

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	TLC Centre Maynooth
Centre ID:	OSV-0000684
Centre address:	Straffan Road, Maynooth, Kildare.
Telephone number:	01 654 9600
Email address:	maynooth@tlccentre.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	TLC Nursing Home Limited
Provider Nominee:	Noel Mulvihill
Lead inspector:	Ann Wallace
Support inspector(s):	Geraldine Jolley;Shane Walsh
Type of inspection	Unannounced
Number of residents on the date of inspection:	140
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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 inform a registration renewal decision. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
11 July 2017 12:30	11 July 2017 18:00
12 July 2017 08:30	12 July 2017 16:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

The centre is located in a residential area a short drive from the town of Maynooth. It comprises of two separate buildings; the original building which includes the dementia care unit known as Oak House and two further units The Courtyard and Corridor Four. The new building accommodates one unit, Kinvara which was opened in 2016. The centre provides a service to individuals with a range of needs including long term care, short term care, brain injury, respite and dementia.

Inspectors found that residents received person centred care from a team of staff who had received appropriate training to ensure that they were able to carry out their role effectively. Residents who spoke with the inspectors said that they were receiving a good service and that they felt safe in the centre.

Residents had an assessment of their care needs prior to admission and care plans were in place for all residents although inspectors found that care plans were variable and improvements were required. This was an outstanding action from the

previous report. Care documents showed that systems were in place to ensure that identified risks were managed without limiting resident's independence and inspectors noted that this was a particular strength of the service. For example where appropriate residents had been encouraged to access local community groups and facilities and one resident had trial home stay in preparation for discharge back into the community. Residents informed the inspection team that they had made significant improvements since they had moved to the centre. They described how they felt better, were able to enjoy life and do things that they thought they would not be able to do again. One resident described eating better and enjoying food again, another outlined how their mobility had improved as they had physiotherapy and staff had encouraged her to walk regularly and another said that being able to go out regularly had made a big difference to life.

Residents had good access to medical services and allied health professionals. However there had been some difficulty in access to specialist mental health services and the inspectors judged that this required attention to ensure that the needs of residents who required this specialist support could be addressed promptly and effectively.

The premises had been designed and furnished to offer resident's comfortable accommodation. Bedrooms were appropriately furnished and there was adequate wardrobe and storage space for clothing and personal possessions. However the inspectors found that the layout of two twin bedrooms in Oaks unit did not adequately ensure the privacy and dignity of the residents who shared these rooms. The centre was found to be in very good decorative condition, well maintained and decorated to a high standard.

There was a wide range of activities taking place in the centre, with residents encouraged to mobilise around the centre to join in the group activities and entertainments and to encourage social interaction. The inspectors noted that there was a real sense of community in the centre. Residents described the service in positive terms. Staff were described as "very approachable and kind", "helpful to us and encourage us to do as much as we can for ourselves, we can go out shopping and out with family". Residents also said they enjoyed a range of interesting activities and said they valued the efforts staff made to make their days interesting and stimulating for them.

There were well established management systems in place that worked to ensure the quality and safety of the service provided were maintained. The centre was sufficiently resourced to meet the needs of the residents.

Some areas for improvement were identified in relation to fire safety and inspectors found that some staff did not have up to date fire safety training completed.

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 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There were effective management arrangements in place to monitor the quality and safety of the service.

Inspectors found that there was a clearly defined management structure in place. The organisational structure helped to ensure that staff were clear about reporting arrangements within the centre. The provider nominee was based in the centre and was in regular contact with the person in charge. The person in charge (PIC) worked full-time at the centre. Residents and staff told the inspection team that they were clear about who to raise any issues with and that the person in charge and senior staff were approachable and available to them.

The person in charge was supported in their role by two Assistant Directors of Nursing (ADON), four Clinical Nurse Managers (CNM) and a Practice Development Nurse (PDN) who worked across the Group. Each of the three units in the centre had an allocated CNM who took the lead in clinical practice, providing support and supervision to nursing and care staff on the unit including night staff.

The inspectors found that the care and services provided were found to be in line with the centre's statement of purpose and its ethos of care. There were a range of well established systems in place helping to ensure that safe and effective care was provided. Monitoring systems included health and safety and risk management processes and a comprehensive audit programme. Audit documentation reviewed by the inspection team showed that information was gathered about practices in the centre and was used to identify areas for improvements and staff training needs. Audits included falls prevention, medications, care plans, pressure sores, nutrition and accidents and incidents.

There were a range of meetings in the centre which supported the centre's monitoring and oversight processes. These included; clinical governance meetings, falls prevention meetings, drugs and therapeutics meetings and general staff meetings with staff from each of the departments. Documentation showed that meetings were well attended and were effective in promoting communications between line managers and their staff and communications between the various departments in the centre.

Feedback from residents and relatives was actively sought through residents' meetings, a suggestion box and the annual review. The inspectors found clear evidence of changes being made in response to resident feedback, for example in the centre's activities programme and its menus.

The inspectors found that the centre had sufficient resources in place to ensure care and services were provided to meet the needs of the residents who made the centre their home.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found that procedures were in place to safeguard and protect residents from abuse. Inspectors found clear evidence that the provider was working towards a restraint-free environment.

There was a policy in place that set out clear procedures for the prevention, detection and response to elder abuse. The staff training records documented that staff had attended training on safeguarding and elder abuse. Inspectors spoke with staff and found that they were able to articulate the policy and procedure to follow in the event of an allegation, suspicion or disclosure of abuse. Staff were also clear about who to go to report concerns regarding abuse. Senior Staff in the centre, including the person in charge were familiar with the procedures to follow in the event of a safeguarding issue and what their role would be. There was a designated person nominated to oversee the investigation of allegations of abuse. The PIC informed the inspectors that all staff working in the centre had Gardaí vetting in place. There were no volunteers working in

the centre at the time of the inspection.

Residents who spoke with the inspectors told them that they felt safe at the centre.

Inspectors reviewed the centre's policy on the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The policy described the types of responsive behaviours and the approaches that should be used for identifying causes of responsive behaviours. Staff had attended training on the management of responsive behaviours.

Staff interviewed by the inspectors knew the residents who might display responsive behaviours and were able to describe the triggers for such behaviour and the most appropriate way to respond to reassure and support the resident. Inspectors found that in most cases this was clearly documented in individual resident's care plans but in some care plans the documentation did not provide the comprehensive information staff needed to care for residents who displayed responsive behaviours.

During the inspection staff were observed using a gentle approach to calm and support residents who became agitated. Inspectors noted that the care provided in the designated centre was person centred.

There was a policy in place setting out the procedures relating to the use of restraint (physical, chemical or environmental). Where restraints were being used, inspectors found that a risk assessment had been completed that identified the risks and the options that had been considered prior to the decision to use restraint. The decision to use restraint and the resident's and or family's consent were clearly documented in the resident's care plan. Restraints were used for the least time possible to manage the identified risks. All restrictions were recorded and reviewed monthly or more often if a resident's needs changed. The centre carried out regular audits of restraints used.

The inspectors reviewed the systems that were in place to safeguard residents' finances with a representative from the group's accountancy team and were satisfied that the current system was transparent and secure.

Judgment:

Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The centre had policies and procedures in place for health and safety, however some areas relating to fire safety were identified for improvement and some staff had not received up to date fire safety training.

The centre had a an up-to-date health and safety statement which had been signed by the CEO of the TLC group. There was a risk register in the centre which identified risks and put appropriate actions in place to mitigate the identified risk. The register had been recently updated. The Person in charge (PIC) informed the inspectors that the accident and incident audit is used to inform the risk register to ensure that it is up to date. The inspectors reviewed the audit of incident and accidents and found it to be comprehensive. There was also a detailed and comprehensive emergency plan in place for response to major incidents.

Individual risk assessments were also in place for residents if required. For example assessments were done for residents who smoked, to determine if they needed assistance or supervision during smoking, or if they had an awareness of danger.

There was a fire safety policy in place. Staff had access to annual fire safety training updates. However training records showed that not all staff were up to date with their fire safety training. The centre was compartmentalised with double fire doors on self closing magnetic mechanisms. The inspectors tested eight sets of fire doors to ensure they closed correctly. Doors to residents' bedrooms were also fire doors on magnetic self closers. All of these doors would automatically close on the sounding of the fire alarm. The doors all had heat seals and smoke seals in place to impede the spread of fire and smoke. There were a suitable number of fire extinguishers in place in the centre and records evidenced that they had been serviced in within the last 12 months. The fire alarm had been serviced on a quarterly basis. The emergency lighting had received one full service in 2016 and regular electrical checks monthly.

The inspectors noted that fire exits in the centre were marked and clearly visible. Inspectors observed that fire exits were kept clear. However one fire door leading out to the residents' smoking hut was observed to be held open using a plastic tie to fix the door handle to a nearby fence. This was raised with the staff who informed the inspector that the door was on a self closing mechanism and was tied open to provide residents with ease of access to the smoking area. Although this was partially addressed during the inspection the inspectors were not sufficiently reassured that the fire door was able to close effectively in the event of a fire. Fire safety precautions in the smoking hut included a call bell, a smoke detector, a fire extinguisher, a smoking apron and a fire blanket. At the time of the inspection the fire safety blanket was hidden behind the smoking apron and not readily accessible if it was required. There was a risk assessment in place for the smoking area but the risks identified by the inspectors as above were not documented in that assessment.

The procedure for evacuation was displayed in all of the nurses' station and was in line with the fire safety policy. Staff who spoke with the inspectors were able to articulate what to do in the event of a fire. Fire drills had been carried out in January 2017 and May 2017. Documentation showed that the centre had identified a need to carry out a minimum of two fire drills per year and to aim to involve all staff in at least one of these drills. The inspectors were informed that a staff member had recently been trained as a

second fire warden in order to achieve this.

The inspectors also reviewed training records and identified that five staff were not up to date with the centre's mandatory fire safety training requirements. Two of these staff members were over one year out of date. The inspectors were told that one of those staff members was a relief staff member and would not be put on duty until the training was completed. Training dates were provided for the other identified four staff in July and August 2017.

Personal Emergency Evacuation Plans were in place for all residents, however some required improvement around identifying the assistance the resident may require for evacuation.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The inspectors found that there were safe systems in place for the management of medicines. There were policies and procedures to guide and inform staff on the ordering, prescribing, storing and administration of medicines to residents. The systems in place were audited by the pharmacist and senior nursing staff regularly.

There were secure storage areas where medicine trolleys could be kept safely. Staff were well informed about the medicines prescribed for residents and precautions that were required in relation to residents' medicine regimes. The inspectors found that resident's medicines were reviewed by doctors, the pharmacist and nursing staff. There was emphasis on ensuring that medicines that were no longer required by residents were discontinued.

Medicine trolleys were stored securely and kept locked when not in use. Medicines that required special control measures were kept in a secure cabinet in keeping with professional guidelines. Nurses maintained a register of controlled drugs. Two nurses signed and dated the register and the stock balance was checked and signed by two nurses at the change of each shift. Inspectors checked a selection of medication balances and found them to be correct.

Prescription sheets included all the appropriate information such as the resident's name

and address, any allergies and a photo of the resident. Nurses were using a computer programme to record medicine administration which nursing staff reported was user friendly, efficient and safe. The system provided alerts when medicines were due and clearly indicated when medicines were not given for any reason.

There was an effective system in place to manage the return of-out-of date and unused medication, with records providing a clear audit trail.

Medication errors were appropriately recorded and followed up to reduce the risk of them occurring again.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There were 140 residents living at the centre during the inspection. Three residents were receiving care in hospital and the centre had one vacant room. The majority of residents were noted to have a range of complex healthcare issues and were being treated for more than one medical condition. There was one outstanding action from the previous report in relation to care plans and reviews.

Pre-admission and initial assessments were recorded in all care plans reviewed by the inspectors. The arrangements to meet residents' assessed needs were set out in individual care plans which were maintained on a computer programme. Recognised assessment tools were used to evaluate residents' needs, progress and levels of risk for factors such as vulnerability to falls, compromised nutrition, pressure area problems and moving and handling requirements. Nursing and care staff were observed to be diligent in their responses to residents' requests for assistance. Inspectors found that care was provided in a manner that ensured individual resident's privacy and dignity was protected. Interactions between staff and residents were seen to be respectful and cheerful.

Care plans were completed for all areas where a care need or goal was identified however inspectors found that the information recorded to guide practice was variable across the sample reviewed. Some care plans provided an informed overview of care needs and how care was to be delivered and included comprehensive reviews of care given. However other care plans did not adequately document the care that was required and did not consistently record where care interventions for example had resulted in improved quality of life and significantly improved levels of independence. For example changes such as weight loss or gain were documented and acted upon however the care records did not always provide a meaningful overview of residents' current health status and the changes that had occurred as a result of the care given.

The inspectors found that good standards of personal and nursing care were in place and this was supported by timely medical and allied health professional input in most cases when required. The exception to this was access to mental health services where delays in assessment were evident which had resulted in staff having to address fluctuating behaviour problems for long periods and a prolonged period of distress for residents.

Staff knew the residents well and were familiar with how individual residents preferred to spend their time including which activities they liked to participate in and how they wished their personal care to be addressed. The inspectors saw evidence that the ethos of person centred care was promoted each day. Residents could for example get up at times of their choice and could remain in bedroom areas or go to the communal areas to meet others or take part in activity. The sitting areas were well supervised throughout the day and the inspectors observed that staff greeted residents and engaged them in conversation when they were in their company. Nurse managers were also noted to readily available to residents who welcomed them into office areas during the day, included them in discussions and general conversations. There was an emphasis on ensuring that all residents were engaged and included in a meaningful way in the general business and day to day life of the centre. Staff informed the inspectors that a choice of male or female carer could be accommodated when requested by a resident.

Residents had access to doctors and other primary care services. Records and information relayed by staff conveyed that doctors visited the centre weekly to review medicines and to respond to changes in health care. Access to allied health professionals such as speech and language therapists, dieticians and occupational therapists was available through referral to the Health Service Executive services and a nutrition company. The centre had full time physiotherapist and residents had regular input when they developed infections to promote their well being and some also had regular sessions to help them maintain their independence and mobility.

There was evidence that residents and relatives were involved in care plans and their views were recorded and incorporated into daily care practice.

The inspectors noted that where residents had dementia there was some detail on communication capacity and what activities/ interventions residents responded to however as described earlier there was variability in the standard of information recorded to guide practice. Communication capacity when it was described indicated where residents were orientated to their surroundings however improvement in the

details records was needed to ensure that staff were aware of residents' ability to recognise family and visitors, to undertake activity such as personal care independently and to inform them of problems such as word finding where resident may need extra time to communicate.

Wound care problems were appropriately assessed, measured and had dressing plans in place. Staff maintained records of all interventions and changes in the condition of wounds were evident from the records reviewed. Long term wounds such as leg ulcers were reviewed regularly and where changes in treatment did not result in improvements the situation was reviewed by specialist tissue viability nurses. Nurses were provided with wound care training updates.

Resident's end-of-life care preferences, personal or spiritual wishes were recorded where possible and where residents and families wished to discuss this aspect of care. The inspectors were told that residents remained in the centre at end of life if that was their wish and staff were supported with palliative care interventions as required.

There were some improvements needed to care plans to ensure they reflected residents' expressed wishes. Where residents had conveyed particular wishes these were recorded and known to staff.

There were procedures in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and shared between providers and services.

Residents had opportunities to participate in activities that were meaningful and purposeful to them, and which suited their needs, interests and capacities. There was a varied and interesting social programme and the inspectors noted a high level of participation in activities. Residents were very complimentary about the opportunities they had to enjoy new experiences such as painting. There was also an emphasis on spontaneous activity initiated by nursing and care staff who encouraged residents to sing, talk and chat together.

Residents had good access to the outdoors and were actively encouraged to go outside. The inspectors saw residents using the gardens to walk around and to sit and enjoy the sunshine. The gardens were attractively cultivated, safe and secure. There were several access points out into the garden areas so that residents did not have far to walk to access outdoor space.

Overall the inspectors found that health and social care was delivered to a high standard

Judgment:

Substantially Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents,

conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The design and layout of the centre met the needs of the residents and was appropriate for its intended purpose. The centre was clean and well maintained. The premises met most of the requirements of schedule 6 of the regulations however some improvements were required.

The centre consisted of two single story buildings. The main building contained three units, the Courtyard, Corridor 4 and Oak House (dementia specific). This building had 79 single rooms and 31 twin rooms. The new building was one unit, Kinvara House which had 41 single rooms and 8 twin rooms. All the rooms were found to be of a suitable size, were decorated in a homely manner and had an en-suite facility. All bedrooms had suitable storage space for residents' belongings, call bells within reach, a flat screen TV and a chair. Many residents had decorated their rooms with their own personal belongings. Some bedrooms had memory boxes installed outside the doors to assist the orientation of residents with cognitive impairment. The inspectors reviewed the twin bedrooms and noted that privacy curtains were in place in all rooms. However inspectors found that one privacy curtain had been taken down that morning for cleaning and no replacement curtains had been put up in the interim period. This was addressed during the inspection.

In general the centre was well lit with both natural and artificial lighting. The centre was appropriately heated. The corridors in the centre were wide and had hand rails were in place. The flooring in the centre was safe and free from any trip hazards. The centre was visibly clean throughout the two days of inspection.

Storage for assistive equipment was noted to be limited. On the Courtyard unit equipment was stored in an area between the corridor and the exit for the external courtyard. It was noted that this practice could pose as a potential trip hazard for residents with limited mobility. On Oak House two hoists were noted to be stored in residents' rooms. The inspectors confirmed that the hoists were only used by the two residents who occupied these rooms. However there was no storage available on Oak unit if additional hoists were required for residents. The inspectors reviewed the servicing records for hoists and found that they had all been serviced within the last 12 months.

The communal areas in the centre were decorated to a high standard. Communal areas such as the open plan foyers and the library in the main building were beautifully decorated and laid out. Large armchairs and couches were arranged in a manner which

promoted social interaction. The communal areas were observed to be well used by residents and their families. Residents occupied these areas throughout the two days of inspection doing various activities such as chatting, reading newspapers, exercise sessions and attending a musical afternoon.

Efforts had been made in the Oak House unit to introduce older style furniture in one of the day rooms as a method of reminiscence for residents. Old style shelving, presses and a decommissioned stove were in place in the day room.

The centre had been thoughtfully laid out to provide a number of quiet seating areas some of which were away from the main communal areas where residents were observed sitting peacefully or meeting with visitors in private. Other small seating areas were close to the main lounges so that residents could observe the social interactions even though they might not want to participate.

The centre had a number of communal toilets in both buildings and most had been fitted with grab rails and call bells. However two toilets did not have grab rails in place at the toilet or the sink. One toilet was also noted not to have a call bell installed.

Residents had access to four secure external gardens. The gardens were large and generally well maintained with appropriate landscaping in place to meet the needs of the residents. The inspectors found that access to the external grounds was unrestricted and throughout the inspection residents were observed using the garden areas independently or with assistance of staff.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Verbal and written complaints were recorded and responded to appropriately in the centre.

The centre had a policy in place for managing complaints. The policy outlined that the person in charge was the designated person to deal with managing complaints. The Director of clinical services for the TLC group was named the person who provided oversight to the management of complaints.

The person in charge of another nursing home was named to act as an independent appeals person if the complainant wished to appeal the outcome of the complaint.

Inspectors found that on all units there was a clear process in place that outlined how residents or relatives could make complaints if they wished. The procedure also contained contact details for the ombudsman. The centre had a conveniently positioned letter box close to the main entrance for complaints and comments.

Verbal complaints could be made to any member of staff and were usually dealt with by a Clinical Nurse Manager or Assistant Director of Nursing. If the complainant wasn't happy with the outcome the complaint was escalated to the person in charge. The inspectors reviewed the records of verbal complaints and found that they were detailed and outlined if the complainant was satisfied with the outcome.

All formal complaints were managed by the person in charge. The inspectors reviewed the process for dealing with formal complaints and found that the person in charge maintained clear and concise records of all actions taken on receipt of the complaint. A formal recognition of receipt of complaints was provided to all complainants. The person in charge made it clear that the centre welcomed feedback from comments and complaints as part of the centre's quality improvement processes.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
The inspectors found that there were arrangements in place to provide residents with a varied and balanced diet that met their nutritional needs and preferences. There were systems in place for assessing, reviewing and monitoring residents' nutritional intake. Residents' food preferences were identified, catering staff were informed about specialist needs and the menu choices and food were discussed at residents' meetings.

There was a food and nutrition policy in place and this was supported by a range of associated nutrition procedures that provided guidance on the management of fluids and hydration, medication management and the care of residents with conditions such as diabetes. Policies and risk assessments relating to nutrition included best practice guidance and had been updated regularly.

Residents said they were very pleased with the variety of food and the way meals were served. Catering staff were described as helpful and staff always ensured that snacks were made available residents told the inspectors. Residents said that they were offered alternatives at times when they were unable to eat a full meal. The different choices available were observed at the mid day and tea time meals. The inspectors observed staff asking residents for the menu choices during the morning. There were snacks and drinks available throughout the day and at night to ensure residents could have a snack on request.

The inspectors observed that food was attractively presented and served in portion sizes that met residents' preferences. The main dining rooms in both buildings were nicely laid out for residents with attractive table settings, condiments and menus on the tables. However the small assisted dining area in the main building was not in keeping with the pleasant dining environment that was available for the residents in the main dining areas.

Residents who needed assistance were supported by staff who sat by them and chatted as they prompted them to manage independently or actively assisted where needed. The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in care plans and made available to catering and care staff.

Nutritional risk assessments were completed and individual resident care plans were available to guide staff where residents were identified to have specific nutritional risks. Resident records documented appropriate referrals to dietitian and speech and language therapy services. All residents were weighed regularly and those at risk were reviewed and referred for specialist opinion. The care records of some residents who had lost weight or who were at risk were reviewed. The inspectors found that interventions had been put in place to ensure residents wellbeing, however as described in the outcome on healthcare, additional factors such as emotional health that impacted on appetite or active behaviours that demanded higher calorie input to maintain weight were not included as risks in care records.

Food and fluid intake was monitored where residents were at risk however inspectors found that in some care records dietary intake and fluid balance records were not kept up to date and as a result it was not clear that residents had been provided with adequate fluids and diet throughout the day. For example in one instance a resident did not appear to have had any liquid from 17:00 hours on 11 July to 09:20 on 12 July. When this was reviewed with staff the inspector found that this was not a reflection of practice and that the resident had taken diet and fluids between these times.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to

exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspectors found that there were arrangements in place to ensure that residents could exercise freedom of choice and that care practice reflected that staff had up to date knowledge on the values of rights, privacy and dignity. However the inspectors noted that the use of screening in the two double bedrooms in the Oak House unit did not ensure that the rights and privacy of the resident who occupied these rooms could be assured at all times.

The rooms were divided in two by one single screening curtain. When the curtain was being used to provide a resident with privacy the other resident in the bedroom would be adversely affected either by not being able to access the bedroom at all or not being able to access their belongings or the en-suite facilities.

The inspectors observed that efforts were made to respect residents' choices and ensure that they had control over their daily life in terms of times of getting up and returning to bed. Independence was promoted, residents were asked where they wished to spend their day and were free to walk around the centre and spend time wherever they wished including the garden areas.

Throughout the inspection it was observed that residents were spoken to in a respectfully and staff were aware of residents' communication needs. Staff engaged well with residents and were calm and reassuring when talking to residents who were anxious or concerned about a problem. Staff conveyed good knowledge about the value of emotional support, sensory stimulation, validation of feelings and reminiscence when supporting people with memory problems or dementia. They were observed to adjust their communication to suit the person they were speaking to and were sensitive to sensory problems and varied communication pathways

There were records that confirmed that residents and relatives were involved and included in decisions about how the centre was organised. There were three monthly residents' council meetings and an annual meeting for family members in addition to meetings that took place to discuss residents' care and welfare. The residents' meeting was facilitated by the residents themselves, however on some occasions they invited an independent advocate to attend and record the minutes of the meeting. Minutes of residents' meetings included topics such as access to information around the centre, daily activities plan and residents obtaining locks for their rooms if they wanted them. Responses and actions were detailed for any requests made, for example the possibility of having a "tuck shop" available was being explored. There was also a regular "food

group” meeting where menus and food choices are discussed and changes made in line with resident's feedback.

Residents had access to Wi-Fi, newspapers, televisions and radio. There were some communal rooms in the centre with no televisions to promote social interaction and allow residents to read, and other rooms where residents could watch movies or television. Notice-boards were in place which provided information for residents and visitors about activities and events in the centre.

Inspectors found that resident’s religious rights were respected. Roman Catholic mass was held in the centre on a weekly basis, and there was an oratory. The inspectors were informed that services for other faiths have been provided when requested by residents or family in the past, and could be provided when required.

Residents were facilitated to vote and the centre had arrangements in place to set up a polling station during local or national elections.

Visiting to the centre was unrestricted and there were rooms available for residents to meet their visitors in private if they wished to do so.

Inspectors spoke with the activities manager who was able to demonstrate how residents were consulted about the activity schedule and the changes that had been made in response to resident's feedback and to the changing needs of individual residents.

Activities staff worked in the centre seven days a week. One activities staff was dedicated to carrying out one to one activities two days a week to ensure residents who were unable or didn’t wish to partake in group activities had opportunities to take part in activities aligned with their interests.

The centre owned a wheelchair accessible mini bus which was used for weekly outings for residents. Previous outings had included Croke Park, Castletown House, the National Stud and Japanese Gardens, local shopping centres and the Victorian Tea Rooms in Straffan. Residents also recently visited Bloom gardening festival where the TLC group had a dementia garden on display.

A Barbeque and garden party which was due to take place the weekend after the inspection was well advertised for residents, their families and the local community. Residents told the inspectors how much they were looking forward to this event which was the highlight in the centre's annual activities calendar. Staff stated this was a big event each year and that there would be live music and activities for families. Residents also had access to a hairdresser and various treatments when requested.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet

the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

Inspectors found that there were appropriate numbers of staff with the necessary skills and experience to meet the needs of residents. However inspectors found that some staff had not attended mandatory fire safety training updates.

Inspectors reviewed the staffing levels, actual and planned staff rosters, staff training records and spoke with staff, residents and visitors. Inspectors found that there were sufficient staff with the required skills to deliver safe and effective care to meet the assessed needs of the residents who lived at the centre. The planned rosters took into account the layout of the centre and the levels of care and supervision required. The person in charge gave verbal assurances that staffing numbers and skill mix were monitored to take into account resident dependency levels. Nursing staff verified that extra staff were made available when nursing staff requested that it was required to respond to increasing resident dependencies or supervision requirements.

There was also sufficient housekeeping, laundry, catering and administration staff to ensure that the centre was run effectively for the benefit of the residents who lived there. Staff from the ancillary departments were observed to be interacting with residents and their families during the inspection. Staff were seen to be respectful and cooperative in their dealings with each other and with the residents and their visitors. Residents and their families expressed high levels of satisfaction in their relationships with the staff team at the centre often commenting on their cheerful and helpful manner and their kindness and courtesy.

Training records showed that all staff had been provided with mandatory training in moving and handling and prevention of elder abuse. The records for fire safety training however was incomplete and not all staff had attended the required training. This is addressed under outcome 8 in the report.

Inspectors reviewed a sample of staff files and found that the required documentation was in place in line with the requirements of Schedule 2 of the regulations.

Judgment:

Substantially Compliant

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:

Ann Wallace
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	TLC Centre Maynooth
Centre ID:	OSV-0000684
Date of inspection:	11/07/2017 and 12/07/2017
Date of response:	10/08/2017

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 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

An external fire door was observed to be held open on the first day of the inspection. The wrong side of the door was observed to be open on the second day of inspection. Both practices would prevent the door from closing independently.

1. Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for

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

maintaining all fire equipment, means of escape, building fabric and building services.

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

The above mentioned fire door is secured by a maglock. In order to protect residents' rights to freely access the outside areas and smoking area, the maglock will now be disengaged during the day, and engaged at night time. This will prevent the door from being left open inappropriately, but will ensure that health and safety regulations will be maintained whilst also protecting residents right to freely access the outside areas. This action is already in effect.

Proposed Timescale: 10/08/2017

Theme:

Safe care and support

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

Fire drills had not taken place in suitable intervals.

2. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

To date, two fire drills have taken place for 2017, with one in Kinvara in January 2017, and one in the main building in May 2017. Both fire trainings included staff across all disciplines, clinical and non-clinical.

One further drill took place on the 10th August 2017 to capture night duty staff with another planned for the 17th August to capture night duty staff on the opposite shift. Proposed fire drills will be planned and discussed quarterly at the Health and Safety committee meetings to ensure regular fire drills are maintained.

Proposed Timescale: Complete and ongoing

Proposed Timescale: 10/08/2017

Theme:

Safe care and support

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

Five staff were identified as not having up to date fire safety training.

3. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the

designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Four of the above identified five staff members have already attended fire training since the inspection. The one outstanding member of staff is a relief staff member and will not – and has not – been furnished with hours until that staff member has attended all out of date training. This particular staff member has not been given shifts since July 2016 due to being out of date with fire and other training. This staff member is invited to each fire training class and is aware that shifts will not be furnished until training has been attended.

Proposed Timescale: Complete and ongoing

Proposed Timescale: 10/08/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Some care plans did not clearly document the care to be given to individual residents. Some care plan reviews did not include a determination of the effectiveness of the plans to meet the needs identified.

Fluid balance and dietary intake charts were not consistently maintained for some residents.

4. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Practice Development Nurse is spending two months on site with the focus being on care plan training and development for Clinical Nurse Managers and Staff Nurses. This will be conducted using "Lunch and Learn" power-point presentations, one-to-one care plan and assessment talks and assessing care plans as they are completed by the nursing staff to monitor for effectiveness in meeting the needs of the residents.

Care plans will be formally evaluated and reviewed at intervals not exceeding four months. The Care Plan evaluation forms will also be reviewed and updated by the Practice Development Nurse and Clinical Nurse Managers.

Fluid balance and dietary intake charts are to be spot checked by the Senior Healthcare

Assistant. Spot check forms to be given in to the CNM on duty for discussion. Any shortfalls are to be addressed directly to the staff member responsible and expectations discussed with that staff member. Spot checks will be done on each shift, and these checks will include the previous 48 hours of fluid/dietary intake. The Senior Healthcare Assistant will choose residents at random, but will also incorporate residents who are most at risk for dehydration, malnutrition and infection, in consultation with the staff nurse.

Proposed Timescale: Immediate and ongoing

Proposed Timescale: 10/08/2017

Theme:

Effective care and support

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

Residents who were identified as needing consultant psychiatric assessment and review were waiting an unacceptable length of time to be seen.

5. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

The provider is in regular ongoing contact with the chief officer of the HSE community health organisation in efforts to increase the access to consultant psychiatric services in conjunction with the local acute Hospital. It is already in practice that the Community Liaison Team review residents on a regular basis, and some of these residents would be for mental health assessments while the resident is awaiting consultation with psychiatry of old age. The Community Liaison Team have been asked to contact the psychiatrist of old age in an effort to improve consultant access for residents requiring consultant psychiatric assessment in the nursing home. An initial acknowledgement has been received by the provider from the HSE regarding the urgent need for an improvement in this service for the centre. The access to this service will be monitored on an ongoing basis, and discussed at the next Drugs and Therapeutic Committee meeting on the 06th October 2017. Communications with the HSE will be discussed and considered at each monthly Clinical Governance Committee Meeting.

Proposed Timescale: 13/10/2017

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Not all communal toilets had grab rails or a call bell installed.

6. Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

All public toilets have grab rails in situ since the inspection took place. Awaiting call bell placement, same is being organised

Proposed Timescale: 30/09/2017 (call bell) Grab rails complete

Proposed Timescale: 30/09/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Residents accommodated in the double rooms in Oak House unit could not use the screening curtain for privacy without infringing on the other resident in that room's ability to access the room/ en-suite/ their personal belongings.

The centre did not have a planned programme for replacing privacy curtains immediately when they were taken down for laundry or repair.

7. Action Required:

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

The double rooms in Oak house have been reviewed, and a plan in place to re-do the curtain rails so that they surround the bed area, and not divide the room in two. This will ensure that the privacy and dignity of both residents is maintained, whilst also ensuring that both residents have access to their wardrobes and en-suite.

Proposed Timescale: 16/08/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Some staff were not up to date with mandatory fire safety training.

8. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

Maintenance of the training tracker is now being monitored by one member of the reception team who is a full time member of staff. They will be responsible for maintaining and updating the training tracker appropriately. They will also be responsible for inviting staff to training before their due training is out of date. This information will be fed back to the management team on an ongoing weekly/daily basis, and any member of staff who has not attended mandatory training prior to their training going out of date will be informed by management that they cannot be rostered for shifts until all training is up to date.

Proposed Timescale: Immediate and ongoing

Proposed Timescale: 10/08/2017