed that the transcribed orders were not signed and dated by the transcribing nurse nor was it co-signed by the prescribing doctor. *Medicines that required strict control measures were managed appropriately and kept in a secure cabinet in-keeping with professional guidelines. Nurses kept a register of all controlled drugs. The inspector confirmed that the stock balance was checked and signed by two nurses. However, this was not done in accordance with guidance issued by An Bord Altranais agus Cnáimhseachais or the centre's policy as stock checks were not completed at changeover of each shift. The inspector observed that medicine management audits had not been completed for some time therefore the deficits as outlined above had not been identified by the management team.

**Judgment:**
Non Compliant - Moderate

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**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
A policy was in place for safeguarding vulnerable adults which outlined procedures and
appropriately referenced current national guidelines. The policy was also available in an easy-to-read format also. Records indicated that regular training on safeguarding vulnerable adults was provided. Staff members spoken with had received training and understood how to recognise instances of abusive situations and were aware of the appropriate reporting systems in place.

There were systems in place to ensure allegations of abuse were fully investigated, and that pending such investigations measures were in place to ensure the safety of residents. The person in charge was well known to residents as observed by the inspector. Staff confirmed that there were no barriers to raising issues of concern.

A restraint free environment was promoted. At the time of this inspection there were nine residents with bedrails raised. A risk assessment was completed prior to using bedrails. Signed consent was obtained. There was evidence of multi disciplinary involvement in the decision making process. There was evidence of trialling alternatives prior to using bedrails. Some residents used lap belts for safety reasons and chemical restraint was not used. Two hourly checks of residents using bedrails were documented and these records were viewed by the inspector.

There were systems in place to monitor residents who used bedrails or lap belts and their continued use was considered as part of the quarterly care plan review. When a resident requested the bedrail was raised for use as an enabler, a risk assessment was undertaken to ensure the practice was safe. However, the inspector observed that there was inconsistent application of the restraint assessment process for example the inspector observed that two risk assessments had not been updated since 2016 which is not in line with best practice.

Some residents had behaviours and psychological symptoms of dementia (BPSD). There were appropriate referrals and reviews from the community mental health team and from psychiatry of later life. There was a policy in place for responsive behaviours. Behaviours logs were being completed to identify triggers and to inform further planned reviews by the psychiatry team. Staff spoken to were knowledgeable regarding how they engaged and redirected the resident to provide reassurance and to reduce the residents’ anxiety. Individual behavioural support logs were developed to inform staff of proactive and reactive strategies to help and ensure a consistent approach.

Training records reviewed indicated that not all staff were facilitated to attend training related to the care of older people with responsive behaviours. This was an area identified for improvement in the action plan of the previous inspection and was not satisfactorily completed.

There were procedures and practices in place to keep residents’ money safe. The centre was a pension agent for one resident. Small amounts of residents’ money were managed on their behalf in the centre. This was held securely, and a robust system was in place to document all transactions. The inspector reviewed a sample of this documentation and found that the corresponding balance was correct and transactions were dual signed.

**Judgment:**
### Outcome 03: Residents’ Rights, Dignity and Consultation

#### Theme:
Person-centred care and support

#### Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

#### Findings:
Resident’s privacy and dignity was respected, including receiving visitors in private. There were no restrictive visiting arrangements, apart from at mealtimes. Visitors were present throughout the day. Residents met visitors in the sitting room or foyer. There were areas for residents to receive visitors in private should they so wish. Since the last inspection, a second visitors' room has been provided. Residents who spoke with the inspector expressed a high level of satisfaction with the service they received and with living in the centre.

The centre had one dedicated full-time activities coordinator and a part-time activity coordinator. They managed a programme of activities and also organised special events and celebrations. The provision of activities for residents had increased since the previous inspection and there were activities planned at weekends for residents. Social care assessments were completed for residents to detail their interest and hobbies and how they like to spend their day. The activity coordinator spoken with explained the range of activities provided daily including spiritual support requested by the residents in line with the ethos of service. At the time of this inspection all residents were getting up each day. While more frail residents retired to bed earlier they were encouraged and supported to be involved in activities suitable to their capacity and life stage.

There were systems in place to support residents to exercise their religious, civil and political rights. There was a residents’ committee in operation. The inspector reviewed the minutes of the last residents’ meeting which had been held on 10 February 2017. Records were maintained of issues raised by the residents at these meetings. It was clear that residents were individually given the opportunity to raise their own issues at these meetings. However, it was unclear whether issues raised by residents were actioned as records did not demonstrate this. The inspectors saw that there was an external advocacy service available to residents or relatives should they wish to obtain help to make a complaint or require assistance to express their views.

The inspector used a validated observational tool to rate and record at five minute intervals the quality of interactions between staff and residents in the centre. The observation tool used was the quality of interaction schedule or (QUIS). These observations took place in the lounge areas and in the dining areas of the centre. Each observation lasted a period of 30 minutes and inspectors evaluated the quality of interactions between staff and residents with dementia.
Some positive interactions between staff and residents were observed during the inspection. However, the inspectors observed that some staff did not avail of opportunities to socially engage with residents. It was also observed during meal times that many staff did not engage residents in conversation except when engaging in tasks. The inspector also completed an observation period in an arts and craft class led by the activity coordinators. During this session all staff were seen to engage in a meaningful way with residents, and staff adapted their approach to residents based on their capabilities. It was evident to the inspector that this activity was a positive experience for all residents engaged in it.

Residents had free access to a secure, well maintained gardens. Residents and staff told the inspector about the garden party they had in July. Residents were involved in planning the event and photographs were displayed in the centre. The inspector discussed with the activity coordinator the provision of external day trips for residents. This had also been raised at the previous inspection by inspectors.

There was a communication policy in place. Communication aids and devices such as glasses or hearing aids were used by some residents, and staff were aware of these various communication needs. Residents' communication needs were documented in care plans reviewed by the inspector and staff were seen to reflect this in practice.

**Judgment:**
Compliant

### Outcome 04: Complaints procedures

**Theme:**
Person-centred care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Policies and procedures which comply with legislative requirements were in place for the management of complaints. The policy was available in an easy-to-read format also. Residents were aware of the process which was displayed. Residents told the inspector that they would have no hesitation reporting an issue to the person in charge or staff.

On review of the record of complaints there was evidence that all complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcomes and a review was conducted to ascertain the satisfaction of the complainant further to issues being resolved.

All complaints were found to be resolved in a timely way. The independent advocacy service was advertised and details of the Office of the Ombudsman were displayed in
Judgment: Compliant

Outcome 05: Suitable Staffing

Theme: Workforce

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found that at all times there were enough staff with the appropriate skills qualifications and experience to meet the assessed needs of residents, including those with dementia. Staff were found to be knowledgeable regarding the needs of residents and appropriately supervised.

Each resident had a named nurse and a key health care worker assigned to them and teams were allocated to work with residents in various wings on a daily basis. There were three regular meetings held in a 24 hour period to update the team about care and welfare issues related to each resident. There was a communication diary used to alert staff about important events such as residents' birthdays, hairdressing and medical appointments.

A programme of training was maintained to ensure that all staff had mandatory training. Staff also had access to relevant training to meet the needs of residents. For example end-of-life care, dementia care, nutrition and wound care. Both care staff and nurses told the inspector about the range of training they had attended. Direct communication with management was facilitated by staff meetings as observed by the inspector.

Residents who had dementia were noted to be particularly well supported and staff could describe to the inspector how they helped residents orientate to their environment and participate in day-to-day life to their maximum ability. They described giving resident's choices and ensuring they had plenty of time to respond to questions, speaking slowly and clearly and encouraging them to participate in familiar activity and in reminiscence sessions.

The inspector found that staff were confident, well informed and knowledgeable of their roles, responsibilities and the standards regarding residents with dementia living in residential care. They were familiar with residents and had sufficient experience and knowledge to provide safe and appropriate care to residents. The inspector observed that residents were at ease in their surroundings and with staff.

Evidence of current professional registration for all rostered nurses was made available.
The inspector reviewed a sample of four staff files. All information as required by Schedule 2 of the regulations was made available. A vetting disclosure was in place in all staff files reviewed and the person in charge gave verbal assurances that all staff working in the centre had a satisfactory vetting disclosure in place.

There were two volunteers operating in the centre. The inspector found that both of these people had Garda vetting in place. However, their roles and responsibilities were not set out and agreed in writing as required by legislation.

**Judgment:**
Substantially Compliant

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**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The layout and design of the centre was suitable for its stated purpose and met the needs of the residents. The premises takes account of the residents’ needs and abilities, and was maintained in line with Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The inspector found the centre to be warm, well maintained and suitably decorated.

Since the previous inspection the registered provider had made further improvements to the designated centre. The centre had become a tobacco free environment and the old smoking room had been converted to a nicely furnished quiet/visitors room. One of the sitting rooms had been reorganised as a dedicated activities room and the inspector saw many residents using this room during the inspection. Some bedrooms had been repainted and refurbished since the previous inspection. The provider was in the process of upgrading the broadband system to support the use of the electronic care planning system and the centre was linking with the pharmacy to commence the use of e-mars.

Residents had good access to indoor and outdoor areas and to external gardens and courtyards. The grounds were well maintained. Sitting and dining rooms and communal rooms were spacious, decorated in a homely fashion with good natural lighting. There were other smaller areas and rooms to sit or dine in, that were pleasantly furnished. Bedrooms were personalised too suit the individual resident and many residents had a picture on the door to help them to identify their bedroom. All bedrooms and communal rooms had a call bell.

Corridors and door entrances of accommodation used by residents were wide and spacious to facilitate movement and equipment by residents. Bedrooms were spacious
to accommodate personal equipment and devices required by existing residents. Hand-rails and grab-rails were provided where required. Paintings and photos of residents were displayed on corridors throughout the premises, and signage was also displayed on some toilets and at junctions to direct residents to communal rooms. Additional improvements in relation to signage and use of contrasting colours would promote the dignity, wellbeing and independence of residents with dementia. It would also support residents with dementia navigating their way around the centre.

Bedroom accommodation was provided through a mix of single and twin occupancy rooms (39 single bedded rooms and four twin rooms). All bedrooms had en-suite shower and toilet facilities. The size and layout of bedrooms met the needs of the residents and screening was used in twin rooms to provide privacy for both residents. All residents had a safe in their bedrooms.

Mobility aids were available to promote safe moving and handling practices. There was a system in place which supported the timely reporting and carrying out of remedial maintenance work. There was documentary evidence to show that equipment was regularly serviced.

Suitable storage arrangements were available throughout the centre. Kitchen facilities are located within the building. A large spacious dining room adjoined the kitchen where residents’ food was prepared, cooked and served from at meal-times.

A laundry facility is available within the centre to launder residents clothing, bedding and curtains. Residents told the inspector that they were satisfied with the laundry systems in place.

**Judgment:**
Substantially Compliant

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**Outcome 08: Governance and Management**

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The governance structure had changed since the previous inspection. The person in charge is also now the provider nominee. There are two company directors onsite daily. The person in charge/provider nominee told the inspector that the company directors were very supportive and always available to her.

The quality of care and experience of the residents had been reviewed in 2016 through an audit programme that reviewed various aspects of the service. The areas reviewed...
included nursing documentation, falls, wound management, privacy and dignity, continence and medicines management. The inspector observed that previous audits did not always include the actions taken to address the problem identified, when the action was implemented or checked to determine effectiveness. This would ensure that deficits had been completed therefore ensuring positive outcomes for residents.

The inspector observed that clinical and non clinical audit had not been consistently carried out 2017 particularly in areas of clinical risk such as medicines management. Therefore the quality of care and experience of residents was not monitored effectively as deficits in practice were not identified and could not positively inform improvements in the safety and quality of care or the quality of life of residents.

An annual review of the quality and safety of care delivered to residents for 2016 was completed that informed the service plan being implemented in 2017. The inspector saw that parts of the quality improvement plan for 2017 as outlined in the annual review had been completed.

**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:**

Ide Cronin
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<thead>
<tr>
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<th>Tinnypark Nursing Home</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000707</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>08/08/2017 and 09/08/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>29/08/2017</td>
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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 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre’s policy in relation to transcribing and guidance issued by An Bord Altranais agus Cnáimhseachais was not consistently implemented in practice. In one instance the inspector observed that the transcribed orders were not signed and dated by the transcribing nurse nor was it co-signed by the prescribing doctor

1. Action Required:

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

Please state the actions you have taken or are planning to take:
Transcribed medicine orders will be signed by two nurses and co signed by the GP within 72 hours.

Proposed Timescale: 29/08/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Procedures in place for checking controlled drugs was not done in accordance with guidance issued by An Bord Altranais agus Cnáimhseachais or the centre's policy as stock checks were not completed at changeover of each shift.

The centre’s medicines management policy outlined that crushing medicines indicates the medicine administration record must always be amended by a medical practitioner. The inspector saw in one instance that this was not consistently implemented in relation to the modification of dosage forms.

2. 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.

Please state the actions you have taken or are planning to take:
Controlled drugs will be checked at changeover of each shift. Kardex to be amended by GPs to indicate when crushing is required for each medication.

Proposed Timescale: 08/08/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inconsistent evidence that the end-of-life needs and wishes of all residents’ with dementia were discussed with them and/or their next of kin as appropriate and documented in a care plan.

3. Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.
Please state the actions you have taken or are planning to take:
Staff nurse has been assigned to ensure all end-of-life needs and wishes of all residents are completed.

**Proposed Timescale:** 30/09/2017

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The inspector observed some institutionalised practices at meal times such as a care staff member feeding two residents at the same time.

4. **Action Required:**
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

Please state the actions you have taken or are planning to take:
Staff have received instructions in relation to assisting residents at mealtimes. Dining room has been altered. Layout changed and table settings improved.

**Proposed Timescale:** 29/08/2017

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were gaps identified in some medicine administration records reviewed, therefore it was impossible to ascertain if the medicines had been given to the resident or not.

The maximum doses of p.r.n medicines to be given in 24 hours were not prescribed in all of the medicine charts reviewed by the inspector.

5. **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:
Training is taking place week commencing 21 August 2017 in EMAR and will commence when all staff are competent in new format. Maximum dose of medicines will be indicated for all PRN medicines.
### Proposed Timescale: 24/09/2017

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspector observed that the date of opening was not recorded for a medicine that had a reduced expiry date when opened. Therefore, staff could not identify when the medicine would expire. The inspector observed that another medicine had expired.

6. **Action Required:**
Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

Please state the actions you have taken or are planning to take:
All out of date medicines will be disposed of in accordance with national legislation.
Date of opening will be recorded on all medicines.

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### Proposed Timescale: 29/08/2017

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### Outcome 02: Safeguarding and Safety

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Training records reviewed indicated that not all staff were facilitated to attend training related to the care of older people with responsive behaviours.

7. **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:
Online training has commenced 14 August 2017. Staff are requested to complete training in care of the older with responsive behaviours.

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### Proposed Timescale: 30/09/2017

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector observed that there was inconsistent application of the restraint assessment process for example the inspector observed that two risk assessments had not been updated since 2016 which is not in line with best practice.

8. Action Required:
Under Regulation 07(3) you are required to: 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.

Please state the actions you have taken or are planning to take:
Risk assessments had been updated in July 2017 in a new format and not shown to the inspector at the time of inspection.

Proposed Timescale: 29/08/2017

Outcome 05: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The roles and responsibilities of volunteers were not set out and agreed in writing as required by legislation.

9. Action Required:
Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
The role of volunteers will be set out in writing for each volunteer.

Proposed Timescale: 14/09/2017

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Additional improvements in relation to signage and use of contrasting colours would promote the dignity, wellbeing and independence of residents with dementia. It would
also support residents with dementia navigating their way around the centre.

10. **Action Required:**  
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

**Please state the actions you have taken or are planning to take:**  
Director of Nursing has consulted provider of another nursing home and is planning to implement new signs to facilitate residents to navigate their way around the home and to find facilities easily.

**Proposed Timescale:** 30/09/2017

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<tr>
<th>Outcome 08: Governance and Management</th>
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<td><strong>Theme:</strong> Governance, Leadership and Management</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The inspector observed that clinical and non clinical audit had not been carried out 2017 particularly in areas of clinical risk such as medicines management.

11. **Action Required:**  
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**  
Audits are being conducted currently. Clinical and non clinical audits will be completed and improvements implemented as required.

**Proposed Timescale:** 14/10/2017