Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	TLC Maynooth
Centre ID:	0684
Centre address:	Straffan Road Maynooth Co Kildare
Telephone number:	01 6549600
Fax number:	01 6549200
Email address:	ctighe@tlccentre.ie
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	TLC Limited
Person in charge:	Catherine Tighe
Date of inspection:	15 March 2011
Time inspection took place:	**Start:** 10:00 hrs **Completion:** 17.00 hrs
Lead inspector:	Valerie Mc Loughlin
Support inspector:	N/A
Purpose of this inspection visit	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

- to follow-up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or well-being of residents
- to randomly "spot check" the service

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

TLC Centre Maynooth is a converted hotel which has been adapted and extended to provide 84 residential places in single-storey accommodation. It provides care for male and females over 18 years of age including people with dementia and people requiring respite care. On the day of inspection there were six residents over the age of 54 years of age, five residents aged between 60 and 70 years of age and 17 residents over 90 years of age. The centre is one of three under the consortium of the TLC Care Group.

The reception area is situated at the main entrance, and the person in charge has an office located near the reception area. There are two spacious open plan sitting areas, an activities room, a coffee dock, and a central dining room. There is a wheelchair assisted toilet off the main dining room and two toilets, one of which is wheelchair accessible, close to the dining room and the reception area. The hairdressing room and treatment room are adjacent to the sitting area.

Accommodation for residents consists of 23 twin bedrooms and 38 single bedrooms. All bedrooms have en suite shower and toilet facilities. These areas are divided into five separate areas for the purpose of allocating care.

Corridor 1 has 10 single rooms and 1 twin room. Corridor 2 has eight single rooms with a sitting area overlooking the courtyard. There is a spacious hoist assisted bathroom, and two separate bathrooms, one of which is wheelchair accessible.

Corridor 3 has 12 single rooms, some of which overlook the courtyard garden.

The Oak Unit has eight single and two twin bedrooms. It is designated as a unit to care for residents with Alzheimer's disease or dementia. Communal areas include a spacious dining room and an activities room, and residents have access to a secure courtyard garden area. The unit has a hoist assisted bathroom and there is a storeroom next to this unit.

Corridor 4 has 20 twin bedrooms, a hoist assisted bathroom, and a sitting room.

Other facilities include an overnight guest room for relatives, a cinema/library, an oratory, administrative offices and staff facilities.

The centre is surrounded by six acres of landscaped gardens with an orchard, a bowling green and an enclosed courtyard.

There are automatic gates at the main entrance and close circuit television (CCTV) in communal areas. Ample parking facilities are available.

Location

TLC Centre Maynooth is situated in the countryside of County Kildare, just off the N4, two kilometres from Maynooth town. There is a regular bus service and relatives can contact the receptionist to arrange a car to collect them from the local station.

Date centre was first established:	October 2008
Number of residents on the date of inspection	82 plus one resident in hospital
Number of vacancies on the date of inspection	1

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	28	10	29	15

Management structure

The nominated provider on behalf of the company is Dr Liam Lacey, who is the Chief Executive Officer. Michael Featherston is the Chairman of the company. The Person in Charge, Catherine Tighe, reports to the Director of Clinical Services, Liz McKeon and she reports to Dr Liam Lacey. The Assistant Director of Nursing (ADON), Wioletta Jackson reports to the Person in Charge and Clinical Nurse Managers report to the ADON. Nurses report to the Clinical Nurse Manager (CNM). Care staff report to the senior carer whom in turn reports to the Care Manager. He reports to the CNM. Catering staff, housekeeping and laundry staff are managed by the catering supervisor, and she reports to the Person in Charge. Other staff such as activities staff, administrative and portering staff report to the Person in Charge. The maintenance supervisor reports to Michael Featherston.

Staff designation	**Person in Charge**	**CNM**	**Nurses**	**Care staff**	**Catering staff**	**Cleaning and laundry staff**	**Admin staff**	**Other staff**
Number of staff on duty on day of inspection	1	1	5	11	5	7	1	10*

*The provider, Dr Liam Lacey was available on the morning of inspection. A CNM was available in a supernummery capacity. One Activities Manager, 2 Activity Coordinators, 1 physiotherapist and 4 maintenance persons were available throughout the inspection.

Background

A registration inspection was carried out on 24 and 25 March 2010. While areas for improvement were identified, overall the inspectors found that the provider and person in charge met the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

On the March inspection, inspectors found that the service was well managed and residents received a good standard of person-centred care. Staff provided care in a professional manner that respected residents' dignity.

Inspectors were satisfied that the nursing, medical and psychosocial needs of residents were met to a satisfactory standard. Staff were trained and skilled to meet the changing needs of the residents and there was ongoing continuing education programmes in place and evidenced based policies to guide their practice.

Twelve residents residing in Oak Unit had dementia but this unit was not designated as a dementia care unit and was not furnished or designed for this purpose. However, the person in charge and provider acknowledged this and had plans to develop the unit in this regard.

During that inspection some improvements were required to comply with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and *the National Quality Standards for Residential Care Settings for Older People in Ireland* as follows:

- implementation of the risk management policy
- implementation of procedures to record any medication errors or adverse reactions and or near miss in relation to each resident
- provision of meaningful and purposeful occupation and leisure activities for residents in Oak Unit (Alzheimer's unit)
- development and implementation of an emergency admission policy
- update of the directory of residents and the Residents' Guide

That report is available to residents, relatives, providers of services and members of the public, and is published on our website www.hiqa.ie.

Summary of findings from this inspection

This third inspection was unannounced and focused on the areas where improvements were required from the registration inspection carried out in March 2010. The inspector met with the provider who was on site on the day of inspection to attend a routine scheduled meeting with the senior management in the centre.

The inspector found that three of the five actions from the inspection of March 2010 had been completed, one partially completed and one action had not been completed.

The inspector found that a safety culture was now embedded in the practice of staff. They were safety conscious and promoted residents' safety. There was no longer a risk to residents of burns from hot water.

Quality improvement activity was in evidence. The person in charge had put a system in place to gather and audit information related to falls and quality of care for residents. There had been a number of quality improvements in the management of falls and provision of activities for residents with dementia related conditions. Staff had participated in training in medication management, falls management and in the provision of meaningful activities for residents.

The person in charge was new to her current position and a fit person interview was scheduled within three weeks of inspection.

Areas for further improvement included the Residents' Guide and an additional issue identified on this inspection, prescribing of some medications and recording of medication reviews. These are addressed in the Action Plan at the end of this report.

Actions reviewed on inspection:

1. Action required from previous inspection:

Implement the risk management policy. Implement and monitor control measures that reduce the risk of residents being at risk of burns from very hot water in communal bathrooms.

Implement and monitor the elopement policy to promote early detection of any vulnerable resident leaving the centre unescorted.

Implement an evidenced based audit methodology to review accidents and incidents on a regular basis.

This action had been partially completed.

Overall, health and safety practices and the management of risk promoted the safety of residents, staff and visitors.

The risk to burns from hot water had been appropriately addressed. The inspector checked the hot water in communal bathrooms and found that water was no longer too hot to touch. Residents confirmed that the temperature of the water was comfortable. The maintenance staff told the inspector that they monitored the water temperature regularly to ensure that it was safe for residents to use.

The inspector reviewed the risk management policy and found that the policy had been updated in August 2010 to provide guidelines for staff for the prevention and management of any unexplained absence of a resident. Staff spoken to were familiar with the policy and it had been implemented. The inspector reviewed a care plan for one resident with poor safety awareness and who was identified as at risk of leaving the centre. The inspector found it to be satisfactory. There was recorded evidence of consultation with the family and authorisation for the use of a safety alarm. The inspector saw records which indicated that all residents were accounted for by the nurse at the change over of the morning and evening shifts. The inspector observed a staff member supervising residents in the main sitting area. The provider had closed-circuit television (CCTV) in place and receptionists monitored the main door between 9.00 am and 10.00 pm. Staff explained that the main door and the front gate were both locked at 10.00 pm.

Incident and accident records were reviewed and found to be satisfactory. They captured the date, time, nature and outcome of incidents. Records indicated that the person in charge reviewed all incidents and accidents in a timely manner and put quality improvement measures in place to minimise risk of reoccurrence, such as commencement of behavioural logs, family meetings and GP reviews. The inspector saw that these measures were recorded in the care plans and staff could tell inspectors how residents were being monitored. However, while each incident was analysed and well managed, there was no collective review or audit of incidents over time. This meant that

trends could not be easily identified and there were missed opportunities for further learning and quality improvement.

Falls were well managed. The inspector reviewed the falls audit and noted that the number of falls were low. All residents had an evidenced based falls risk assessment completed on admission and three monthly thereafter, or more frequently if required. Staff ensured additional safety measures were put in place for residents who had fallen more than once, such as increased supervision, use of non restrictive alarms, low-low beds and the use of cushioned mats beside beds. These measures were recorded in the care plans and staff spoken to could tell the inspector about their role in falls prevention and management. The person in charge told the inspector that the use of bed side rails had been reduced by 20% following the introduction of new risk assessments. The inspector saw that two residents identified as high risk of falls used low–low beds to reduce their risk of injury. The person in charge said she was expecting a delivery of additional low–low beds in June 2011.

The inspector found that there was evidence of learning from falls and related injury from falls. There was a weekly falls prevention meeting in place which included the person in charge, ADON, nurses and the physiotherapist. There was recorded evidence that family members were also involved in falls prevention care planning. The person in charge notified the Chief Inspector as required by the Regulations of any injuries sustained by residents.

2. Action required from previous inspection:

Implement regular auditing of medication management as outlined in the medication policy

Develop and implement procedures to record any medication errors or adverse reactions, and or near miss in relation to each resident.

This action was partially met.

The inspector met with the nursing staff and they were vigilant in detecting and reporting variance in medication management practice. They had attended training in February 2011, on detecting and managing medication error and on completing the new variance reports. They explained that they reported and recorded all errors including any near misses (an error that almost happened), and any potential adverse medication reaction. Staff showed the inspector the variance reporting forms they had completed and the care plans that they had in place to address the issues. The inspector noted that interventions for residents with cogitative impairment who refused to take their medications included discussions with the GP and pharmacist to seek alternatives such as using liquid medications and seeking advice from the psychiatric service when required. Relatives of one resident told the inspector that their father's medication was well managed whenever he was upset, and that the staff always contacted them so that they could assist in his care. The inspector observed this resident with his family and staff and noted his care was well managed, recorded and monitored.

The person in charge told the inspector that the pharmacist reviewed residents' medications and that they were working towards implementing a more structured approach to medication review. She told the inspector that she had recently commenced data collection on variance in medication management practices. She planned to commence quarterly audits. The inspector found that the variance reporting form was comprehensive and well structured to collect relevant data for the purpose of audit.

3. Action required from previous inspection:

Provide opportunities for residents to participate in development of activities appropriate to his or her interests and capacities.

This action had been completed.

The inspector met with one of the activity coordinators and she had attended a number of training seminars in St James's hospital. She said that aspects of the training focused on working with people who had dementia, obtaining life stories and managing behaviours that challenge. She had undertaken a diploma in activities and she had incorporated a lot of the learning into practice. The inspector saw that she had arranged for ten residents from Oak Unit to attend a baking demonstration in the main unit on the day of inspection. The inspector noted that the activities of the day were posted in various locations in the unit and around the building. Residents said they were satisfied with the range of activities on offer such as quizzes, sing alongs and daily newspaper readings in the main sitting room.

The nursing staff and the activities coordinators were involved with the residents and their families in obtaining comprehensive social care assessments and life stories. The inspector saw detailed social care assessments and care plans in place for residents. The inspector observed the care staff spending "one to one" time with residents on the Oak Unit, playing games and chatting with residents and visitors. Some residents were provided with opportunities for meaningful occupation such as wiping the tables after coffee and clearing away the cutlery.

Relatives spoke highly of the care and attention residents received from the staff. They said that they were very happy that the same staff worked on the unit because this meant that the staff knew the residents' likes and dislikes. A visitor said that her father's memory was poor but that he recognised the staff and this made him feel content and safe. She said, "It's a home from home here and the staff play his favourite old time music which he enjoys".

Since the previous inspection the provider had made the Oak unit more homely. The inspector saw that a fire place had been installed, an old style range cooker and an old fashioned style dresser, which had a display of brightly coloured delph. There were two rummage boxes available with a variety of items of different textures and colours. Some wind mills had been provided in the secure garden and one resident said that she enjoyed going out to the garden for a walk.

The inspector noted that bedrooms were personalised with residents' private possessions, photographs and soft furnishings. Relatives told the inspector that the staff encouraged them to decorate the resident's bedroom in any way that would appeal to the resident. They said that they were in the process of making a collage of the resident's favourite photographs.

The person in charge explained that the provider had recruited an activities manager to coordinate a person-centred activities programme in the groups' three centres. The inspector met the activities manager. She explained that she worked with activity staff in each centre and she planned to spend time in the centre with the activity coordinators and staff on Oak unit from mid April. The staff were enthuastic about making further improvements such as provision of a sensory garden and decorating communal walls in line with best practice guidelines for people with dementia.

4. Action required from previous inspection:

The directory did not provide the name and address of the referring authority or organisation which arranged the resident's admission.

This action was complete.

The inspector saw that the directory of residents contained all the information required by the Regulations including the name and address of the authority, organisation or other body which arranged the resident's admission to the designated centre.

5. Action required from previous inspection:

Develop and implement as emergency admission policy as required in Schedule 5 of the Regulations.

This action had been completed.

The inspector saw that there was a comprehensive emergency admission policy in place dated August 2010, which was understood and had been implemented by staff. The policy outlined specific criteria to guide staff in the event of an emergency admission. Staff told the inspector that they would never accept an emergency admission unless the person in charge had made arrangements to accept the admission as outlined in the policy.

6. Action required from previous inspection:

Further development of Residents' Guide to includes all of the requirements outlined in Article 21 of the Regulations.

Supply a copy of Residents' Guide to the Chief Inspector and a copy to each resident.

This action had not been completed.

The inspector saw that residents were provided with a folder that contained information about the centre and a copy of the Residents' Guide. However, the Residents' Guide had not been amended since the last inspection and it did not contain all the information required by the Regulations. Information such as a summary of the statement of purpose and the complaints procedure were not included.

Other issues identified at inspection:

Medication Management

While there was evidence that residents were reviewed regularly by their GP there was no recorded evidence that residents' medications were reviewed on a three-monthly basis. The inspector noted that where medication was prescribed as required (PRN), the total dose to be administered within a 24-hour period was not recorded on the prescription. This could result in poor outcomes for residents. The person in charge said that she would address both of these issues to ensure residents' safety.

Closing the visit

At the close of the inspection visit, a feedback meeting was held with the person in charge, Catherine Tighe and the clinical nurse managers, Tintu Thomas and David Wallace to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by

Valerie McLoughlin
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

18 March 2011

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
24 and 25 March 2010	☒ Registration ☐ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced
28 January 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced
13 and 14 October 2009	☐ Registration ☒ Scheduled ☐ Follow up inspection ☐ Announced ☒ Unannounced

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Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to additional inspection report*

Centre:	TLC Centre Maynooth
Centre ID:	0684
Date of inspection:	15 March 2011
Date of response:	26 April 2011

Requirements

These requirements set out what the registered provider must do to meet the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The provider is failing to comply with a regulatory requirement in the following respect: The total dose of PRN medications to be administered within a 24 hour period was not recorded on the prescription.
Action required: Put in place appropriate and suitable practices and written operational policies relating to prescribing and administration of medications and ensure that staff are familiar with such policies and procedures.
Reference: Health Act, 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management Standard 15: Medication Monitoring and Review

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

Please state the actions you have taken or are planning to take following the inspection with timescales:	Timescale:
Provider's response: We have amended our current medication management policy with regard to PRN medication prescribing. The policy now states that the maximum dose of each PRN medication to be administered in a 24 hour period must be clearly documented by the prescriber. An operational instruction has been issued to our General Practitioners to advise them of this requirement. A receipt of same has been received. All staff have been advised of this requirement, and education on the amended medication management policy is being delivered. A medication management audit was carried out on PRN prescribing following the inspection. All residents whose PRN medication prescription does not include a maximum dose in 24 hours have been identified. Initial risk management procedures have been instituted whilst the multidisciplinary team continue to conduct a full medication review of each resident.	Complete Complete For completion by May 2011 For completion by July 2011

2. The provider is failing to comply with a regulatory requirement in the following respect: There was no collective review or audit of incidents over time.	
Action required: Implement an evidenced based audit methodology to review accidents and incidents on a regular basis.	
Reference: Health Act, 2007 Regulation 35: Review of Quality and Safety of Care and Quality of Life Standard 30: Quality Assurance and Continuous Quality Improvement	
Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: Our scheduled quarterly audit of accidents and incidents was conducted on 31 March 2011. An evidence based tool was used, adapted from guidelines issues by the State Claims Agency as used in the STARS web database.	

A copy of the audit is attached for your information. Action plans are currently in development to mitigate future risk and reduce the likelihood of recurrence.	Complete For completion by May 2011

3. The provider is failing to comply with a regulatory requirement in the following respect: The Resident's Guide it did not contain all the information required by the Regulations. Information such as a summary of the statement of purpose and the complaints procedure were not included.
Action required: Further development of Resident's Guide to includes all of the requirements outlined in Article 21. Supply a copy of Resident's Guide to the Chief Inspector and a copy to each resident.
Reference: Health Act, 2007 Regulation 21: Provision of Information to Residents Standard 1: Information

Please state the actions you have taken or are planning to take following the inspection with timescales:	**Timescale:**
Provider's response: The Residents' Guide has been redeveloped to include all the information required by the Regulations. A summary of the State of Purpose and Function now forms part of the document, and the complaints procedure is summarised. The Residents' Guide is attached for your information and a copy has been provided to each resident.	Complete

Recommendations

These recommendations are taken from the best practice described in *the National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard : Supplementary Criteria for Dementia- specific Residential Care Units for Older People	Continue to assess and develop the environment in the Alzheimer's Unit (Oak Unit) to bring it in line with dementia – specific residential care settings for older people.
	Provider's response: We note your best practice recommendations and we endeavour to continually review and develop the Oak Unit on an ongoing basis utilising evidence based practice. We are continually researching approaches to dementia specific residential care settings, and in this regard we have made links with other facilities that provide specialised dementia care. We have visited these facilities to assist us in developing idea's to improve the environment for persons with dementia.

Any comments the provider may wish to make:

Provider's response:

On 15 March 2011 we participated in an unannounced follow up inspection with the Authority. It turned out to be a very successful visit and in general was once again a very good exercise from TLC's point of view in ensuring that the care of our residents was at the forefront of our service. All points raised in the action plan have already been put in place.

I would like to take this opportunity to thank all of our staff for their loyalty, dedication and professionalism in providing the highest standards of care to our residents. I would like to thank all our residents for their help and contributions to the running of TLC Maynooth.

We feel that we provide a five star service and are committed to continuing in this vein. I would particularly like to compliment our Director of Nursing Catherine Tighe for her leadership and integrity in the continuing development of TLC Maynooth.

Provider's name: Dr. Liam Lacey
Date: 22 April 2011