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:	TLC Centre Maynooth
Name of provider:	Veritdale Limited
Address of centre:	Straffan Road, Maynooth, Kildare
Type of inspection:	Unannounced
Date of inspection:	03 August 2022
Centre ID:	OSV-0000684
Fieldwork ID:	MON-0035555

About the designated centre

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

TLC Centre Maynooth is a ground-floor nursing home located on the outskirts of Maynooth, Co. Kildare. The centre is registered to accommodate up to 141 residents within two buildings that are divided into five areas- Kinvara House, The Courtyard, Oak House, Arkle House and Champ House (Corridor 4). Kinvara House is in a separate building that accommodates 57 residents. Bedroom accommodation consists of 41 single bedrooms and eight double/twin bedrooms with full en-suite facilities. A variety of open-plan and communal spaces were available. Meals were transported to the Kinvara House kitchenette/dining room from the kitchen located in the other/main building. Oak House, located in the main building, accommodates 13 residents living with dementia or Alzheimer's disease. Bedrooms comprise eight single and two twin/double. The Courtyard accommodates 31 residents in single en-suite bedrooms. Arkle House and Champ House (Corridor 4) consist of 20 twin/double en-suite bedrooms. These areas share the facilities and communal areas within the main building. The ethos of the centre is to promote residents' independence and value individuality. The aims of the centre are to meet the individualised needs of residents by encouraging them to continue to lead as active and fulfilling a life as is within their desires and capacities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	119

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
Wednesday 3 August 2022	09:05hrs to 17:45hrs	Helena Budzicz	Lead
Wednesday 3 August 2022	09:05hrs to 17:45hrs	Deirdre O'Hara	Support
Wednesday 3 August 2022	09:05hrs to 17:45hrs	Arlene Ryan	Support

What residents told us and what inspectors observed

This inspection took place over the course of one day. The inspectors spent time in each of the units in the centre to see what life was like for residents living there and spoke with eight residents and four visitors during the day. Overall feedback from residents and their families was positive regarding the residents' quality of life and the services that were provided. Residents told inspectors that they felt safe in the centre, were well cared for, and that staff were kind and caring. Residents were observed relaxing in the various communal rooms throughout the day of the inspection. The residents were nicely dressed and well groomed. A number of residents were unable to have a conversation due to speech or cognitive impairments but were observed to be content and comfortable in their surroundings. The staff in the centre appeared familiar with the residents and were seen to be patient and attentive towards the residents. Staff were visible on each of the units, and call bells were answered in a timely manner.

Following an opening meeting, the inspectors walked through each of the centre's units with the person in charge and the two assistant directors of nursing. There were 119 residents residing in TLC Centre Maynooth at the time of inspection and 22 vacancies. The two buildings of the designated centre are single-storey, comprising single and double-occupancy bedrooms, a number of communal rooms and external garden areas and courtyards. There was a range of comfortable seating in convenient locations in some areas of the centre where residents could sit and rest as they walked around. However, inspectors observed restricted access to the garden area in the Oak House, and there was no appropriate seating available. Additionally, most of the doors leading to the garden areas or courtyards were locked. As a result, residents had to ask staff to unlock the doors if they wished to enjoy the outside space.

Residents' bedrooms were personalised with ornaments, family photos and personal items of significance. All rooms were en-suite with shower, toilet and wash-hand basin facilities. However, inspectors saw that there was no adequate storage available in some of the double-occupancy bedrooms for personal items. Furthermore, the design and layout of some rooms was not supporting resident's rights in terms of ensuring privacy and the available space was not sufficient to ensure residents could have access to personal belongings, a chair and table, as further detailed under Regulation 17: Premises.

The dinner was observed to be an enjoyable, social event for the residents in the dining room. The meals served appeared wholesome and nutritious. Some residents preferred to stay in their own room for their meals, and this was respected by staff. Many residents were eating independently, and sufficient staff were available to support those who required some assistance or prompting. Residents who spoke with inspectors confirmed that their meal was hot and that there was a variety of food offered, and that they enjoyed their meals.
There was signage located throughout the designated centre, which informed staff,

residents and visitors of the protocols to follow to reduce the risk of infection, such as the wearing of personal protective equipment (PPE), hand hygiene and cough etiquette.

Staff were seen to use personal protective equipment (PPE) appropriately. While hand hygiene practice was good, a small number of staff were seen to wear nail varnish or wrist jewellery, which impacted on effective hand hygiene.

While the centre largely provided a homely environment for residents, there were infrastructural issues which impacted effective infection control. For example, the layout of water pipes in cleaners' rooms, carpets and damaged radiator covers and flooring in communal rooms, and the kitchen units in Oak House were damaged. These surfaces did not support effective cleaning or ensure sufficient comfort for residents. Hand-hygiene sinks were available in the communal areas and the clinical rooms, which were dedicated for staff use. These sinks did not comply with the recommended specifications for clinical hand-wash basins. This is further discussed under Regulation 27: Infection Control. In general, flooring and furnishings in the centre were not in good repair in several areas of the centre. The inspectors saw that while an internal refurbishment action plan was underway, there were numerous aspects of the premises that impacted on residents' safety, quality of life and lived experience in the centre. Activities were coordinated and provided by either the activities coordinators or health care staff on a daily basis. The activities schedule was displayed on each unit. Residents had opportunities to participate in a variety of group activities every day. One-to-one activities were also available for residents.

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The next two sections of the 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 centre has a good history of regulatory compliance; however, the findings of this inspection showed that the standard of care provided and the oversight of the service had not been sustained. Significant action was required now to bring the centre into compliance with the care and welfare regulations and ensure a safe and appropriate service was provided.

This was an unannounced risk inspection by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and to review the information submitted

by the provider in respect of the application to renew the registration of the centre. Additionally, the compliance plan from the previous inspection carried out in July 2021 was followed up, and inspectors found that some items had still not been completed, and more focus was required to bring the centre into full compliance with the Care and Welfare Regulations. The oversight, monitoring and maintenance of the premises, resident's rights, fire precautions, infection control management systems, medication management and effective management of the risks identified on the day of inspection were not sufficient.

The centre was operated by Veritdale Limited, which is the registered provider. There was a clearly defined management structure with identified lines of accountability and responsibility for the service, and staff and residents were familiar with these arrangements. However, while there were structural management systems in place, some of the managerial arrangements to oversee the effective running of the service were not adequately implemented. On the day of inspection, inspectors found that many of the quality and safety aspects of the service had not been monitored appropriately as outlined under relevant regulations in this report.

Evidence of regular governance and management meetings was seen by inspectors, including the centre's monthly governance meeting and the clinical and corporate monthly governance meeting. There was an extensive agenda relating to both clinical and non-clinical aspects of the centre, including a review of the audits undertaken. Some of the findings from this inspection had been recognized in the audits and had been appropriately escalated in these meetings. Action plans had been developed, but some required stringent timelines to address risks and many aspects of the action plans were outstanding. In addition, a significant number of issues identified on the day of inspection had previously been identified during the environmental audits and action plans closed. However, some of these same issues were still present on the day of inspection, such as the storage of items above floor level in the storage rooms, de-cluttering the tops of wardrobes and general maintenance issues. The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. Barriers to effective hand hygiene practice and premises deficits, and inadequate supervision and oversight of cleaning practices were identified during the course of this inspection.

The centre had experienced three significant COVID-19 outbreaks since the last inspection. One outbreak affected mostly staff, while the other outbreaks affected a large number of residents and staff. The centre was supported during these outbreaks by Public Health and the Integrated Framework Team from a local hospital. The provider completed formal reviews of the management of the outbreaks and used learning from outbreaks to improve the quality and safety of care in the centre. Examples of improvements seen were zoning of staff break areas to prevent cross-infection and additional training for the correct use of PPE and hand hygiene practice.

Regular infection control audits were carried out and recommended actions with the responsible persons were clearly identified. However, the audit tools used did not identify findings on the inspection day. Gaps in examples seen were in the

monitoring of the cleanliness of shower and commode chairs and hand hygiene product dispensers, which were observed to be unclean. There was a range of store rooms used for storing medical supplies and continence wear, which were in a poor state of repair. This was evidenced by holes in walls and concrete floors with high levels of dust and debris and birds dropping seen on packets of continence wear. Builders' supplies were seen to be stored in another room together with residents' equipment and hygiene supplies. This meant that there were insufficient local assurance systems in place to ensure compliance with infection control measures.

There were clear lines of accountability and responsibility with regard to governance and management arrangements for infection control in the centre. Outbreak emergency plans were updated regularly. The person in charge was the lead in the event of an outbreak. The infection control programme was supported by a link practitioner and hand hygiene associates among healthcare staff. The infection control program was developing, and monitoring of antimicrobial use, indication, and duration were evident in the stewardship program. While there was an infection prevention and control policy, it did not include guidance information on the cleaning and management of nebulizers and other residents' equipment. The inspectors were shown a copy of an equipment cleaning and decontamination policy. It was in draft format and not yet accessible to staff. This may result in equipment not being cleaned appropriately and safe for further use.

Staff vacancies were low and new staff had been recruited into any existing vacancies. Some of these new staff were awaiting An Garda Siochana vetting prior to commencing employment. An orientation programme was in place for new staff covering aspects of training required to undertake their individual roles.

Staff informed the inspectors that they had access to training and the training matrix (an overarching record of all staff education and training activities) showed that staff had received their mandatory training. However, the oversight of staff practice was not sufficient to ensure they implemented the learning on a day-to-day basis. The nursing management team monitored mandatory training records, and completion levels had increased from the previous year. Nurses on duty had a current Nursing and Midwifery Board of Ireland (NMBI) registration.

Registration Regulation 4: Application for registration or renewal of registration

The provider had submitted a completed application to renew the registration of the designated centre within the required time frame.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was a registered nurse who worked full-time in the centre and had the required qualifications and experience required in the regulation.

Judgment: Compliant

Regulation 15: Staffing

There were adequate numbers and skill-mix of staff to meet the assessed needs of residents and given the layout of the designated centre on the day of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

There was a lack of staff knowledge in relation to some policies and procedures and best-evidenced practices. The observations made by inspectors on the day of the inspection found that there was a lack of oversight in staff practices, as detailed under Regulation 21: Records, Regulation 5: Individual Assessments and Care Plans, Regulation 27: Infection Control, Regulation 8: Residents' Rights, Regulation 28: Fire Precautions and Regulation 29: Medicines and Pharmaceutical Services.

Judgment: Not compliant

Regulation 21: Records

- A review of the incident records since January 2022 found that in some cases where residents had unwitnessed falls, the neuro-observation assessments had not been monitored and documented in line with the centre's policy. This could lead to staff failing to timely recognise neurological decline or symptoms of a brain haemorrhage.
- The Manual handling assessments placed in residents' rooms were not the most up-to-date assessments, but some of them dated back to 2018. While the person in charge stated that the most updated assessment was available on the computerised system, these outdated records posed a high risk for new staff members or agency staff using incorrect or outdated manual handling practices.
- There were records in residents' bedrooms who no longer resided in the centre. This did not ensure that all residents' records were safely and appropriately filed and stored at all times.

Judgment: Not compliant

Regulation 23: Governance and management

While governance and management systems were in place to ensure the service was safe, appropriate and effectively monitored, this inspection found significant gaps in the oversight, recognition and management of risks. The findings of the inspection are:

- Infection prevention and control governance, guidelines, oversight and monitoring systems were not adequate. The clinical and non-clinical auditing programme and the audit tools were not sufficiently robust to effectively identify all areas of risk or the improvement required as identified by inspectors on the day. For example, the housekeeping audits were not comprehensive enough to capture findings as detailed under Regulation 27, and environmental audit action plans were not completed. The auditing and oversight of cleaning and decontamination processes did not support effective infection control practices and procedures.
- There were gaps in updating, implementing and monitoring Schedule 5 policies in line with national guidelines and best practices. This contributed to gaps in staff practices as detailed under Regulations 21: Records and 5: Individual Assessment and Care Planning.
- The care planning auditing system had failed to identify that appropriate care plans and clinical assessments were not being initiated in a timely manner.
- The centre's own quality assurance systems had not identified and acted upon in a timely manner on a number of areas of non-compliance found by inspectors. For example, the inspectors found inconsistencies in the management and recognition of some of the clinical risks, such as the management of wounds, falls and seizures.
- The system of monitoring and reviewing medication management was ineffective. The medication errors identified on the day of the inspection had not been identified by the management team during the medication management audit.
- While arrangements for the identification of the risk and controls required to mitigate those risks were in place, many of the risks identified on the day of the inspection had not been identified in the centre's risk register, and consequently, appropriate controls were not implemented to manage these risks.
- The inspectors were not assured that the provider had adequate precautions and training systems in place to protect residents from the risk of fire. This is further discussed under Regulation 28: Fire Precautions.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A review of the contracts for the provision of services showed that they met the regulatory requirements and included the residents' rooms number and occupancy.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was aware of the requirement to submit notifications to the office of the Chief Inspector of Social Services. However, not all details relevant to restrictive practices were communicated in line with the requirements set out in Regulation 31 Schedule 4 (2)(k).

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The medicine policy was not updated in accordance with NMBI Guidance for Registered Nurses and Midwives on medicine Administration (2020).

While the equipment cleaning policy was in draft format, it was not available to staff to guide safe practice with regard to cleaning and decontamination of equipment.

Judgment: Substantially compliant

Quality and safety

While residents were satisfied with the service, significant clinical risks were identified during this inspection as detailed under individual regulations. The findings of the inspection did not provide the inspectors with the assurance that the registered provided had taken all appropriate steps to provide a safe and effective service which was appropriately monitored to ensure it met residents' needs. Supervision and oversight of care delivery and associated documentation were not sufficiently robust to ensure that the rights and choices of the residents were consistently promoted. Furthermore, inspectors observed that parts of the premises were poorly maintained and in a poor state of repair. The provider was proposing to reduce the occupancy of some of the double-occupancy bedrooms; however, during

this inspection, inspectors found that most of the double-occupancy bedrooms did not meet the requirements of the regulations as outlined in this report.

Residents were supported to access appropriate health care services in line with their assessed needs and preference. Residents' general practitioners (GPs) made site visits on a regular basis. Inspectors observed evidence that residents had a medical and medication review completed on a four-monthly basis. Residents were further supported by a team of social and health care professionals, including physiotherapy, occupational therapist, dietitian, speech and language therapist, optician, geriatrician and psychiatrists of old age. The hairdresser and the chiropodist visited on a regular basis, and these visits were documented. However, a review of residents' records showed that residents were not always facilitated with timely access to healthcare services, which could potentially have an adverse impact on their outcomes. This is further discussed under Regulation 6.

A sample of residents' nursing notes recorded on an electronic system was reviewed by inspectors. The staff demonstrated a good awareness of the individual care needs of the residents. However, the assessment and care planning process requires a stronger oversight, including the knowledge of pressure ulcers and recognition when an appropriate referral to seek external review by social and health professionals is needed.

Admission and transfer documentation included comprehensive infection prevention and control history or risk assessment. While safety-engineered sharps were used by staff, one clinical waste bin stored externally was unlocked and was open to public access. Staff demonstrated good knowledge with regard to the management of blood and body fluids spills and the management of needle stick injuries.

A seasonal and COVID-19 vaccination program was ongoing in the centre, which was available to residents and staff. Residents who wished to be vaccinated had received their second COVID-19 booster in recent weeks. There were good monitoring systems to identify signs of COVID-19 infection for all residents, staff and visitors to the centre. Serial testing for staff to allow for early detection of COVID-19 infection was continuing on Public Health advice. Notwithstanding the positive findings, further review and development under Regulation 27: Infection Control was required. Details of issues identified are set out under Regulation 27.

All residents spoken with were complimentary of the staff and the care they provided. Residents had access to television, radios, newspapers, telephone and Wifi. Residents had access to an independent advocacy service. However, inspectors found that residents were not always free to exercise choice about how to spend their day.

On the day of the inspection, the inspector found that medication management was not in line with the best nursing evidence-based practice. This will be discussed under Regulation 29: Medicines and Pharmaceutical Services.

The management of fire safety was reviewed. Quarterly servicing had been completed, and there was an annual certificate for the servicing of fire fighting equipment. Records documented that fire drills had been completed on a regular

basis. However, the inspectors observed that the staff practices and facilities in the centre did not support adequate fire precautions as outlined under regulation Regulation 28: Fire Precautions.

Regulation 11: Visits

Visiting for residents was unrestricted and in line with public health guidance for visitation in long-term care facilities. Visiting was observed throughout the day, with the majority of visitors attending the residents' room.

Judgment: Compliant

Regulation 17: Premises

The registered provider, having regard to the needs of the residents, did not ensure that the premises conformed to the matters set out in Schedule 6. For example:

- Areas of the centre were not well-maintained, and parts of the centre required painting and repair. For example, damaged tiles and stained grout on sinks and floors were observed in many areas throughout the building, damaged and scuffed wood work, plaster work and walls.
- The flooring and the units at the nursing station were damaged in the front sitting room in Oak House.
- Some communal bathrooms did not have assistive grabrails to support and maintain the safety of residents.
- There was a foul smell from unclean and stained carpets in the residents' bedrooms and in some of the bathrooms.
- The ventilation units were not in working order in the Kinvara House.
- The centre's storage facilities outside the Oak House were not fit for purpose.
- Emergency call-bell chords were not accessible from each resident's bed and in every room used by the resident.
- The ceiling spotlights in the oratory were hanging down, and a number of sockets in the residents' bedrooms were broken.
- There was no furniture in the garden in the Oak House for the residents' use on the day of the inspection.
- The external garden areas in the Oak unit were overgrown with some damaged palettes and flower pots.

The provider informed inspectors that they reviewed the beds and occupancy in the double-occupancy rooms in order to meet the needs of the residents, and they were going to reduce the occupancy by 16 beds. However, inspectors identified that in most of the double-occupancy rooms seen, the available floor space for each resident was not in line with SI. 293 requirements, and the available space did not

support residents' needs.

- Furthermore, due to the layout of a number of the double-occupancy bedrooms, there was insufficient space for each resident to have a chair, wardrobe or other personal storage space appropriate to the needs of the resident or where there was a space, some of the units were missing.
- Access to the window in other rooms was also restricted due to the placement of beds, or some beds were placed beside the radiators' covers, which could pose a risk to residents.
- Furniture such as wardrobes, lockable units or chairs were missing in some of the double-occupancy bedrooms.

Judgment: Not compliant

Regulation 27: Infection control

Overall, the inspectors found that the provider had not taken all necessary steps to ensure full compliance with Regulation 27 and the National Standards for infection prevention and control in community services (2018). This was evidenced by;

- The water from four hand hygiene sinks (in the laundry, two-day rooms and a store room) did not appear to reach adequate temperature. The water was either cold or tepid. The provider confirmed that they would rectify this without delay.
- The provider had not identified that cleaning water hoses used for constituting cleaning chemicals were lying directly on the sink drain. Bottles of the cleaning solution were stored on or in the janitorial sinks. A hose was used in one cleaners' room for staff hand hygiene and the making up of cleaning chemicals. These arrangements and practices increased the risk of contamination of cleaning products and staff hands.
- Staff did not have access to up-to-date policies with regard to the cleaning and decontamination of medical equipment. For example, the safe cleaning and storage of re-useable nebulisers and feeding tube administration sets. Nebuliser masks were seen to be unclean, and chambers were not rinsed with sterile water and stored dry in dust-proof containers. Four staff who spoke with inspectors gave differing accounts with regard to how to clean this equipment or how often they should be changed. A feeding tube administration stand had evidence of dried in nutritional product on it. This practice could result in the risk of transmitting a healthcare-associated infection.

The provider failed to ensure that care is provided in a clean and safe environment that minimises the risk of transmitting a healthcare-associated infection. This was evidenced by:

- A large proportion of wall-mounted alcohol-based rub dispensers viewed were

unclean, and a small number of hand rubs had expired. This may have impacted on their effectiveness.
- Wear and tear were visible in some areas, and the quality of surfaces and finishes on furnishings, fittings and fixtures did not always support effective cleaning. Examples of this were in external store rooms, floorings such as stained carpets and damaged flooring, furnishings and radiator covers.
- Hand-wash sinks did not support effective hand hygiene practices to minimise the risk of acquiring or transmitting infection. They contained overflows or water poured directly into the drain, and the seals or splashbacks behind some sinks were either not intact or clean.
- Seven care staff were seen to wear wrist jewellery or nail varnish, which may impact effective hand hygiene.
- Sterile water and sterile dressings were not used in accordance with single-use instructions. Dressings and open bottles of sterile water were stored with unopened supplies and could result in them being re-used.

The inspectors were not assured that equipment was decontaminated and maintained to minimise the risk of transmitting a healthcare-associated infection. This was evidenced by:

- A large proportion of the underside of commodes and shower chairs, intravenous trays and hoists inspected were not visibly clean. A high number of commodes had rusty wheels, the surfaces of one drug trolley, two grabrails and physiotherapy balance bars were damaged, and the kitchen floor had high levels of debris on it. This meant that they had not been or could not be cleaned after use.
- Cleaners were inappropriately using disinfectant chemicals for general cleaning purposes when there was no indication for their use.

Judgment: Not compliant

Regulation 28: Fire precautions

At the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire, nor were fire precautions being adequately reviewed. There were a number of serious concerns identified in this regard. By way of example:

- The inspectors observed holes in the walls in the store rooms beside the Oak House, which posed a fire containment risk, and there were no fire extinguishers available nearby. Furthermore, the cage for oxygen bottles was located beside the wall in this area.
- The storage of oxygen bottles was not appropriate. There was no safety signage in use, and oxygen bottles were seen inappropriately stored behind the linen trolley. Additionally, where the oxygen bottles were stored, they were not stored standing upright and were not securely locked as the key

was permanently left in the lock.
- Fire exits were obstructed by several trolleys or by the residents' furniture/sofa.
- A number of fire extinguishers were misplaced, they were not securely locked on the wall, or they were obstructed.
- Electrical items such as a hoist and specialised wheelchairs were stored in the assisted bathroom used by the residents, posing a safety risk- this had not been recognised by the management team.
- The chargers for hoists stored in the electrical store room on Corridor 4 were full of dust, posing a risk.
- Inspectors observed damaged fire doors. The provider had an improvement plan in place to replace them. The fire door frames were already replaced; however, some walls around the frames were damaged.

As a result of these findings, immediate action was issued to the provider in respect of fire safety, and the management personnel on duty were asked to remove all fire safety obstructions on the day of inspection.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors were not assured that the medication management systems in place were safe and effectively monitored as they directly contributed to medication-related errors. These errors had not been identified by management or staff.

- Medications which were no longer required by a resident or were out-of-date were not segregated from other medications, or returned to the dispensing pharmacy and were kept on the medication trolley, in the store room or in the cupboards potentially leading to errors.
- The opening date (for example, on bottles or creams with a short lifespan) was missing on several medicinal products.
- In one example, inspectors found that over-the-counter medication was regularly administered without being prescribed. This posed a safety risk as interactions with other prescribed medications had not been considered.
- Some medicinal products supplied for residents were not stored safely or in line with the product advice. Inspectors saw the temperature records for the medication room in Kinvara House, which showed a room temperature of 26 degrees Celsius for a number of days. Labelling of some of the medications stored stated that storage was required at a temperature maximum of up to 25 degrees Celsius. Other medications were stored in the external general store room. This room was not insulated, and no records of temperature monitoring were available.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed records for residents with pressure ulcers and found that there was no evidence of tissue viability review for a resident with necrotic tissue. No recent wound assessment was recorded, and no wound management plan was in place to support the wound healing. The care plan for the pressure ulcer was generic and did not reflect the current wound status, and there were no actual interventions recorded to guide the staff with safe and effective care delivery.

The care plans for the management of seizures were not consistently in place for all residents who required them. Where the care plan was in place, the specific actions to guide staff on how to manage a resident with a seizure were missing, including the timing of the administration of anti-seizure medication, the circumstances and the frequency of administration.

In a care plan viewed for a resident who had a percutaneous endoscopic gastrostomy (PEG), there was no direction for staff with regard to cleaning agents for the PEG site or how often to change the administration sets to prevent infection.

Judgment: Not compliant

Regulation 6: Health care

The inspectors found that staff did not consistently provide a high standard of evidence based nursing care.

- For example, staff did not always record neurological observations following an unwitnessed fall and as detailed in the local falls management policy. This would allow for early identification of clinical deterioration and timely intervention.
- Management of wounds and pressure sores was also not in line with best practice. For example, inspectors found that some staff did not have the required skills and knowledge in respect of wound assessment and management. Where additional professional expertise in respect of pressure ulcer management was required, this need was not recognised by staff, and additional expertise such as tissue viability support was not sought.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

A review of residents' care plans in relation to responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) found that responsive behaviours were appropriately managed within the centre. The care plans identified the triggers and the distraction techniques to eliminate the risks associated with responsive behaviours and subsequently guided the staff on how to continue to support residents' dignity and privacy during these episodes.

Judgment: Compliant

Regulation 8: Protection

Staff had access to and were provided with training in safeguarding vulnerable adults and demonstrated awareness of the safeguarding procedure in the centre. The provider was a pension agent for 13 residents. The process in place was in line with the Department Social of Protection guidance.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' right to undertake personal activities in private was restricted. The layout of double-occupancy rooms did not uphold residents' rights to privacy, dignity and decision-making about their lives. For example:

- Residents were unable to make choices relating to their environment due to the layout of the double-occupancy rooms, which meant residents could not control the light in their bed spaces or watch television in privacy as there was only one small television in the bedroom. Individual hearing devices were also not available for residents' use.
- The personal space of the residents who had their beds positioned near the wardrobes had their privacy limited as the other resident would have to stand near their bed if they wanted to access their personal possessions in the wardrobe. One wardrobe was positioned in the window space in the double-occupancy bedroom, so there was insufficient natural light for the second resident living in the room.

Residents were not always able to exercise their choice. By way of the example:

- Doors to the outdoors in the Oak House were keypad-code locked, and residents did not have access to the outside spaces without asking staff to open the doors.
- There was no furniture in the garden in the Oak House for the residents' use

on the day of the inspection. Some residents in the Oak House whose bedrooms overlooked the side wall of the centre did not have an opportunity to enjoy the view as the area was overgrown with some damaged palettes and flower pots. The wall was also damaged, and the view did not support residents' positive experience.

- The communal sitting room C5 for residents was used as a staff room. An urgent compliance plan letter was issued to the provider during the inspection to address this issue immediately in order to come into compliance with Regulation 9: Residents' rights (S.I. No. 415/2013 Health Act 2007) Care and Welfare of Residents in Designated Centres for Older People Regulations 2013. Assurances were received after the inspection that this sitting room is available for residents' use.

Judgment: Not 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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for TLC Centre Maynooth OSV-0000684

Inspection ID: MON-0035555

Date of inspection: 03/08/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: By 30th September 2022, all updated policies will have been circulated for staff to read and sign. The content of the policies will be reiterated in daily safety pause meetings and this forum will also be used by managers as an opportunity to check staff knowledge. By 31st October 2022, the medication management policy will have been reviewed and updated. By 31st December 2022, an audit by the Quality Team will have been completed to ensure compliance with updated policies and regulatory requirements. The decontamination of equipment policy has been updated to include cleaning of medical equipment e.g. nebuliser machines- Complete.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A system has been implemented to ensure that all documentation relating to discharged or deceased residents is filed appropriately and in a timely manner. The system will be audited 3 monthly from 31st October 2022. A 3 monthly audit will commence from 30th September 2022 to check that all printed assessments/documentation used in resident care is up to date and in accordance with assessments documented on the EPIC system.	

A protocol to guide staff on neurological observations following falls has been developed and circulated to staff- Complete.

From 30th September 2022- adherence with this protocol will be monitored by nurse managers on duty as falls occur and by the Director of Nursing and Assistant Directors of Nursing monthly and when reviewing all incidents of falls.

By 31st December 2022, all staff will have received specific falls prevention training which will include instruction on immediate actions to be taken following a fall.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
By 31st October 2022, a review of the current audit schedule for the centre will be completed and a new schedule agreed and in place. The revised audits will be specifically aimed at reviewing care plans to ensure they reflect assessed individual resident care needs, clinical and non-clinical risks and to ensure practice is in accordance with the centre's policies and excellent clinical practice.

By 30th September 2022, the centre's risk register will be updated to ensure all risks are identified, documented and appropriate controls are in place.

From 1st November 2022, the centre's audit schedule will be monitored at the monthly governance meeting to ensure audits are completed on time and appropriately, and that actions identified have been addressed satisfactorily.

From 1st November 2022, the centre's action plan will be reviewed quarterly by the Senior Management Team to address outstanding/delayed actions and to ensure adequate support for corrective actions.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
By 30th September 2022, the centre's risk register will be updated to ensure all risks are identified, documented and appropriate controls are in place. This includes the use of

keypads.

The use of sensor mats for falls prevention and keypads has been included in quarterly notifications- Complete.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
By 30th September 2022, all updated policies will have been circulated for staff to read and sign. The content of the policies will be reiterated in daily safety pause meetings and this forum will also be used by managers as an opportunity to check staff knowledge.

By 31st October 2022, the medication management policy will be reviewed and updated.

By 31st December 2022, an audit by the Quality Team will have been completed to ensure compliance with updated policies and regulatory requirements.

The decontamination of equipment policy has been updated to include cleaning of medical equipment e.g. nebuliser machines- Complete.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
By 30th September 2022, a review of all twin rooms will be completed to ensure they comply with regulatory requirements and all rooms in the centre will be reviewed to ensure the position of, and access to call bells is optimized for all residents.

By 31st December 2022, all identified painting and tiling works will be completed and replacement furniture will be in place.

By 31st October 2022, the identified flooring replacement and grab rail installation will be completed. In addition, the reconfiguration of the storage area will be completed by 31st October 2022.

A review of extraction fans, electrical fittings and water temperatures has been completed and by 31st October 2022, a system will be in place to monitor and ensure their ongoing functioning by the maintenance team.

By 31st March 2023, all new clinical sinks will be in place. This installation will commence in October 2022.

By 30th September 2022, a review of current housekeeping audits and cleaning schedules will be completed to ensure they appropriately identify risks and areas for enhanced cleaning/replacement.

From 1st November 2022, the centre's action plan will be reviewed quarterly by the Senior Management Team to address outstanding/delayed actions and to ensure adequate support for corrective actions.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
By 30th September 2022, a review of current housekeeping audits and cleaning schedules will be completed to ensure they appropriately identify risks and areas for enhanced cleaning/replacement

The equipment cleaning checklist has been updated and circulated - Complete

By 30th November 2022, all staff will have completed refresher training on uniform policy and IP&C (including for example, single use/single patient use items, hand hygiene and decontamination of equipment).

From 30th September 2022, the monthly audits schedule will review adherence to IP&C policies and practices and nurse managers will be supported to supervise day to day adherence by staff and to deliver training to staff as required.

From 1st October 2022, the monthly governance meeting will monitor action plans arising from audits and will support the Director of Nursing to address non compliances and to escalate outstanding actions.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
By 30th November 2022 all identified repairs to doors, walls and frames will be completed and a new storage cage for oxygen will be installed.

By 30th September 2022, a robust system will be in place to confirm fire exits are systematically checked so as to ensure they are kept clear at all times and that firefighting equipment is stored appropriately. This will be audited monthly from 31st October 2022.

All bathrooms have been cleared of electrical items and fire extinguishers are securely fixed in place- Complete

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
From 30th September 2022, nurse managers will be supported to supervise day to day adherence by staff to safe practice and to deliver training to staff as required.

By 31st October 2022, a review of the current audit schedule for the centre will be completed and a new schedule agreed and in place. This will include medication management audits to ensure that risks and non-compliances are identified and corrective actions are put in place.

By 31st December 2022, all nursing staff will have attended refresher training on the safe prescription, administration and storage of medicines.

By 31st December 2022, an audit by the Quality Team will be completed to ensure compliance with updated policies and regulatory requirements

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
By 31st October 2022, a review of the current audit schedule for the centre will be completed and a new schedule agreed and in place. The revised audits will be specifically aimed at reviewing care plans to ensure they reflect assessed individual resident care needs, clinical and non-clinical risks and to ensure practice is in accordance with the centre's policies and excellent clinical practice.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A protocol to guide staff on neurological observations following falls has been developed and circulated to staff- Complete.

From 30th September 2022- adherence with this protocol will be monitored by nurse managers on duty as falls occur and by the Director of Nursing and Assistant Directors of Nursing monthly and when reviewing all incidents of falls.

By 31st December 2022, all staff will have received specific falls prevention training which will include instruction on immediate actions to be taken following a fall.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Use of keypads originally for isolation area have been disabled facilitating independent access to the garden for residents - Complete.

Area used to ensure social distancing during pandemic has been converted back to original use- Complete

By 31st October 2022, replacement garden furniture and individual listening devices will be in place.

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(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/12/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Yellow	31/12/2022
Regulation 17(1)	The registered provider shall 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.	Not Compliant	Orange	31/03/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular	Not Compliant	Orange	31/03/2023

	designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/12/2022
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	31/12/2022
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.	Not Compliant	Orange	31/10/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/11/2022

Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/11/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/11/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/11/2022
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.	Not Compliant	Orange	31/12/2022
Regulation 29(5)	The person in charge shall 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	Not Compliant	Orange	31/12/2022

	provided by that resident's pharmacist regarding the appropriate use of the product.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed 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.	Not Compliant	Orange	31/12/2022
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	30/09/2022
Regulation 04(1)	The registered provider shall	Substantially Compliant	Yellow	31/10/2022

	prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.			
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	31/10/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	31/10/2022
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 admission to the designated centre concerned.	Not Compliant	Orange	31/10/2022
Regulation 6(1)	The registered provider shall, having regard to the care plan	Not Compliant	Orange	31/12/2022

	prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	31/12/2022
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	31/10/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	31/10/2022

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.	Not Compliant	Orange	31/10/2022