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 Carton
Name of provider:	TLC Spectrum Limited
Address of centre:	Tonlegee Road, Raheny, Dublin 5
Type of inspection:	Unannounced
Date of inspection:	19 January 2024
Centre ID:	OSV-0005800
Fieldwork ID:	MON-0042619

About the designated centre

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

TLC Carton is a purpose-built nursing home designed to meet the individual needs of the older person, while facilitating freedom and independence for the more active. TLC Carton is located off the Malahide Road and close to Beaumont Hospital, and can accommodate up to 163 male and female residents over 18 years of age. The building has three storeys consisting of 135 single bedrooms and 14 double/twin bedrooms. Each bedroom has full en-suite facilities, and furniture which includes a television, call bells and a phone. Each floor is serviced by stairwells and passenger lifts and access to outdoors spaces are available on the ground and first floor.
TLC Carton provides long term, respite care and stepdown care to meet the health and social needs of people with low, medium, high and maximum dependencies. The centre provides 24-hour nursing care. The provider's aim is to ensure freedom of choice, promote dignity and respect within a safe, friendly and homely environment that respects the individuality of each resident who chooses to reside in TLC Carton.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	147

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
Friday 19 January 2024	08:45hrs to 15:30hrs	Bairbre Moynihan	Lead
Friday 19 January 2024	08:45hrs to 15:30hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

The inspectors arrived to the centre and observed that appropriate signage was in place to alert visitors that there was outbreaks of COVID-19, Norovirus and an Influenza like illness. Hand sanitising facilities and masks were available at reception. Visitors to the the centre were restricted to nominated persons on the day of inspection. Those that did visit were supported by staff in a safe way.

Inspectors were greeted by the deputy director of nursing and following an introductory meeting inspectors were guided on a tour of the premises with an assistant director of nursing from their respective floors. During the walk around with the assistant directors of nursing, three residents with respiratory symptoms were observed in communal areas with transmission based precautions not implemented. Two of these residents were freely interacting closely with other residents. These practices are not in line with national guidance and are discussed in more detail under Regulations 23: Governance and management and 27: Infection Control.

The centre had three floors consisting of 135 single bedrooms and 14 twin rooms, 32 single bedrooms and three twin bedrooms on the ground floor; 61 single and six twin bedrooms on the first floor; 42 single and five twin bedrooms on the second floor. Some twin rooms were occupied by one resident. The first and second floor were divided into A and B on each floor. On the day of inspection the ground floor had 13 residents in isolation, the first floor had seven residents and the second floor had nine residents. Each room had access to en suite facilities. Management provided assurances that each floor had designated staff, staff changing facilities and rest rooms per floor and this was evidenced by what the inspectors observed on the day. Residents had access to a well-maintained garden which was accessed via the sitting and dining room on the ground floor. One of the doors was unlocked for residents to access the garden if they so wished. Due to the cold weather no residents were observed using it at the time of inspection.

Residents appeared happy in the centre. It was evident from talking to staff that they were familiar with the residents and were able to describe their likes and interests. Inspectors spoke with four residents and two visitors, all were complimentary in their feedback. All interactions observed between staff and residents were respectful and kind. No residents were observed in the sitting rooms during the day. Furthermore, residents in one unit did not have access to a sitting room as it was occupied by a resident isolating and the second sitting room was designated for a staff rest room. This restricted residents who had no symptoms of infection from accessing these areas.

The registered provider is registered against their statement of purpose which states that there should be six whole-time equivalent (WTE) activities co-ordinators. On the day of inspection one activities co-ordinator was on duty. Inspectors were informed that there were three WTE employed at the time of inspection. It was challenging

for one person to provide meaningful activities to 147 residents. Inspectors did not observe any group activities taking place. The activities timetable was on display outside the dining room on the ground floor. This was was not updated for the week of inspection.

The dining experience was observed in two floors. A small number of residents attended the dining rooms. Two residents were assigned per table to maintain social distancing. Residents were provided with a choice at mealtimes including residents who required a modified diet. There was a sufficient number of staff in the dining rooms to provide assistance to those residents that required it. Residents who were isolating remained in their room and meals were delivered on trays. Meal trays for residents in isolation were covered in a red alginate bag on collection from the room for cleaning in the kitchen. This practice was addressed on the day of inspection as it was time consuming and unnecessary.

Copies of newspapers were available for residents at the entrance to the centre. Residents had access to televisions in their rooms and in communal areas.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This was a risk based unannounced inspection carried out following the receipt of unsolicited information to specifically focus on the management of three infection outbreaks in the centre. Evidence was found to substantiate a number of the concerns raised with the Chief Inspector of Social Services. Overall inspectors identified that the governance and management systems in the centre were not effective to manage three outbreaks of infection and there was poor oversight of staff and staffing resources during the outbreak that was impacting on the quality and safety of residents. Following the inspection an urgent compliance plan was issued to the registered provider requesting assurances that the centre had effective systems and oversight in place in place to manage three outbreaks.

TLC Spectrum Limited is the registered provider for TLC Carton. The centre is part of a wider group who own and run a number of centres throughout Ireland. The lines of accountability and responsibility were outlined to inspectors. The person in charge reported to a regional operations manager who in turn reported to a company director who was also the registered provider representative. Inspectors were informed that the regional manager had attended on site on the day prior to inspection and was on site during the inspection to oversee the management of the outbreak. The registered provider representative and regional operations manager attended the feedback meeting at the end of the inspection via video link and in-person respectively. The person in charge worked full-time and was supported in the role by a deputy director of nursing and two assistant directors of nursing who all

worked full-time, supernumerary. All three assistant directors of nursing were on-duty on the day of inspection, one assigned to each floor. In addition, there was one clinical nurse manager working in a supernumary capacity. The person in charge was the infection prevention and control lead for the centre and the infection prevention and control link practitioner. These competing demands limited the time that the person in charge could dedicate to both the person in charge role and the the infection prevention and control lead and link roles. Inspectors identified that there was a reduction in staffing on the day of inspection. 16 staff were on unplanned leave. Management stated that they were managing the gaps in the roster with agency staff from the groups' internal agency. However, on the day of inspection there were insufficient staffing to facilitate effective implementation of transmission based precautions. For example; two healthcare assistants were rostered to care for 13 residents requiring transmission based precautions on the ground floor.

The registered provider notified the Chief Inspector of Social Services on 04 January 2024 of a Norovirus outbreak. At the time of inspection 14 residents were either confirmed as being positive for Norovirus or were displaying symptoms. Two residents remained in isolation. On 17 January, 2024 the Office of the Chief Inspector received a notification of a COVID-19 outbreak in the centre affecting three residents. On the day of inspection inspectors were informed that two residents had tested positive for Influenza A. One of those residents was admitted from another facility with influenza. A further 24 residents were presenting with symptoms of an Influenza like illness. Management and staff stated that none of these residents had tested positive for COVID-19 on an antigen test. Viral swabs were taken and were being processed at the time of inspection. Inspectors were informed that the centre was closed to admissions on the advice of public health.

The registered provider had an infection prevention and control out break preparedness plan in place which was clear and up to-date. In addition there was an infection control policy available to guide staff. However, despite having these in place, practices identified on the day of inspection were not in line with the preparedness plan or the policy.

Inspector's requested infection control audits through a documentation request at the commencement of the inspection and again in the afternoon. Three hand hygiene audits for October, November and December were provided and an audit on staff compliance with for example; adherence to the uniform policy. Audits identified issues with, for example; staff not adhering to the five moments of hand hygiene and staff knowledge of managing a resident with a multi-drug resistant organism. The audits were completed on an information technology software and inspectors were informed that there was a suite of infection prevention and control audits however, no further audits were provided. An environmental audit was completed by the household staff. This audit was identifying areas for action and it contained a time bound action plan.

Clinical governance meetings were taking place monthly. Infection control was a standing agenda item at these meetings and items for discussion included recent infections, infection control audits, vaccination uptake amongst residents and staff

and hand hygiene training. An action from the meeting was to identify an infection prevention and control link nurse for each floor. However, no action owner was identified for actions, the actions were not time bound and they had not been completed. There was evidence that outbreak meetings were taking place daily since the commencement of the outbreaks. These identified that meetings had taken place with clinical staff, household staff and public health. The meeting minutes were in draft format at the time of inspection.

An inspector reviewed the outbreak report from a COVID-19 outbreak in August 2023. The report was comprehensive and detailed lessons learned which stated that they were shared at staff meetings and reflective sessions. Actions included the "ramping up of infection prevention and control training during any outbreak" and the "strengthening of centre-wide clinical governance" and the "identification of an infection prevention and control lead for specific support". No time bound action plan accompanied these actions and there was no evidence on the day of inspection that these actions and learning were implemented**.**

An inspector reviewed the incident and complaint log. No incidents were recorded on designated centre acquired COVID-19 or influenza. This is a missed opportunity for learning. No complaints were recorded in relation to infection prevention and control.

Regulation 23: Governance and management

The registered provider had not ensured clear governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control. There was insufficient resources allocated to :

- Ensure the effective and safe delivery of care for residents in a manner that could respond to and manage outbreaks.

The management systems in the centre required strengthening to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- There were inadequate governance and management arrangements to ensure that there was effective oversight and supervision of staff to ensure that correct and effective transmission based precautions were implemented during the outbreaks of COVID-19, Norovirus and an Influenza like illness.
- The registered provider did not ensure that there was effective clinical monitoring of residents to identify those that maybe deteriorating. For example; a sample of resident observation records reviewed indicated that residents did not have twice daily observation monitoring (Temperature.Pulse.Respiration) during the outbreak in line with national guidelines. Furthermore, a sample of residents' observation charts reviewed indicated that observations were not completed regularly. Some residents displaying symptoms of an influenza like illness or who were positive for

COVID-19 did not have observations completed since the onset of their symptoms .

- No infection control audits had been completed since the onset of the outbreak. Management stated that they had completed a walk-around since the outbreaks commenced and had identified the same issues identified on inspection. However, no report was completed following the walk-around so no time bound action plan was devised to improve the areas for attention.
- Management did not provide relevant information to inspectors at the opening meeting or subsequently regarding a resident status.
- Incidents were not logged on the information technology system when residents had a confirmed diagnosis of COVID-19 and Norovirus.
- Meeting minutes reviewed of the clinical governance meeting from November 2023 indicated that an infection prevention and control link nurse was required for each floor in the centre. There was no assigned action owner and this had not been actioned at the time of inspection.
- The registered provider had developed a comprehensive preparedness plan, however, this had not been fully implemented.
- Inspectors were informed that there was sufficient supply of viral swabs in the centre, however, on review by an inspector the centre had a small number of swabs in stock. Inspectors were informed that they were ordered and the registered provider provided assurances that a supply would be provided from another centre within the group.

Under this regulation the provider was required to submit an urgent compliance plan to address the urgent risks. The provider's response did provide assurance that the risks were adequately addressed.

Judgment: Not compliant

Quality and safety

Overall, while residents expressed satisfaction with the care provided, deficits in the governance and management of the centre were impacting on effective infection control practices. Some practices used by staff were not evidenced based and in line with the centres' own policies, insufficient staff resources impacted negatively on the provision of care to the residents. Additional details of issues identified are discussed under Regulation 27.

Barriers to effective hand hygiene practice were observed during the course of this inspection. For example, there were insufficient numbers of alcohol hand gel dispensers. A ratio of one alcohol hand gel dispenser to four resident beds was observed in one area. National guidelines recommend that alcohol hand gel be readily available at point of care to promote effective hand hygiene. Management stated that they had identified that there was a risk of ingestion of the alcohol hand

gel by residents and for this reason they were not placed at the point of care. This identified risk was not risk assessed or placed on the risk register.

Overall, the ancillary facilities at the centre supported effective infection prevention and control. Clean and dirty areas were distinctly separated, and the work flow in each area was well-defined. For example; the housekeeping room included a janitorial sink and ample space for storing and preparing trolleys and cleaning equipment. This room was also well-ventilated, neat, and clean, with surfaces easy to clean. Additionally, the layout of the on-site laundry effectively separated the clean and dirty stages of the laundry process.

The inspectors found that the centre had adequate housekeeping staff and a housekeeping supervisor to meet its infection prevention and control needs. The provider had established several measures to ensure good environmental hygiene standards, including detailed cleaning protocols, checklists, and the use of color-coded cloths to reduce the risk of cross-contamination. An examination of cleaning records confirmed that all areas were consistently cleaned daily and twice daily where required. On the day of inspection one housekeeping trolley was visibly dirty which was addressed while inspectors were onsite.

The sluice room on each floor was spacious and clean with sufficient racking for bedpans, urinals and commodes.

The infection prevention and control training matrix was provided to inspectors. Staff were required to undertake infection prevention and control training online yearly. Good compliance levels with online training were identified, for example; ninety one per cent of staff had completed donning and doffing training. Management informed inspectors that they had identified a knowledge gap between the theory and practice in infection control practices in the centre. However, despite identifying it, no face to face training was provided to staff to bridge that gap. Management failed to identify that it is the responsibility of the registered provider and the person in charge to ensure that staff have access to appropriate training. Notwithstanding this, an infection control nurse from a private provider was onsite at the request of the registered provider on the day of inspection. Inspectors were informed that there was a plan to provide face to face training on the week following inspection

A sample of care plans were reviewed of residents who were in isolation. The care plans had not been updated in line with residents' changing needs and therefore were not sufficiently comprehensive enough to guide care. There was evidence from review of residents' records that residents with COVID-19 or those displaying symptoms of an influenza like illness were reviewed by a general practitioner.

Vaccination records were kept for all residents of Influenza and COVID-19 with a good uptake.The vaccination team were booked to give boosters where required.

Notwithstanding some good practices identified, significant improvements were required in outbreak management in the centre. These are discussed under Regulation 27: Infection Control.

Regulation 27: Infection control

Significant actions were required in order to ensure procedures are consistent with the *National standards for Infection Prevention Control in community services* (2018). For example:

- Inspectors identified that effective transmission based precautions had not been implemented. For example; clinical waste bins were not appropriately placed inside and outside the rooms of residents who were isolating and a number of instances were identified where staff did not complete donning and doffing correctly.
- A small number of residents with confirmed COVID-19 infection and suspected Influenza infection were not isolated and were seated in through fares or walking with purpose in their respective units while the inspectors were on site. Management had not identified this as a risk and implemented a plan to manage residents' needs and prevent the onward spread of infection.
- No updated training on transmission based precautions had taken place since the onset of the outbreak despite this being identified as an area for action in the outbreak report completed following a COVID-19 outbreak in August 2023.
- Care plans were not updated in order to guide care following residents' diagnosis or suspected of having COVID-19 and Influenza A.
- Hand hygiene practices were not always completed in line with evidence based practice. For example; a staff member was observed washing their hands in a bathroom despite a number of compliant hand wash sinks being available and located at convenient locations in each unit. A second staff member was observed walking on a corridor with gloves, removed the gloves and entered a residents' room without performing hand hygiene.
- No hand hygiene sanitisers were available at point of care. While management informed inspectors that they had identified a risk with this practice, it was not risk assessed or placed on the risk register.

Under this regulation the provider was required to submit an urgent compliance plan to address the urgent risks identified. The provider's response did provide assurance that the risks were adequately addressed.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 27: Infection control	Not compliant

Compliance Plan for TLC Carton OSV-0005800

Inspection ID: MON-0042619

Date of inspection: 19/01/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Enhanced supervision by the Deputy Director of Nursing (DDON) and Assistant Directors of Nursing (ADON) has been put in place to ensure oversight of infection control and prevention practices, oversight of care practices (including recording of physical observations and diagnosis of infection) and to ensure audits and checklists are completed. Identified issues and a plan to address same are agreed with relevant nurse managers and overseen by the Director of Nursing (DON) and Regional Director. (Complete and ongoing).

Additional audits completed by ADONs and Clinical Nurse Managers (CNMs) and overseen by the DON were introduced to ensure practices in the centre align with national guidelines and best practice including daily audits on donning and doffing, daily hand hygiene audits, daily clinical equipment cleaning checklists, twice daily resident surveillance by the nurses, bi-weekly isolation area spot checks and checks on clinical supplies such as swabs. (Complete and ongoing).

Following closure of the outbreak, a Root Cause Analysis (RCA) will be undertaken by the Provider and the centre's preparedness plan will be updated by the DON to capture any learning. Implementation of same will be overseen by the Regional Director and kept under regular review at monthly governance meetings from March 2024 onwards to ensure the learnings are reflected in practice.

Four identified nurses are to complete an Infection Prevention and Control (IPC) course on 4 March 2024 and will serve as IPC Link Nurses to support the IPC lead, to support and improve IPC practices and deliver training onsite.

The Provider has agreed a revised approach within the centre for providing information requested by inspectors in a timely manner. The availability of prescribed records including care is now audited quarterly by a Regional Director.

All staff have been reminded of the need to update electronic records following a confirmed diagnosis of COVID-19, Norovirus or similar. Adherence to this is monitored by an ADON and reviewed by the Person in Charge.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

Enhanced supervision by the Deputy Director of Nursing (DDON) and Assistant Directors of Nursing (ADON) has been put in place to ensure implementation of effective transmission based precautions (including equipment such as clinical waste bins & personal hand hygiene sanitisers); oversight of infection control and prevention practices and to guide staff where applicable to adhere to IPC guidelines (Complete & Ongoing).

Following the inspection, the management of residents positive or suspected with COVID-19 or Influenza infection was reviewed by the Regional Director, DON and an external IPC Nurse specialist. Following discussion with the resident and their family (as applicable) alternative isolation arrangements were introduced to more effectively manage the risk of onwards transmission of infection while still meeting the needs and wishes of each resident (Complete).

Care plans of residents identified in the line listing are audited daily by CNMs and overseen by ADONs to ensure that nursing interventions prescribed effectively guide staff caring for residents' diagnosed or suspected of having COVID-19 and Influenza infection.

Enhanced IPC training focusing on transmission-based precautions, refresher hand hygiene and donning & doffing commenced immediately post-inspection and will continue until closure of outbreak.

The process whereby assessed risks are escalated and placed on the register has been reviewed and revised by the Regional Director to ensure assessed risks are recorded and responded to appropriately. Immediately following the inspection, the Person in Charge provided all staff with point of care hand sanitisers which addressed the assessed risk.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Red	24/01/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	24/01/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of	Not Compliant	Red	24/01/2024

	healthcare associated infections published by the Authority are implemented by staff.			