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:	29 July 2021
Centre ID:	OSV-0000684
Fieldwork ID:	MON-0033835

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 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:	126

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
Thursday 29 July 2021	08:30hrs to 17:10hrs	Niamh Moore	Lead
Friday 30 July 2021	08:30hrs to 13:30hrs	Niamh Moore	Lead
Thursday 29 July 2021	08:30hrs to 17:10hrs	Deirdre O'Hara	Support
Friday 30 July 2021	08:30hrs to 13:30hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

From what residents told us and from what the inspectors observed, it was clear that resident's rights were respected and that residents were consulted about the running of TLC Centre Maynooth. Inspectors observed over the two days of inspection that there was a good atmosphere. The general feedback from residents was one of satisfaction with the care and services provided in the centre. However, some improvement was required in relation to activity provision, care planning and infection control.

On arrival at the centre, the inspectors were met by the receptionist who conducted a COVID-19 risk assessment and ensured a temperature check and hand hygiene was completed prior to entering the centre. All those entering the building had a facemask prior to entering the designated centre. While this was in place for visitors, observations by inspectors on both days of inspection showed that at times face masks were not used appropriately and hand jewellery worn by staff could impact effective hand hygiene.

On the first day of the two day inspection, a short opening meeting was held with two members of the management team. Following this meeting, the inspectors were guided on a tour of the centre. The designated centre comprised of two buildings, named as the main building and Kinvara House. During this tour, inspectors greeted staff and residents in the corridors, in communal areas and in some bedrooms. Residents told inspectors that staff were good to them and would help them if they needed and 'were not rushed by staff to do anything'. Inspectors observed interventions between staff and residents, and spoke at length with eight residents to gain an insight into their lived experience in the centre.

Overall the centre was found to be well-laid out with suitable communal areas for the number of residents and their assessed needs. While communal spaces such as dining and lounge areas were spacious and bright, improvements were required in the maintenance of the premises such as replacement of flooring in communal areas and some bedroom areas. A smoking cabin was in a poor state of repair and some bedroom and dining furniture required replacement. The provider had plans in place to address these issues. However call bells were required in two bathrooms and a communal room, to allow residents to call for assistance easily.

Inspectors observed the centre to have a calm relaxed atmosphere within these communal spaces on both days of inspection.

Feedback from resident surveys and from what residents told inspectors, they were satisfied with the cleanliness of the centre and that they were content with their bedrooms. There was sufficient storage for their belongings and they could personalise their space. Bedrooms were seen to be decorated nicely and contained personal items such as residents' framed family photographs and ornaments. They said they were 'very happy with visiting arrangements and were looking forward to a

time when things can go back to normal'.

Inspectors spent time within communal areas, observing and speaking with a number of residents and staff. Staff were seen to engage with residents in a patient, respectful and friendly manner. Residents who spoke with the inspectors said that they felt safe and that they were happy living in the centre. Residents said that staff were kind and considerate and if they had any concerns they would speak with staff.

Menus were displayed outside dining rooms. Inspectors were told that residents were asked their preference each morning. Soft background music played in communal rooms when meals were being served. Inspectors observed a meal-time in both buildings and found it to be a pleasant and enjoyable experience for residents. Residents had a choice of where they wanted to dine and were assisted in a respectful and dignified manner and staff were observed moving at the residents' pace. Residents who requested alternative dishes were seen to be accommodated. Residents said that 'the food was very tasty and served properly' others said the food was always hot and they particularly liked the porridge.

Residents said that they enjoyed opportunities to take part in various activities such as bowling, exercise and movement classes, sing-alongs, small group arts and music sessions, pampering sessions, pottery and bingo. An art specialist came to the centre on the inspection day who gave an art appreciation class, where the residents who attended said they really enjoyed classes and always learnt something from them.

The centre recently had a barbecue, where a marquee was put up in the grounds. There were trips out to local areas of interest such as Donadea Park and the Phoenix Park. Canal walks and visits to a local hotel were also part of the activities on offer. A lady's chat group also took place regularly in one of the sitting rooms.

Mass took place in the main dining room, each Thursday, for those who wanted to attend. There was also an oratory available for resident use.

In Kinvara House there was an activity board which recorded activities from Monday to Sunday. Activities recorded on the board during the days of inspection were mostly 1:1 engagements. Inspectors were told that 1:1 activities suited the needs of residents in this house where most of the residents spent long periods of time in their room. Inspectors observed that a resident had their nails recently painted by staff. However, two residents told inspectors that their days are 'boring' and 'there are not really any activities happening'. Inspectors reviewed records of activities, rostering of activity staff and were not assured of the availability of recreation opportunities for all residents.

Inspectors reviewed minutes and found that regular residents meetings took place. Inspectors found that the provider used feedback gathered to improve services, such as a new clothing labelling system was put in place to ensure that resident clothes were easily identifiable and returned to them.

The next two sections of this report present the inspection findings in relation to governance and management in the centre and how governance and management

affects the quality and safety of the service being delivered.

Capacity and capability

There were effective management systems in the centre, ensuring good quality clinical care was being delivered to the residents. On the days of inspection, there was sufficient numbers of suitably qualified staff on duty to support residents' assessed clinical needs, however improvements were required in resources to facilitate the centres activity programs and recreation for residents. Other findings on the day showed that records required improvement as the complaints policy was not updated to reflect key personnel and the statement of purpose and floor plans required updating to reflect the premises seen.

Veritdale Limited is the registered provider for TLC Centre Maynooth. There was a clear management structure in place. The person in charge reported to a director of the company. The person in charge was supported in their role by two assistant directors of nursing, five clinical nurse managers and a practice development nurse. The management structure identified specific roles and responsibilities for all areas of care provision within the centre, with oversight from the provider.

This inspection was unannounced to monitor compliance with regulations and to follow up on concerns raised through the receipt of unsolicited information which was focused on staffing levels, the provision of activities and access to visits within the centre.

All residents who spoke to inspectors knew the person in charge and were happy to raise any issues with them. The management team had oversight of the quality care being delivered to residents. There was clear evidence of learning and improvements being made in response to audit reports and feedback from residents.

The centre had notified the Chief Inspector of five outbreaks of COVID-19 since the start of the pandemic. The first notification was reported on 21 March 2020. During these five outbreaks, a total of 33 residents and 37 members of staff had tested positive for COVID-19. Sadly six residents passed away.

Overall the centre was well resourced. Inspectors found that the staffing numbers and skill mix of clinical staff on both days of inspection was adequate to meet the needs of residents. However, improvements were required in staffing resources for the provision of activities. Plans were in place to increase the number of staff dedicated to the provision of activities.

Inspectors were informed that activity staff were assigned to an individual house each. However, this was not found to be in practice on one of the days of inspection or from a review of worked and planned rosters. Inspectors were told by a health care assistant that they do not assist with the provision of activities. Residents were observed to spend long periods of time alone in their bedrooms or communal spaces

with limited meaningful engagement. This was also reflected in some residents' feedback to inspectors and activity records seen.

Staff had access to mandatory training, with further dates scheduled in the weeks following the inspection. Supplementary training was available in responsive behaviours, Cardiopulmonary Resuscitation (CPR) and the prevention of pressure ulcers. Inspectors were informed that four staff were trained to take swabs for the detection of COVID-19 infection.

The supervision of staff was good. Staff were clear about their roles and responsibilities. A clinical nurse manager worked in the centre Monday to Sunday. There was an on call-out of hours system and roster in place that provided management advice if required. Staff performance reviews and appraisals were seen in a sample of records reviewed. Staff advised inspectors that they were well supported by management.

The provider had changed some room functions and the bed occupancy for one bedroom, however they had not submitted two of the four essential criteria necessary to make an application to vary condition one of the centres' current registration. Although the provider had submitted revised floor plans and an updated statement of purpose, inspectors observed, during a tour of the centre, that the submitted information did not accurately reflect the layout of the centre in all areas. This will be reflected under Regulation 23: Governance and Management.

The centre had a complaints policy issued in September 2019. There was a complaints procedure in place which was prominently displayed in the reception area for residents' and relatives' information. This information within the centre's policy and procedure required review as it referenced a contact person to manage appeals who no longer worked within the centre. Residents who communicated with inspectors on the days of inspection, reported feeling comfortable sharing any complaints or concerns they might have with staff and management. One resident said that they were confident that if they had any concerns, they would be addressed.

An annual review had been completed for 2020, which included consultation with residents and family members.

Registration Regulation 6: Changes to information supplied for registration purposes

The registered provider did not submit information within the required time frame of eight weeks' notice when notifying the Chief Inspector of changes to company personnel.

Judgment: Not compliant

Regulation 15: Staffing

Inspectors found that there was insufficient staff to provide meaningful recreational activities in line with residents assessed needs in the centre. There were 11 days on the roster for the month of July where there was one activity staff member on duty assigned to both buildings. This was not a sufficient allocation of staff providing activities for the size and layout of the centre. Evidence was noted in gaps in activity records for residents and from feedback from residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff working in the centre had access to training. From records seen, staff had attended the required mandatory training in infection prevention and control, manual handling, safeguarding of vulnerable adults and fire safety.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that following changes made to the premises, management systems had not identified the following:

- The centres statement of purpose required review to ensure it accurately detailed the occupancy and description of bedrooms in the designated centre. For example the occupancy detailed 142 residents while the centre was registered for 141.
- The floor plan had incorrect room numbers recorded and were not an accurate reflection of the designated centre.
- The management system in place did not give assurance that the service provided was safe. For example, the fire evacuation plan required review to ensure room numbers and occupancy levels of bedrooms were clear to ensure safe and timely emergency evacuations.
- Following the changes made to the premises, an application to vary condition one of the centres registration certificate was required.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The centre had a complaints policy and procedure which outlined the person in charge as the complaints officer. A staff member was also allocated to ensure that all complaints were appropriately responded to. The inspectors reviewed the complaints register for the months of April, May and June 2021. Inspectors found that the centre recorded the investigation, the outcome and the satisfaction level of the complainant.

Judgment: Compliant

Quality and safety

Overall, the findings showed that on the days of inspection, the provider was delivering good quality care and support. Residents had good access to healthcare and there was evidence of consultation with medical professionals when required. Some improvements required were identified within individual assessment and care planning, resident rights, premises and infection control.

Residents' health care and nursing needs were met to a good standard. Care records showed that residents had timely and satisfactory access to GP services, allied health and community care professionals. Where recommendations were made by specialists, these were translated into the care given and the associated care plans.

Nursing staff were found to be familiar with resident needs and records showed there were links with local community services and local hospitals to ensure residents ongoing needs were being met. A range of assessments were carried out to identify if residents needs were changing. There was also close monitoring of residents by the staff, with links to the general practitioner and other specialists as required.

While nursing staff knew residents well, the recording of care plans was not clear. This made it difficult for staff to identify resident's current care and support needs. In addition, there was a risk that new staff would not have clear guidance on how to deliver safe care. Additionally, two care plans were not developed within the required time frame. This will be further discussed under regulation 5.

Evidence was seen that end of life care decisions were made in consultation with doctors and the residents or their representatives. There were arrangements detailed in residents care plans which described where they wished to spend their final days. Where this was at the centre, the provider had made arrangements for anticipatory prescribing of medication to ensure residents were comfortable.

At the time of the inspection the COVID -19 restrictions had been eased and

residents were able to spend time in the communal areas. Some residents reported they felt there were good opportunities for social engagement within the centre. This included one-to-one activities in their rooms, small group activities in communal areas and trips out to the garden. Inspectors observed residents being supported to join activities in communal areas and the provision of a stimulating and interesting environment. Inspectors were not assured that other residents who liked to spend time in their rooms and not partaking in group activities were provided with enough opportunities to participate in activities in accordance with their interests and capacities. There was evidence of the lack of opportunity to participate in recreation in the gaps in activity records.

Residents were supported to vote in the centre when the occasion arose. They also had access to an advocacy service which was advertised in the centre. Residents were able to exercise choice in relation to how they spent their time, their food and refreshments and how they personalised their bedrooms.

Residents had access to a safe supply of drinking water and were provided with choices at mealtimes. The meals offered to residents were properly prepared, cooked and served. The provider had purchased heated food trolleys following the last inspection. This was put in place to ensure that food was served at the correct temperature for residents to enjoy.

Residents who had been identified as having weight loss, had a detailed care plan in place which had been updated following dietitian review. Sufficient staff were available to assist residents at mealtimes. There was a well-stocked kitchenette on each building, with a twenty four hour restaurant open to residents.

Inspectors reviewed the training matrix and saw that staff had training in safeguarding of vulnerable adults. A refresher training was also scheduled for the weeks following the inspection. Whilst speaking with staff members, inspectors were assured that they had the confidence, knowledge and skills necessary to report any safeguarding issues if they arose

Residents had access to television, papers, magazines, radio and the internet. The staff worked hard to maintain the links with the local community. Visiting of families and friends was facilitated in line with national guidance. Residents were also supported to attend visits outside the centre.

Infection prevention and control strategies had been implemented to effectively manage and control a potential outbreak in the centre. These included but were not limited to:

- Implementation of transmission based precautions for residents where required.
- There was a good standard of cleaning and disinfection of the centre.
- A seasonal influenza and COVID-19 vaccination program had taken place with vaccines available to both residents and staff. There had been a high uptake of the vaccines among residents and staff.

While there was evidence of good infection prevention and control practice in the

centre there were gaps in practice such as appropriate storage, hand hygiene and appropriate wearing of PPE which are further detailed under Regulation 27: Infection Control.

Overall the premises' was observed to be clean, well-ventilated and bright which were seen to be improvements from the last inspection. There were signs of wear and tear on flooring, on the paintwork and some furniture such as dining tables and bedroom furniture. The smoking cabin in one courtyard was in poor condition and was not fit for purpose. While there were plans underway to update the environment, they remained outstanding. A review of access to call bells in toilets was required, in addition to the provision of a call bell in one communal room. This was outstanding from the last inspection.
Records showed that there was a plan for refurbishment and the replacement of damaged furniture to take place in 2022. The provider carried out flooring audits every two months to identify and replace at least two bedroom carpets each month and other damaged flooring in the centre. The garden areas outside of the centre were clean and well-maintained and were planted with a wide selection of colourful plants.

There was evidence of the implementation of the provider's risk management policies and procedures in the centre. There was a risk register in place, which evidenced a good understanding of the risks in the centre. Where risks were identified, a corresponding risk assessment was in place which assessed the level of risk presented and documented control measures in place to mitigate and manage the risk. For example, risk assessments were seen to be in place relating to a trend in complaints regarding missing clothes, with proactive control measures identified and in place.

Regulation 11: Visits

Visiting was facilitated in many areas in the centre and was well managed in line with national guidelines.

Judgment: Compliant

Regulation 13: End of life

A selection of end-of-life care plans were reviewed during this inspection and were found to be respectful to resident's final wishes. Care plans which detailed residents wishes regarding their social, cultural, religious and psychological needs were in place and written in a sensitive manner.

Judgment: Compliant

Regulation 17: Premises

The registered provider had ensured that TLC Maynooth premises was appropriate to the number and needs of the residents. However, the following improvements were required to ensure the designated centre conformed to Schedule 6 of the regulations:

- There was no call bell in one communal room and call bells seen in two resident toilets were installed at a distance from the toilet. This meant that should a resident require assistance they may not be able to reach the bells.
- Carpets in some communal areas were heavily marked and stained.
- The flooring in the Oak Unit communal room had deep scrapes and marks.
- There was inappropriate storage in one communal room such as a hoist, PPE trolley and a treatment couch. This meant that this space was not available for residents to use.
- There was damage to the finishes on cupboards in Oak Units' nurses' station and kitchenette cupboards. There was damage to a large number of tables in the main dining room and Oak Unit. This meant that they could not be cleaned to the required standard.
- Inappropriate storage of used sharps bins on the floor of a sluice room awaiting collection. The provider had identified storage as an issue in this room and had a plan to install shelving to allow for adequate floor cleaning.
- The smoking cabin in one courtyard was in a poor condition and could pose a trip hazard due to uneven flooring and injury from broken glass panels splinters.
- A disused fish tank in one communal area was not clean and could impact a homely environment for residents.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Meals, snacks and drinks were seen to meet dietary and preference requirements of residents. They were well presented with a choice at mealtimes according to resident wishes.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy which had been reviewed in March 2021. This policy met the requirement of the regulations, for example, it included the measures and actions in place to control the risk of abuse and the unexplained absence of any resident.

Arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents was included in the centres safety statement and reviewed in February 2020.

Judgment: Compliant

Regulation 27: Infection control

While there was evidence of good infection control practice outlined above, there were issues important to good infection prevention and control practices which required improvement:

- Staff hand hygiene practices required review as staff were seen to wear watches stoned rings, bracelets and nail varnish. This meant that they could not effectively clean their hands.
- While there were ample supplies of personal protective equipment (PPE) available, a number staff were seen not to use PPE in line with national guidelines. For example face masks not being worn when required or were not worn correctly, gloves worn while using computer boards, and on one occasion no apron was worn when dealing with dirty laundry. This practice could pose a risk of transmission opportunities of harmful pathogens.
- One medicines storage fridge was not clean, there was brown sticky residue on the bottom shelf.
- I.V. trays in one clinical room were not clean which could pose a risk to residents if they were not cleaned before further use.

Storage practices in the centre required review from an infection prevention and control perspective. For example:

- Sterile dressings were not used in accordance with single use instructions, they were stored with un-opened dressings and could result in them being re-used.
- The doors on a cleaner's trolley were broken and could not be cleaned properly which could result in cross contamination.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While the person in charge had identified that there were issues with care plans and was taking steps to improve them, there were areas for improvement needed as follows:

- While there were care plans in place for most residents, one recently admitted resident had only one care plan to guide staff in their care delivery.
- Of two new admission care plan records seen, they were not developed within the specified timeframe.
- The format being used to show care plans meant the residents current needs could not be easily identified. The information at the end of the care plan was outdated and incorrect, with changes and updates at the start of the care plans. Incidents such as falls were also recorded in care plans. This meant clear and up-to-date information about residents needs was not easily accessible which could lead to incorrect care and support being delivered.
- While records showed that residents changing needs over time were being recorded, the care plans were not being consistently reviewed on a four month basis for example for end of life care plans.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to appropriate medical care. There was a general practitioner linked to the centre, and access to a doctor during out of hours. Referrals were made to appropriate allied health professionals when required. For example physiotherapist and speech and language therapy. There was oversight of a range of care needs, and regular reviews to ensure appropriate steps were being taken. Where recommendations had been made for care, this was reflected in residents' records.

Judgment: Compliant

Regulation 8: Protection

Inspectors reviewed a sample of safeguarding incidents. Inspectors found that these had been appropriately investigated and responded to in line with local and national safeguarding policies.

Judgment: Compliant

Regulation 9: Residents' rights

The centre recorded a daily activity report which showed residents attendance and satisfaction levels regarding the activities on offer. However improvement was required to ensure that all residents had access to enough opportunities to participate in activities in accordance with their interests and capacities.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 6: Changes to information supplied for registration purposes	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for TLC Centre Maynooth OSV-0000684

Inspection ID: MON-0033835

Date of inspection: 30/07/2021

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**
Registration Regulation 6: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes: With immediate effect the Registered Provider will comply with Registration Regulation 6 Changes to information supplied for registration purposes within the time frame prescribed (not less than 8 week)	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. By 30th of September 2021, a staffing review will have been completed to ensure appropriate provision of activities to residents while awaiting full recruitment into the vacant post. 2. One additional person has been recruited since the unannounced inspection on 29.7.2021. 3. Management are taking ongoing steps to advertise current vacancies and interview appropriate candidates with required experience and qualification. It is anticipated that the vacancies will be completed by the 30th September 2021. 4. From 6th of September 2021, Person In charge will continue to oversee comprehensive and accurate documentation of activities on a weekly basis.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The Provider and PIC will complete an application to vary and include updated floor plan along with the statement of purpose and send it to the registration office in HIQA by 30.09.21
2. PIC along with Head of Maintenance will review Fire evacuation plan to ensure rooms numbers and occupancy levels of bedrooms are clear in order to ensure safe and timely emergency evacuation. This will be completed by 30.09.2021
3. PIC will carry out a comprehensive fire safety risk assessment quarterly to identify gaps and develop improvement plans on an ongoing basis.
4. Head office have partnered with a fire protection consultant company to provide a fire risk assessment for TLC Maynooth, this has been actioned and scheduled for 30 September 2021.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Call bell to be installed to the sitting room in Oak unit by 31.10.2021.
2. Pull cord near resident toilets in corridor 1 and corridor 4 to be installed by 17.9.2021
3. Replacement of carpet in the communal areas has been allocated in the budget for completion by 30 June 2022.
4. The floor in the oak unit communal room needs to be replaced. This will be done by 30 June 2022.
5. Inappropriate use of communal areas has been addressed and all items have been removed by 13th of September 2021.
6. From 13th of September 2021, nurse managers will monitor these areas to ensure its appropriate use.
7. Oak unit nurses station is scheduled for refurbishment by 30 June 2022
8. Dining tables in all areas will be reviewed and identified for repair and/or replacement by 30 June 2022
9. By 13th of September 2021, staff have been informed to remove sharps bin to the external bin storage area on a daily basis. From 13th of September 2021, this practice will be supervised and monitored by senior management on a daily basis and audited as part of the monthly health and safety audit.
10. The smoking shed in corridor 4 to be removed and repaired/replaced by 30 June 2022
11. Fish tank to be removed from the oak unit and is now cleaned on a weekly basis. Maintenance of the fish tank will be included in the environmental hygiene audit to ensure cleaning is done on an ongoing basis from 13th of September 2021.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. From 13th of September Hand hygiene audit will be carried out on a Bi-weekly basis and staff who are found non-compliant with hand jewelry and nail varnish will be brought to the attention of management.
2. By 31st October 2021 all staff will have attended Hand Hygiene awareness sessions to ensure all staff are aware of the importance of same.
3. From 13th of September 2021 PIC will review weekly hand hygiene audits and completion of staff mandatory training in hand hygiene and discuss outcome and trends at the monthly clinical governance meeting.
4. PIC and Practice development Nurse will continue to educate staff in appropriate use of PPE including face mask, gloves and handling of linen. Staff adherence to same will be monitored and audited through weekly Infection Prevention and control audits from 13th of September 2021.
5. An audit tool has been developed to monitor the hygiene of Drug fridges, IV trays, storage of dressing material and Insulin pens. PIC will oversee the outcome of same on a monthly basis commencing 13th of September 2021.
6. New part has been ordered to replace the broken part in the cleaning trolley. Additionally, new Cleaning Trolley is included in the budget for next year and will be replaced by 31.03.2022

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:
From September 2021 Clinical Nurse Managers will audit completion of care plan every month using existing tools. Senior management will supervise and monitor completion of same actively and follow up when necessary. This audit will ensure residents care plans reflect current needs and also evaluation of care plan are completed in a timely manner.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: It is anticipated that the activities will be fully staffed by 30th of September 2021. The activities team maintain attendance record on all activities provided which will be used to ensure all residents have access and opportunities to participate in activities appropriate for them. The records will be available on EPIC and will be monitored and audited by PIC from the 30th of September 2021.	

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
Registration Regulation 6 (4)	The registered provider shall give not less than 8 weeks notice in writing to the chief inspector if it is proposed to change any of the details previously supplied under paragraph 3 of Schedule 1 and shall supply full and satisfactory information in regard to the matters set out in Schedule 2 in respect of any new person proposed to be registered as a person carrying on the business of the designated centre for older people.	Not Compliant	Orange	30/09/2021
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having	Substantially Compliant	Yellow	30/09/2021

	regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2022
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.	Substantially Compliant	Yellow	31/10/2021
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.	Substantially Compliant	Yellow	31/10/2021
Regulation 5(3)	The person in charge shall prepare a care	Not Compliant	Orange	30/09/2021

	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.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/09/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/09/2021