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## TLC City West, OSV-0000692, 24 May 2018

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	TLC City West
<b>Centre ID:</b>	OSV-0000692
<b>Centre address:</b>	Cooldown Commons, Fortunestown Lane, Citywest, Co. Dublin.
<b>Telephone number:</b>	01 468 9300
<b>Email address:</b>	citywest@tlccentre.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	TLC Health Services Limited
<b>Lead inspector:</b>	Sheila McKeivitt
<b>Support inspector(s):</b>	Nuala Rafferty
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	135
<b>Number of vacancies on the date of inspection:</b>	4

## **About Dementia Care Thematic Inspections**

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

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

Please note the definition of the following term used in reports:  
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 23 April 2018 10:30 To: 23 April 2018 18:45

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Substantially Compliant
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Compliant
Outcome 04: Complaints procedures	Substantially Compliant	Substantially Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Compliant

**Summary of findings from this inspection**

This was an unannounced inspection conducted by two inspectors over one day. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. In order to determine this inspectors focused on six outcomes. They also reviewed information received since the last inspection, notifications submitted, followed up on action plans from the last monitoring inspection and on an action plan submitted to the ombudsman.

Ninety eight residents in the centre had a diagnosis of dementia. The centre did not have a dementia specific unit.

Inspectors found the centre met the care needs of residents with dementia in an inclusive manner. Staff had received training which equipped them to engage and work therapeutically with residents who had dementia. The environment enabled

residents with dementia to flourish. Residents with dementia had choices in relation to all aspects of their life and their personal choices were respected by all staff.

The providers self assessment was similar to those findings on inspection.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.**

*Outcome 01: Health and Social Care Needs*

**Theme:**

Safe care and support

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

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

**Findings:**

The nursing, medical and social care needs of residents were met. End of life preferences were not recorded for every resident.

Residents had access to medical and allied health care professionals. Most residents had chosen a general practitioner and pharmacist close by to care for them. They had access to a geriatrician and a consultant psychiatrist. There was no delay in referring residents for assessment to any of the allied health care team members. Inspectors saw evidence of referrals made, assessments completed and recommendations made in resident files. The provider sought external companies to come in and routinely assess residents' eyesight and dental hygiene needs. There was evidence that all residents had their medical needs reviewed on a frequent basis. The pharmacist delivered medications to the centre and conducted audits on medicines management. There was a multidisciplinary approach to reviewing medications, including psychotropic medications. The pharmacist, general practitioner and person in charge contributed to these three monthly reviews.

Residents had comprehensive assessments completed on admission. Those reviewed reflected the resident's individual needs. Each need had a corresponding care plan although these did not always reflect the care required by the resident in order to meet that need. For example, an end of life care plan reviewed did not reflect the care or medication being provided to a resident. Assessments and care plans were updated on a four monthly basis. There was evidence that residents and their families were involved in the residents care plan.

Staff provided end of life care to residents' with the support of their general practitioner and the palliative care team if required. Some residents had their end of life preferences recorded. Those reviewed reflected each resident's wishes and preferred pathway at end of life care. They were detailed and included input from both the resident, their family and general practitioner. Residents who had been transferred into and out of hospital had copies of their transfer letter from the centre to the acute hospital on file together

with nursing and medical transfer letters from the acute hospital back to the centre.

Residents nutritional needs were met and they were supported to enjoy the social aspects of dining. Inspectors saw table settings in the dining room promoted independence. Residents' were given the choice as to where they wanted to eat their meals, their choice was respected and facilitated by staff. The menu provided a varied choice of meals to residents, those with a diagnosis of dementia had the same choice as other residents. Residents who required support at mealtimes were provided with timely assistance from staff. Residents had a malnutritional risk screening tool (MUST) completed on admission and this was kept under review. They were routinely weighed and had their body mass index calculated on a monthly basis. Those with nutritional care needs had a nutritional care plan in place. There were no residents identified as at risk of malnutrition. Inspectors saw that residents likes, dislikes and special diets were all recorded. These were known by both care and catering staff.

**Judgment:**

Substantially Compliant

***Outcome 02: Safeguarding and Safety***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Measures to protect residents with dementia from harm or abuse were in place. Residents spoken with stated they felt safe in the centre. There was a policy and procedure in place for the prevention, detection and response to abuse. There was evidence that reported incidents were investigated in line with this policy. Staff spoken with had a good knowledge of what constituted abuse and they all had up-to-date refresher training in place and all had been garda vetted. The management held petty cash on behalf of a number of residents' practice observed was safe and reflected the policy. A number of residents pensions were managed by the provider. The practice reviewed reflected the centres policy. The accumulative pensions for these residents went into a separate residents' account. Residents did not have individual interest bearing accounts. This practice required review.

The centre was moving towards a restraint free environment. Residents with bed rails in place had assessments completed, a number reviewed did not state what alternatives were trialled prior to bed rails being used. Residents had care plans in place to reflect the care provided when using bed rails.

Staff spoken with had good knowledge of residents displaying behaviours that challenge. They knew the triggers, diversion therapies and psychotropic medications for individual

residents. Inspectors found that this level of detail was not reflected in residents' care plans. The use of psychotropic medications was monitored and reviewed three monthly by the multidisciplinary team. Inspectors saw that they were used as a last resort to deal with behaviours that challenge.

**Judgment:**

Non Compliant - Moderate

***Outcome 03: Residents' Rights, Dignity and Consultation***

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Residents with dementia were consulted with and actively participated in the organisation of the centre. Residents privacy and dignity was respected. They had access to meaningful activities and had choice in relation to how they lived their life.

Residents with dementia had access to advocacy services. Contact details for the national advocacy service were available throughout the centre and an independent advocate chaired two residents' meetings each year. A review of minutes from these meetings showed they took place every two months. Residents with dementia contributed at these meetings, requesting activities and meals of their choice and attended appropriate events outside of the centre. Residents with dementia were included in external trips which took place every Tuesday to a place of interest. Residents had visited the emigration museum the week previous to this inspection. Local groups came into the centre, for example children from the local primary and secondary schools have visited on a number of occasions and the residents expressed satisfaction with their visits.

Residents were treated with dignity and respect. Residents with dementia spoken with confirmed this to inspectors. Also, inspectors observed that staff including, nurses, care assistants, catering and household staff communicated and treated residents with the utmost respect. Staff appeared to know the residents well. They took time to communicate with residents and did so in a kind and patient manner.

Residents privacy was respected. They received personal care in their own bedroom or a bathroom which could be locked. There were no restrictions on visitors and residents could receive visitors in their own bedroom or in either of the many communal sitting rooms. Inspectors saw a constant stream of visitors being welcomed into the centre. Residents, staff and visitors all appeared to know each other creating a warm atmosphere.

Inspectors were told all residents were registered to vote. They were facilitated to vote within the centre or at the local polling station. Residents confirmed that their religious needs were met.

There was a wide and varied range of activities available to residents to choose from. There were four activity therapists who organised the activities and facilitated residents to take part. Inspectors saw residents taking part in activities and others just observing within the same room. Residents residing in their bedrooms informed inspectors that they were always asked by staff if they wished to take part in activities, some confirmed that they had no interest and staff respected this. Activities such as imagination gym, rummage boxes, reminisce therapy and sonas (stimulation therapy) were available to meet the needs of residents with dementia.

Residents had access to daily newspapers if requested and all residents had their own television. They had access to radios on request.

Contracts of care were signed by the resident or their next of kin, they included the room number, layout of the room and the fees to be charged.

**Judgment:**  
Compliant

#### ***Outcome 04: Complaints procedures***

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

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

**Findings:**  
The complaints of each resident with dementia, his or her family, advocate or representative, and visitors were listened to and acted upon. Inspectors noted that a record of all verbal complaints was not being maintained.

There was a complaints policy in place which met the regulatory requirements. A copy was on display on each floor inspected. Residents with dementia told inspectors that they would complain to the person in charge or any of the staff. A review of complaints recorded to date showed that they were all dealt with promptly by the designated complaints officer. The outcome of the complaint and the level of satisfaction of the complainant were all recorded. There was an appeals process. Complaints were being overseen by the clinical care director and they were discussed at management meetings. Inspectors noted verbal complaints were not being recorded when received by staff on each floor. Recording verbal complaints would enable trending and enhance complaint management.

**Judgment:**

Substantially Compliant

**Outcome 05: Suitable Staffing****Theme:**

Workforce

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

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

There were appropriate staff numbers and skill mix to meet the assessed needs of residents with dementia and for the size and layout of the centre.

There were effective recruitment procedures in place. A random number of staff files reviewed contained all the required documents outlined in schedule 2. A sample of staff nurses files checked had an up-to-date registration with the relevant professional body in place and a copy of annual staff appraisals were available for review.

Staff had up-to-date mandatory training in place. A significant number had attended education sessions on providing care to dementia residents and to those with behaviours that may challenge. Inspectors formally observed care being delivered on two different floors of the centre, overall the level of communication was neutral or task orientated. There was two observations of positive connective communication. The evidence supported the need for more training for health care staff on communication with dementia residents.

Supervision on each floor had improved since the last inspection with the employment of additional clinical nurse managers. Inspectors were informed that there was now a manger allocated to each floor, and they covered each others floor when off duty. There was also an additional an qualified member of staff on cover at night time. Inspectors observed care being delivered to residents and noted that evidence based care was not always provided. For example, on two occasions health care staff were observed standing over residents when assisting them to eat their lunch and nurses who observed this practice did not intervene. Inspectors found that qualified staff on each floor required compliant management and leadership and/or management training.

Volunteers came into the centre to interact with residents, assisting with the provision of activities and meeting the residents religious needs. A sample of volunteer files reviewed contained an outline of their roles and responsibilities and evidence that they had garda vetting in place.

**Judgment:**

Substantially Compliant

## ***Outcome 06: Safe and Suitable Premises***

### **Theme:**

Effective care and support

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

No actions were required from the previous inspection.

### **Findings:**

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

The layout and design provided a good standard of private and communal space and facilities. Residents and visitors were observed enjoying the different spaces provided. The environment was bright, clean and well maintained throughout. Hand rails were available to promote independence.

The premises offered an appropriate environment for people with dementia. The centre had a secure garden area which all residents could access from the ground floor. The sliding door which opened into this garden required review as when it was opened the large volume of cold air blew directly into an open plan seating area for residents causing a draft. Inspector noted in the complaints file that this had been brought to the providers attention by relatives. Inspectors were informed that a plan for a porch was being drawn up.

Bedrooms were comfortable, had adequate wardrobe space and storage for personal possessions. There were a mixture of single and twin rooms, all were ensuite. There was an assisted toilet close to the sitting and dining room areas. The dimensions of the bedrooms and number of bathrooms met the requirements of the National Quality Standards for existing buildings. There was a functioning call bell in all bedrooms, bathrooms and in all communal areas. Each bedroom on the first floor had wall mounted memory boxes outside the bedroom door. They were filled with personal items which would enable the resident recognise that it was their bedroom. Inspectors were informed that the plan was to install these on the all floors. Staff had developed signage with residents for their bedroom door. The sign included their name and an item of interest to them, for example, one resident loved reading and pictures of books surrounded her name. This again enabled residents with dementia to find their room independently. Improved directional signage and an increase use of colour and may assist residents' with dementia maintain their independence for longer.

The centre and its grounds were maintained to a good standard. Inspectors observed a high standard of cleanliness throughout, and residents and relatives expressed satisfaction with the facilities provided and with the standard of maintenance and cleanliness.

### **Judgment:**

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:***

Sheila McKevitt  
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 report<sup>1</sup>

<b>Centre name:</b>	TLC City West
<b>Centre ID:</b>	OSV-0000692
<b>Date of inspection:</b>	23/04/2018
<b>Date of response:</b>	24/05/2018

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 01: Health and Social Care Needs

#### Theme:

Safe care and support

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

Some care plans reviewed did not reflect the care being delivered to residents.

#### **1. Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

<sup>1</sup> 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:**

1. Continue with ongoing care planning training in the centre. This is currently being rolled out on a regular basis.
2. The Key Performance Audit (KPI) process completes a comprehensive review of 18 care plans per month evenly across the centre and highlights areas of good practice and any improvements required. Action plans are devised from this. This process will continue with the aim of improving compliance to care plans.
3. Some PCs will be moved to quieter areas to facilitate nurses to be able to have an environment conducive to recording the care that they plan to and are delivering. This will be completed by the end of June 2018.

**Proposed Timescale:** 30/09/2018

**Outcome 02: Safeguarding and Safety**

**Theme:**

Safe care and support

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

Restraint assessments did not reflect alternatives trialled prior to bed rails being used as a form of restraint.

**2. Action Required:**

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

1. Refresher training will be provided to staff to ensure that they have good awareness of the national policy, are completing & recording assessments correctly and devising appropriate care plans.
2. Key Performance Audit (KPI) process completes a comprehensive review of 18 care records per month evenly across the centre and highlights areas of good practice and any improvements required. Action plans are devised from this. This process will continue with the aim of improving compliance to this particular requirement.
3. The use of enablers/restraints/alternatives will continue to be discussed and recorded at the weekly MDT meetings and at the monthly clinical governance meetings.

**Proposed Timescale:** 30/09/2018

**Theme:**

Safe care and support

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

Residents pension being collected on their behalf by the provider was not going into an interest bearing account.

**3. Action Required:**

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

A system is in place whereby residents for whom TLC is pension agent, is lodged into an interest-bearing bank account and the interest is apportioned to each individual resident annually.

**Proposed Timescale:** 24/05/2018

**Theme:**

Safe care and support

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

Residents challenging behaviour care plans did not reflect their triggers, diversion therapies or psychotropic medications prescribed.

**4. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

1. Refresher training will be provided to staff to ensure that care plans contain all of the above in accordance with the resident's specific needs.
2. The Key Performance Audit (KPI) process completes a comprehensive review of 18 care plans per month evenly across the centre and highlights areas of good practice and any improvements required. Action plans are devised from this. This process will continue with the aim of improving compliance to care plans.
3. DON will continue to ascertain at MDT meetings whether the care plans have the required information included.
4. The use of psychotropic medication and its alternatives will continue to be discussed at the weekly MDT meetings and at the monthly clinical governance meetings.

**Proposed Timescale:** 30/09/2018

**Outcome 04: Complaints procedures**

**Theme:**

Person-centred care and support

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

A record of verbal complaints received on each unit about the operation of the centre and the action taken in response to such complaints was not being maintained.

**5. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

1. Complaints refresher training is being rolled out in May & June 2018 to ensure that all staff are aware of and follow the procedures in place.
2. CNMs will be reminded to ensure that they discuss each month's complaints data at their floor handovers and staff meetings as required.
3. A new tracker has been put in place for CNMs per floor so that they can monitor their complaints management process.

**Proposed Timescale:** 30/09/2018

**Outcome 05: Suitable Staffing**

**Theme:**

Workforce

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

Further training for staff was identified in the following areas: communication with residents with dementia and complaint management training.

**6. 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:**

1. Training is currently ongoing in the centre with all staff required to attend the 6 HSE dementia modules that are rolled out onsite. A renewed focus will be completed to ensure that all staff have attended the modules.
2. Refresher training on complaints managements will be rolled out during May & June 2018 and on an ongoing basis.
3. Continue to hold the person-centred care (dementia) committee meeting with representatives from all disciplines of staff; currently held on a monthly basis. This committee holds a training function as part of it's terms of reference.
4. Continue with having a system of ensuring that senior staff (DON/ADON/CNMs) are on the floor regularly and acting as role models for staff.
5. Continue to promote staff attendance at our monthly Dementia Café that is held for residents/families/staff and the community.

**Proposed Timescale:** 30/06/2018

